Essays are divided and labelled as those aimed at either introductory or for more advanced undergraduate students, where more depth of answer will be required.

Chapters 1 – 3

Introductory: **Outline and critically evaluate three models of the development of phobias**

After an introduction in which phobias are defined, ideally using a technical description such as that given by DSM 5:

- The most obvious starting point in this essay would be a description of the basic classical conditioning process that results in the development of phobias. A conditioned emotional response analogous to the conditioned responses in animals explore by Pavlov.
- That is, a previously neutral stimulus (e.g. car) which is paired with an unconditioned stimulus (fear associated with a car accident) becomes a conditioned stimulus and elicits of fear response.
- A second arm of the process which accounts for the continuation of the conditioned fear responses involves the operant conditioning response of negative reinforcement in which the individual is rewarded for avoiding the feared stimulus through the reduction of anxiety. This second process was initially described by Mowrer (1947).
- This basic model can be criticised on a number of grounds, including people experiencing phobias in the absence of a conditioning experience and the apparently odd distribution of phobias, with high levels of phobias to benign animals such as spiders, but low levels of phobias to cars, guns etc that carry considerable threat value.

The essay could then take a number of tuns. Ideally a second and third model would be compared to the behavioural model. What does each add or change in our understanding of phobias?

- The evolutionary, *preparedness*, model of Seligman explained why we may be more likely to develop phobias to little creatures than the basic conditioning model.
- The *social learning model* of Bandura, with his emphasis on *vicarious learning*, adds to the basic behavioural model by explaining how we 'learn' phobias from observation of other people.
- The *cognitive behavioural model* considers not just the association between a stimulus and response, but explains how our thinking about, our appraisal, of a stimulus can explain why we develop a fear. A car phobia, for example, may be explained by an expectation that driving a car is likely to result in a life-threating crash, and so on.

Critically, none of these explanations replace the basic model of phobias, but they embellish it and add to its explanatory power. The behavioural model still sits at the heart of our explanations of phobias as it does to their treatment.

Advanced: **Outline and critically consider the development of the three so-called 'waves' of psychological treatments for emotional problems.**

The three waves of psychological therapies can be considered in terms of their key attributes.

- The first wave therapies were based on simple conditioning models, and best suited to the treatment of anxiety conditions such as phobias and/or obsessive-compulsive disorder. Key to their approach was the notion of exposure to the feared stimulus, whether in a graded

manner (known as systematic desensitization) or more rapidly using a procedure known as flooding. Both approaches evoked behavioural explanations for any reductions in anxiety, involving counter conditioning (replacing a fear response with a relaxation response to the feared stimulus) or habituation to the feared stimulus. The interventions proved effective and remain at the heart of modern treatments for anxiety.

- The second wave therapies shifted the emphasis in two key ways:
    - Firstly, by shifting the emphasis of therapy to the changing of cognitions – the beliefs driving the problems the person is facing.
    - Secondly, and as a consequence of this more generic theoretical shift, the therapies could be used to treat a wider range of conditions, with treatments for depression developed by clinicians such as Beck and Ellis gaining significant traction. These so-called cognitive behavioural therapies remain the mainstay of clinical psychology.
    - It is important to note that this shift to a more cognitive approach was evolutionary rather than revolutionary. Despite Beck's approach being called 'cognitive therapy', it included significant behavioural elements. A key strategy in the treatment of depression, for example, was known as 'behavioural hypothesis testing'. This involved setting new goals that may have previously been avoided or feared and learning that these were manageable and that any fears were exaggerated. Critical to the cognitive approach was that this process may be supported by the use of new more positive appraisals established in therapy using procedures such as Socratic dialogue. Accordingly, therapies aimed to improve mood/reduce anxiety through a combination of changing cognitions and changing behaviour.

- The third wave began to challenge the need for this dual approach. Theorists such as Teasdale argued that procedures such as Socratic dialogue achieved short term cognitive change, but long-term change required evidence to support them. That is, long-term cognitive change was developed through the behavioural testing of any new beliefs. Successful behaviour change (e.g. in the context of depression success in during behavioural hypothesis testing; in the context of anxiety, exposure to the feared stimulus) resulted in long-term cognitive change (Yes, I *can* do it!), which led to long term emotional benefits. More radical therapies such as Acceptance and Commitment Therapy (ACT) were based on more behavioural principles. Behaviour change was seen as paramount, with cognitive change either deemed irrelevant or secondary. So, therapies such as meta-cognitive therapy of Wells and ACT, although they had differing theoretical underpinnings began to focus on behavioural change as key to improvements in mood.
- In this way, there has been something of a circularity in these waves, with waves one and three largely involving behavioural interventions (albeit with those in the third wave being often more elaborate than those in the first), while wave two focused on direct attempts to change cognitions.

Chapter 5

Introductory-advanced: **Identify and critically consider the role of external psychosocial factors in the development of mental health problems.**

- An introductory paragraph may note that most psychological models of mental health problems pay little account to factors beyond the individual that do moderate the risk of their onset. Yet, there are a range of factors that influence risk both in the long and short-term. Long-term factors include prenatal and perinatal stresses and our childhood experiences. Short-term factors focus largely on ongoing stresses associated with a range of factors including family dynamics and the stresses associated with a range of societal challenges. Note the title focuses on psychosocial factors, so although genetic and other biological factors may contribute to risk, these should not be addressed in the answer.
- *Experiences in childhood* also have significant impact on risk for mental health problems. These may include a range of experiences both within and without the home, including maternal neglect, sexual abuse, bullying, parental separation and so on. These are considered in Chapter 5. For introductory level essays, you may want to consider the evidence of links between these factors and later mental health problems.
- *More advanced level essays*, or super keen introductory level essays (!) may consider *why* and *how* these experiences give rise to later problems. Freud may explain these through unconscious processes arising from trauma. More modern explanations may focus on issues such as the development of inappropriate schema about the self and the world, failure to learn good coping strategies, and so on.
- *More immediate psychosocial factors* that may trigger problems can be found in the family (see discussion of the causes of anorexia in Chapter 5 and 12 and the problems linked to negative emotional expression in schizophrenia in chapter 13). The wider context can also impact. Financial insecurity, marital problems, the experience of prejudice and a range of other stressors can increase risk for mental health problems, including depression, anxiety, and psychosis.
- Finally, in all cases, there is no absolute relationship between events and mental health. They influence risk but don't determine it, so they are explained by a diathesis-stress approach, which states that both immediate stress and longer-term risk factors combine to trigger mental health problems.

Chapter 6 onwards

For each of the chapters concerned with specific conditions several generic forms of question can be asked.

Introductory: **Compare and contrast two therapy approaches to the treatment of [name condition]**

The key choice here may be deciding which therapy approaches to compare. At one level you may want to compare radically different approaches such as psychoanalysis and cognitive behavioural therapy. While this may be an interesting comparison, the challenge here is to identify descriptions of some therapies in sufficient depth to allow you to describe in detail and compare and contrast them. So, this question may boil down to comparing therapeutic approaches you can access in detail, which are likely to be cognitive behavioural and a third wave approach such as mindfulness or ACT.

- The essay should start, as always, with a brief introduction to the planned essay.

- Secondly, describe the nature of each treatment approach you have chosen. What are the elements of the treatment and how are they used in the context of the particular condition? This section can be guided by the discussion in the chapter relevant to the condition under examination, and referral to chapters 2 and 3 which may provide more detail on the strategies within each therapeutic approach.
- As a final discussion, consider what they have in common, how do they differ? You may also want to consider whether these differences have any impact on their outcome, although this is not a central issue to the question.

Advanced. **Critically compare and contrast two key theories that explain the development of [name condition] and how these may inform the treatment of this condition**

As an overall outline, this essay could follow a format such as:

- Brief identification of the condition in question. This could be linked to the DSM 5 diagnostic criteria. However, this is really setting the scene for the essay and should not be extensive.
- Briefly, identify which two theories that are to be addressed. These could be radically different, for example comparing psychoanalytic and cognitive behavioural theories, or more fine-grain, comparing cognitive behavioural with third wave theories such as Wells' S-REF theory.
- Under separate sections, outline each theory in some detail. This specificity may be crucial, particularly where there are relatively subtle differences between theories.
- In these same sections, consider the implications of each theory for the treatment of the condition.
    - Each factor identified by the theory as contributing to the condition needs to be addressed in therapy. Psychoanalytic models indicate the need to address unconscious processes triggered by childhood trauma, basic cognitive behavioural models need to address beliefs/schema etc, while more complex cognitive models may need to address plans, attentional biases and so on.
    - Identify strategies of change that are typical of the intervention approach and how they address these processes. In the case of anxiety, for example, exposure with response prevention may address both conditioned fear and cognitions underpinning the fear response, mindfulness may help people cope with the stress of engaging with previously feared stimuli, and so on.

A final summary section, outlining the key issues addressed and comparing the key targets and strategies of change can finish the essay.

Advanced; **Critically consider which long and short-term factors may contribute to the development of [name condition], and how they may exert this influence.**

The first part of the essay invites a relatively simple exploration of what long and short-term factors contribute to the development of a range of conditions. The second part is the more challenging as it asks to consider the mechanisms through which these influences may exert their impact.

Accordingly, the first part may involve:

- Consideration of the long-term risk factors for a condition. These may be wide-ranging, and even occur before birth. Genetic factors, and on some conditions such as schizophrenia perinatal factors, may exert an influence from birth.
- Childhood experiences may also be relevant as they may influence risk, as may background stresses in adulthood that can trigger an episode or worsening of a condition. Negative Expressed Emotion, for example, may be a significant trigger to episodes of schizophrenia.
- In addition, there may be specific factors that trigger specific conditions at any time of the life course. Being in road traffic accident, for example, may trigger a phobia or post-traumatic stress disorder, even in the absence of previous problems. Obsessive Compulsive Disorder, by contrast is likely to be a longer-term process starting in adolescence/early adulthood and gradually becoming worse over time.

The second part may be more challenging, as it invites exploration of how these factors influence risk for conditions. The first section allows for empirical links to be made between events and conditions. The second really pushes to consider how these various experiences are linked.

- Negative childhood experiences may trigger adult problems through a number of routes, including:
    - Establishing negative self or world-schema, leading to a range of disorders from depression to generalised anxiety disorder.
    - Teaching inappropriate coping behaviours (or not teaching *appropriate* coping responses), or ways of living, which are adopted by the individual leading to risk of depression, anxiety, or even anti-social behaviour disorder.
    - They may trigger neurological processes that contribute to disorders, such as the impact of stress on the developing brains of people diagnosed with schizophrenia.
    - Neglect as a child may lead to difficulties in attachment, that contributes to a range of adult disorders.
- Also important to consider is whether risk factors are specific to conditions, or if they are more generic and place the individual at risk for mental health problems in general - with the nature of those problems linked to other factors. We know, for example, that abuse or neglect as a child may increase risk for a number of mental health conditions. It may be a more generic risk factor than one that predicts specific mental health outcomes.
- Adult experiences may also contribute to risk. These may be specific events or more global stresses. But why does living in a lower SES or being single much increase risk for mental health problems? We know they increase risk, but exploration of how they achieve this would add to the essay.
- Finally, some risk contexts may trigger neurological processes. This may be particularly relevant to schizophrenia, but this association is not unique and may be relevant.

Advanced: **What is the best form of treatment for [name condition] and why?**

Well, the short answer to this question may be ‘there isn’t one!’ (see the relevant discussion in Chapter 2). But a bit more information may be necessary before this point is reached!

The essay has a reasonably standard structure.

- Identify two or three approaches to the treatment of the specified condition. The most researched approaches are cognitive behavioural interventions and third wave therapies such as Acceptance and Commitment Therapy or mindfulness. It may be best, therefore, to

describe and compare the effectiveness of these two approaches. If you want to compare a radically different approach, alternatives involve psychodynamic or humanistic therapies. But these have largely been under-researched and may be more difficult to describe and critique. A full description of the treatment approaches will be in both the relevant chapter in the second section of the book, and also one or both of chapters 2 and 3.

- Secondly, describe the nature of each treatment approach. What are the elements of the treatment and how are they used in the context of the particular condition? What do they have in common, how do they differ?
- Then, review the relevant empirical literature evaluating their effectiveness. A good starting point are meta-analyses (such as those reported in the Cochrane reviews) that provide measures of their overall effectiveness. This data is typically expressed as odds ratios (the odds of the intervention being better than a control/no treatment condition). It may also be of value to consider individual studies which the review may suggest are particularly important either due to their size or strong methodology. In this discussion you may want to consider the strength of any studies you include in your review. Strong studies, for example, will have a placebo comparison, comparison with other active interventions or have large numbers of participants.
- Finally, a summary and discussion. This may find that the interventions are equally effective, which may lead you to consider why this may be the case, perhaps drawing on evidence from the discussion in chapter 2. If there is a clear winner between the interventions you have selected, then now is the time to consider why this may be the case. What differences in the interventions may have resulted in these discrepancies? Given this is the heart of the essay, in order to to get really good marks this needs to be a substantial part of it, not a quick summary at the end.

In addition, more specific essay topics can address individual chapter topics where appropriate.

Chapter 9

Advanced: **What is recovered memory, and can we trust it in clinical settings?**

The introduction to the essay needs to define recovered memory (of sexual trauma) and briefly note its history, emerging in the 1980s and then rapidly become an almost routine occurrence, particularly among women in psychotherapy. The implications for therapy, and in particular those who were accused of sexual abuse could usefully be addressed. This is a highly charged issue with significant implications for all those involved. Accordingly, both the overall evidence and the context of the individual in therapy need to be considered.

The essay could follow a number of routes following this introduction. However, one route could be as follows:

- *What is the evidence for recovered memory?* Well, there is clear evidence that many people, and particularly women, report having spontaneous recovered memories of sexual abuse as a child. From a naïve perspective, one could therefore argue that these events have occurred and are genuine recovered memories – the argument proposed by Bass (1988). In addition, there are viable theoretical explanations for *why* these memories may be repressed and then recovered. The strongest of these explanations may be the idea of dissociation during repeated abuse leading to fragmented memories of the event that are

difficult to access and retrieve except under particular circumstances including hypnosis and/or the process of therapy. Accordingly, there is both evidence and explanation for repressed memories and their recall.

- *What is the status of this evidence?* This is the point of challenge of these data and explanations. This can take two strands:
    - There is reason to question the quality and strength of these data from a number of perspectives outlined in the chapter. These include a general lack of corroborating evidence (perhaps not a strong argument against the concept given the nature of the events), the lack of plausibility of some claims (alien abduction, gang rape etc), memory of events that are physiologically implausible and so on.
    - In addition, there are alternative explanations for the generation of memories that appear to be true, but are in fact known to be false. There is strong empirical evidence that memories of events can be implanted and embellished using relatively simple techniques. Accordingly, evidence of recovered memory needs to be obtained using methods that are robust and free from bias. This is clearly not the case in many instances of recovered memory. There is direct evidence from recordings of famous cases that memories may have been suggested and implanted. There is also indirect evidence that indicate many memories are recalled following hypnosis, direct and repeated questioning which are both known to influence memory and by a limited number of therapists. Of course, much evidence is from clinical settings, where clear experimental procedures cannot be followed. Nevertheless, there is enough evidence to lead to significant challenges to the veracity of the accumulated evidence.
- *How do these various strands of evidence reconcile?* Despite the difficulties of obtaining strong irrevocable evidence, there does appear to be a rapprochement between protagonists on both sides of the argument. In particular, some on the 'contrary' side of the argument are willing to entertain the notion that there are plausible mechanisms through which memories may be repressed and recalled, while also noting that many may also be instilled by the therapeutic process. The key may be to determine which 'memories' are which.

Chapter 11

Advanced: **What makes a psychopath? Can they be treated?**

The introduction needs to enter into the diagnostic criteria of DSM 5 which does not distinguish between Antisocial Personality Disorder (APD) and the psychopathy, unlike Hare and similar authors who distinguish between the two. Accordingly, the definition of psychopath is more likely to follow the criteria of Hare than DSM 5.

- The factors that contribute to psychopathy are as multifactorial as in other conditions. We know that maltreatment as a child is a risk factor, while the case of Fallon is indicative of the protective effect of a warm and caring family. As with APD, other negative experiences that may result in a blunting of emotions and the establishment of deviant behaviours are also likely to of relevance. Bourduin (1999), for example, noted the following risk factors: *peer relations*: high involvement with deviant peers, poor social skills, low involvement with pro-social peers; *school factors*: poor academic performance, drop-out and low commitment to education; *neighbourhood and community*: criminal sub-culture, low organizational

participation among residents, low social support and high mobility. By contrast, Burt and Klump found strong peer affiliation to be protective. These factors are perhaps more dominant in the development of APD but are likely also to have a role in the development of psychopaths.

- These, as well as genetic factors, may lead to the neurological deficits found in true psychopaths that lead to emotional blunting and a 'low fear' state. These deficits are characterised by low activation of the limbic system, responsible for emotional processing, leading to the callous and cold personality associated with psychopathy.
- How these deficits are behaviourally expressed is likely to be a function of the beliefs and behaviours established in childhood. While there are many criminal psychopaths, psychopaths may also excel in more socially acceptable settings such as driving entrepreneurship and so on. These different strategies may be driven both by childhood experiences and the beliefs established as a consequence.
- Treatment tends to focus on criminal psychopaths for obvious reasons – high functioning and successful psychopaths are unlikely to volunteer to change their personality. A number of approaches have been used to treat them including: psychoanalysis, therapeutic communities, and cognitive behaviour therapy. Unfortunately, despite early low quality evidence suggesting success for psychoanalysis, better quality studies have found no intervention to be effective.
- Given this poor outcome, a good essay would speculate on how we should treat criminal psychopaths. Both immediately following a crime and also perhaps on release from prison, considering the likelihood to re-offend.

Chapter 12

Advanced. **What are the key differences and similarities between anorexia and bulimia nervosa? Select one condition and critically consider how best to treat it?**

- The simplest way of discriminating between anorexia and bulimia is simply to identify the diagnostic criteria for each disorder, which are clearly different. However, Fairburn has argued that the two conditions are different sides of the same coin, and many people shift from one condition to the other over time. So, it is worth considering their similarities and differences in more depth.
- Differences and similarities may be considered in terms of a range of factors including:
    - *Biological underpinnings*: including the potentially different role of serotonin in each condition.
    - *The goals/cognitive factors* driving each behaviour, which may include looking attractive to gaining and maintaining control
    - *The social/family factors* that drive each condition, including the role of family control and family dynamics
- The theory of Fairburn that anorexic people are well controlled bulimics – and vice versa could be seen as a rapprochement between the two apparently very different models. That said, the evidence suggests differing aetiology and maintaining factors for both conditions, so this may not be a strong hypothesis/model.
- In terms of treatment, cognitive behavioural interventions appear to be the optimal treatment, although family therapy may also have a role, particularly in anorexia. The goals and phases of treatment vary markedly in each condition:

- For anorexia, a two-stage process is usually followed, with the first stage involving weight gain, often rewarded in a form of operant conditioning. More complex cognitive behavioural interventions (cognitive restructuring, behavioural hypothesis testing, etc) are saved for the second phase. The exact nature of the intervention is likely to be based around a formulation specific to the individual and may also usefully involve the family either meeting as a family group or separately with the therapist. The overall benefit from these interventions is unfortunately limited, and the most likely positive outcome is continued disordered eating, but at a level that does not cause concern, although complete remission is possible.
- A more structured approach is typically followed in bulimia, with the enhanced cognitive behaviour therapy of Fairburn or similar interventions appearing to be most effective. This involves primarily working with the individual with classic cognitive behavioural strategies including cognitive restructuring and behavioural hypothesis testing along side a graded withdrawal of bulimic behaviours. The approach may be popular because it follows a treatment approach familiar to most therapists, but other interventions such as interpersonal therapy and focal dynamic psychotherapy have proven equally effective. These findings may suggest common therapeutic factors that may be relevant, as discussed in Chapter 2.

Chapter 13

Advanced: **Outline and critically evaluate psychological models of psychosis.**

An introductory paragraph may focus on the problems of diagnosing schizophrenia, and the factors that have led psychologists to a more discrete series of theories that attempt to explain both delusions and hallucinations in ways consistent with modern psychological theory. The chapter provides an introduction to the theories and some of the relevant evidence. But a good essay will explore the experimental evidence beyond that considered in the chapter. The extent of evidence relevant to each theory, with the possible exception of Frith's theory of mind, is not substantial. So, identification and inclusion of relevant studies in some detail is critical to a good essay.

Key theories are: Frith's theory of deficits in the 'theory of mind', theories involving a failure to filter incoming stimuli, including the work of Hemsley, and a more psychodynamic model of delusions developed by Bentall. Each should be outlined and then the evidence for and against considered.

- *Theory of mind*: this suggests that people with schizophrenia have odd experiences and behave in apparently odd ways because they fail to develop a theory of mind. That is, they fail to develop an understanding of their cognitive processes leading to: (i) experiences of passivity, being out of control, and potentially delusions and even hallucinations, (ii) a failure to understand others minds and actions meaning they struggle in everyday interaction and may become withdrawn and isolated. There is a large corpus of evidence that supports this contention. Work on abstract thinking, understanding others' intentions, and cognitive emotions has all supported this theory as have studies of the neurological correlates of these failures. A good essay will identify relevant research beyond those considered in the chapter to support or context these conclusions.
- *Attentional failure*. Based on the limited capacity model of Broadbent within cognitive psychology, researchers such as Hemsley have argued that hallucinations result from a

failure to filter out irrelevant stimuli and giving all sensory stimuli equal weight: a process that leads to the individual becoming overwhelmed. These attentional deficits also result in the individual being unable to distinguish between their own internal verbalisations and those of other people, with a resulting confusion as to the source of such stimuli. These confusing processes lead to a confused view of the world, and hallucinations as the source of images and thoughts are difficult to determine. As with the theory or mind, there is evidence supporting these contentions, with individuals who have experienced hallucinations both evidencing attentional problems and being distressed by them.

- *Ideal v. actual self*: adopting a psychodynamic/humanistic model, Bentall argued that delusions arise from a dynamic between what the person wishes to be (their ideal self) and how they actually believe themselves to be (their actual self). As identified in a recent meta-analysis, there is consistent evidence supporting the model, but also some that directly contradicts it. The theory also needs to explain why the many people who have a discrepancy between their ideal and actual selves do not show evidence of schizophrenia or psychosis.
- Finally, a comparison of the models would be of value. Are their processes common to all, or are they unique? Do they fit a model of schizophrenia or may they contribute to our understanding of other disorders as well, or even be part of everyday experience for many with no such diagnosis.

Chapter 15

Advanced: **How effective are the psychological treatment options for the neurological problems associated with head injury and dementia?**

Although the mechanisms through which cognitive function may decline due to Alzheimer's and health injury, both conditions can result in similar types of loss of cognitive function, whether this is loss of memory, executive function, or other neurological skills.

- If one looks at the research into memory and Alzheimer's, the key approach has been relatively low key, and of modest (at best) value. Through the use of repetition and memory cues Reality Orientation aims to help maintain memory and awareness of time and place, as well as personal history and other key information. Unfortunately, it appears to be of only modest benefit, and any information that is retained is specific to the therapy, does not result in wider improvements and dissipates rapidly. For this reason, the rote learning of RO has frequently been replaced by interventions such as cognitive stimulation which aims to maximise cognitive processing rather than memory. According to Woods, this has modest but seemingly consistent benefits on measures of quality of life, memory and communication. As a consequence of this lack of success, a number of alternative, more humanistic, therapy approaches have been developed to help improve the quality of life in people with Alzheimer's.
- Efforts to improve memory in people following severe head injury have been more intensive. Early studies showed improvements in specific memories or training in tasks that require memory, such as recall of the route from A-B, were difficult to achieve and did not

generalise. As a consequence, much of the focus on memory rehabilitation following severe head injury has focused on teaching people to manage their loss of memory rather than regain it. Here, the use of diaries and other organisational aids, and training (perhaps significant training!) in their use has become perhaps the intervention of choice. Similarly, attempts to improve executive function have focused on re-learning the skills of problem solving; breaking problems down into manageable small goals, checking that new strategies are being used. The skills required to achieve the various steps, such as planning, inhibiting non-relevant behaviours and so on are practiced within the rehabilitation programme. These types of programme have achieved significant gains relative to no intervention.

- Alzheimer's Disease and severe head injury have no aetiological commonalities, and the natural history of the conditions are also very different, with Alzheimer's leading to a chronic deterioration in mental capacity, while the damage follow head injury is either static or will show modest improvement over time. Nevertheless, there are strong arguments that both conditions may benefit from similar interventions, as well as support from those around them in implementing them. For people with Alzheimer's disease these may be combined with more humanistic therapies, and perhaps be less intensively applied.