

Cambridge AS & A Level · Psychology 9990 · Notes

Anxiety and fear-related disorders

A2

Read online at pastopic.com/cambridge/psychology-9990/notes/anxiety-and-fear-related-disorders

Last checked 6 October 2026

Read first: [Research methods](#)

© 2026 Pastopic. Free for personal study. Please share the link, not the file.

What you need to know

Anxiety and fear-related disorders are a disorder in the Clinical psychology option (Papers 3 and 4). You should be able to:

1. **Diagnose them with ICD-11:** the criteria for **generalised anxiety disorder (GAD)**, **agoraphobia** and **specific phobia**, with **blood-injection-injury (BII) phobia** as the example of a specific phobia.
2. **Describe two measures:** the **Generalised Anxiety Disorder assessment (GAD-7)** and the **blood injection phobia inventory (BIPI)**, with a study of it such as **Mas et al. (2010)**.
3. **Explain fear-related disorders biologically:** the **genetic** explanation, with a study such as **Öst (1992)**.
4. **Explain them psychologically:** the **behavioural** explanation (classical conditioning, e.g. **Watson and Rayner (1920)**, "Little Albert") and the **psychodynamic** explanation (e.g. **Freud (1909)**, "Little Hans").
5. **Describe treatments:** **systematic desensitisation** for any fear-related disorder, **cognitive-behavioural therapy (CBT)**, and **applied tension** for blood-injection-injury phobia, with the key study **Chapman and DeLapp (2013)**.
6. **Evaluate all of it**, using the issues, debates and methods the syllabus names: questionnaires, psychometrics, subjective and objective data, validity, reliability, nature versus nurture, determinism versus free will, case studies, longitudinal studies, idiographic versus nomothetic, self-reports and generalisations from findings.

The cognitive explanation of phobias (DiNardo et al., 1988) was on the 2021–2023 syllabus and is **not** on the current one; it is covered briefly below only because older questions ask about it.

Understand it

Anxiety, fear and a disorder

Everyone feels fear (an alarm about a danger now) and anxiety (worry about a danger that might come). It becomes a **disorder** when the fear or worry is **excessive** (out of proportion to any real danger), **persistent** (months, not days), leads to **avoidance**, and causes real **distress or difficulty** at home, school or work. "He is scared of spiders" is not a disorder; "he is so terrified of spiders that he will not enter his own garden" may be.

ICD-11: the three disorders

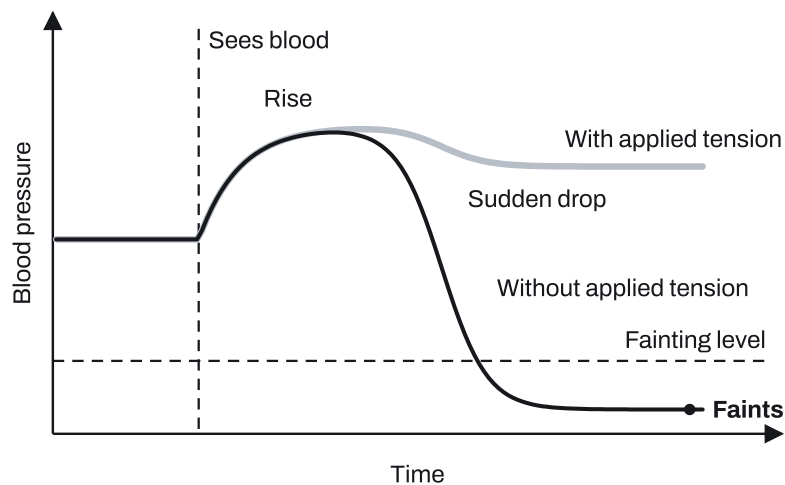
Disorder	Core feature	Other signs	Duration
Generalised anxiety disorder	free-floating apprehension, or excessive worry about many everyday things (family, health, money, school or work), on more days than not	muscle tension or restlessness; signs of an over-active sympathetic nervous system (racing heart, sweating, trembling); feeling nervous; poor concentration; irritability; disturbed sleep	at least several months
Agoraphobia	marked fear of several situations where escape might be hard or help might not be available : public transport, crowds, being outside the home alone, shops, queues	the person fears a panic attack or other embarrassing or disabling symptoms there, so they avoid the situations, go only with a trusted companion, or endure them with intense fear	at least several months
Specific phobia	marked fear that occurs every time a particular object or situation is met or expected (an animal, heights, flying, enclosed spaces, blood or injury), out of proportion to the real danger	the object or situation is avoided or endured with intense fear	at least several months

For all three, the symptoms must cause **significant distress** or **impairment** in personal, family, social, educational or work life, and must not be better explained by another condition or a drug.

Blood-injection-injury (BII) phobia

BII phobia is an extreme, lasting fear of **blood**, **injections** or **injury**, and of medical procedures such as blood tests. People avoid doctors, dentists and vaccinations, which can harm their health.

It has a body response no other phobia has: the **diphasic (two-phase) response**. When a person with another phobia meets the feared thing, heart rate and blood pressure **rise** and stay up. In BII phobia they rise at first, then **drop suddenly**. The fall (driven by the **vagus nerve**) can starve the brain of blood, and the person **faints**; this is **vasovagal syncope**. This is why BII phobia has its own treatment, applied tension.



Measure 1: the GAD-7

The **Generalised Anxiety Disorder assessment (GAD-7)** (Spitzer et al., 2006) is a short **self-report questionnaire** used to **screen** for GAD and rate how severe it is. It asks: "Over the **last 2 weeks**, how often have you been bothered by the following problems?"

1. Feeling nervous, anxious or on edge
2. Not being able to stop or control worrying
3. Worrying too much about different things
4. Trouble relaxing
5. Being so restless that it is hard to sit still
6. Becoming easily annoyed or irritable
7. Feeling afraid as if something awful might happen

Each item is scored **0** (not at all), **1** (several days), **2** (more than half the days) or **3** (nearly every day). The total runs from **0 to 21** (7×3): the higher, the more severe.

Total	Severity (Spitzer et al.'s cut-offs)
0–4	minimal
5–9	mild
10–14	moderate
15–21	severe

A score of **10 or more** usually means the person should be assessed further. Some mark schemes print slightly different bands (0–5 mild, 6–10 moderate, 11–15 moderately severe, then severe); what matters is 7 items, 0–3 each, a total out of 21, and higher meaning more severe. The GAD-7 is a **screening tool**: a high score leads to referral and a full clinical assessment, not a diagnosis by itself.

Measure 2: the BIPI, and Mas et al. (2010)

The **blood injection phobia inventory (BIPI)** measures how severe a person's BII phobia is.

- **18 situations** (stimulus content), such as seeing your own blood after a finger prick, hearing a conversation about blood, or thinking about the colour red.
- For each situation, the person rates **27 possible responses**, of three kinds: **cognitive** ("I think I'm going to faint"), **physiological** ("My heart beats faster", "I go pale") and **behavioural** ("I leave the situation at once").
- Each response is rated on a **4-point scale** from **0 (never)** to **3 (always)**; higher totals mean more severe phobia.

Mas et al. (2010) developed the BIPI in Spain and tested it on **174** Spanish-speaking participants. It had very high internal **reliability** (Cronbach's alpha of **0.98**, where 1 would be perfect agreement between items) and good **validity**: scores agreed with other measures of blood fear (concurrent and convergent validity) and were not simply measuring something else (discriminant validity). One underlying factor explained most of the answers, suggesting blood phobia is a **single** thing being measured. The BIPI is longer and more detailed than the GAD-7, so it can support a **formal diagnosis**, whereas the GAD-7 only screens.

Evaluating diagnosis and measures

Issue	For	Against
Questionnaires and self-reports	Quick and private; the person is the best judge of their own feelings; the same questions for everyone	People may under- or over-state symptoms (social desirability , embarrassment); they may misremember the last two weeks
Psychometrics	Standardised scoring lets a score be compared with norms, between patients, and before and after treatment	A number cannot capture the whole experience; the GAD-7 asks how often , not how badly a symptom disrupts life
Subjective and objective data	Scoring is objective (anyone adds the numbers the same way)	The ratings themselves are subjective judgements; "several days" and "more than half the days" are easily confused
Validity	The GAD-7's items match the ICD-11 symptoms of GAD; BIPI scores agree with other blood-fear measures (Mas et al.)	Symptoms overlap with depression and other anxiety disorders; a short screen can mislabel people
Reliability	Fixed items and scoring; the BIPI's alpha of 0.98	Answers vary with the day's mood; a 2-week window may miss changes

Explanation 1: genetic

The genetic explanation says some people **inherit** a greater tendency to develop a fear-related disorder, so phobias **run in families**. For BII phobia, what may be inherited is the tendency to the **vasovagal (fainting) response**.

Öst (1992) studied **81** people with **blood phobia** and **59** with **injection phobia**. They answered questionnaires about their history and family, and were tested while facing their fear (blood phobics watched a film of surgery; injection phobics had a finger prick), with **heart rate** and **blood pressure** recorded.

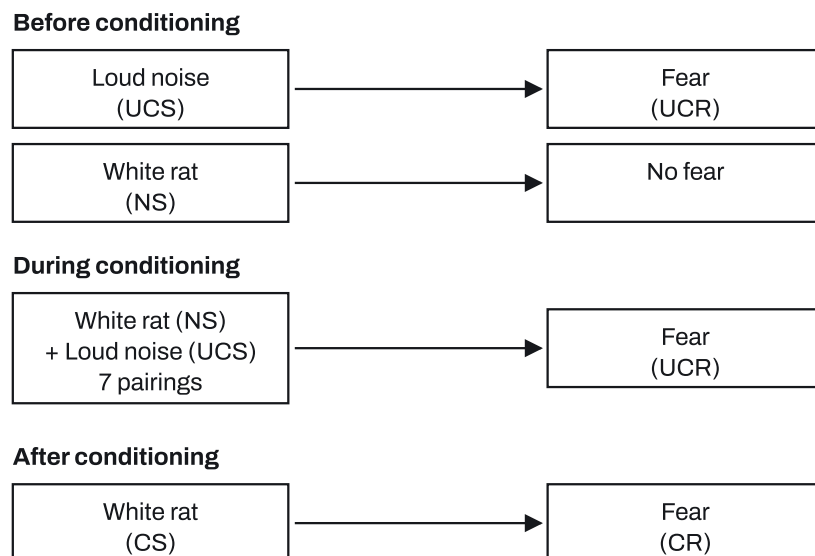
- **61%** of the blood phobics had at least one **first-degree relative** (parent, sibling or child) with the same phobia, compared with **29%** of the injection phobics.
- Blood phobics were more likely to fear fainting (**77%** against **48%**).
- **Conclusion:** blood phobia, the type most linked to fainting, seems to have a strong family (possibly genetic) link.

Family studies cannot separate genes from upbringing: a child may **copy** a parent's fear rather than inherit it.

Explanation 2: behavioural (classical conditioning)

A phobia is **learned by association**. A **neutral stimulus (NS)** that causes no fear is paired with an **unconditioned stimulus (UCS)** that naturally causes fear (the **unconditioned response, UCR**). After one or more pairings, the NS alone triggers fear: it is now a **conditioned stimulus (CS)** producing a **conditioned response (CR)**. One very frightening pairing (a trauma) can be enough. **Avoiding** the object then relieves the fear, which keeps the phobia going.

Watson and Rayner (1920), "Little Albert": Albert was a healthy baby. At about **9 months** he showed **no fear** of a white rat, a rabbit, a dog, masks or cotton wool, but he did fear a **loud noise** made by striking a steel bar with a hammer behind his head. From **11 months**, each time he reached for the rat the bar was struck. After **7 pairings** (over two sessions a week apart) the rat **alone** made him cry and crawl away. The fear **generalised** to similar furry things: a rabbit, a dog, a fur coat, cotton wool and a Santa Claus mask, and it was still there about a month later. Albert left before the fear could be removed.



Explanation 3: psychodynamic

Freud argued that a phobia is the visible sign of a hidden, **unconscious** conflict.

1. In childhood, the **id** (instinctive desires) clashes with the **superego** (the internalised rules of parents and society), often during a **psychosexual stage** such as the **phallic stage** (about 3–6 years).
2. The anxiety this causes is too much for the **ego**, so it uses **defence mechanisms**: the forbidden wish or fear is **repressed** into the unconscious.
3. The fear is then **displaced** onto a safer object that **symbolises** the real source. Fearing and avoiding a horse is easier than fearing your own father.

In the phallic stage, a boy goes through the **Oedipus complex** (desire for his mother, jealousy of his father, and **castration anxiety**); a girl goes through what is often called the **Electra complex** (**penis envy**, blaming her mother and turning towards her father). An unresolved complex can surface as a phobia of an object linked to it; Freudians would read a long, snake-like object as a **phallic symbol**.

Freud (1909), "Little Hans": Hans developed a fear that a horse would bite him or fall down, at about age 4–5. Almost all the data came from **letters** written by his **father**, a follower of Freud; Freud met Hans only briefly. Freud said Hans was in the **Oedipus complex**: he wanted his mother to himself and feared his father would castrate him. Hans **displaced** this fear onto **horses**: the black around a horse's mouth was like his father's **moustache**, and its **blinkers** were like his father's **glasses**. The phobia faded when Hans worked through the conflict in **fantasies**, such as imagining himself as the father of his own children with his father as their grandfather. The case followed Hans from about age 3 to 5, so it is **longitudinal**.

The cognitive explanation (old syllabus only)

Questions before 2024 asked for this. A phobia comes from **irrational thoughts**: after a bad experience, the person **overestimates** how dangerous the object is and believes the bad event **will happen again**. **DiNardo et al. (1988)** found that about half of people with a dog phobia remembered a frightening experience with a

dog, but so did about two-thirds of people **without** a phobia; the difference was that the phobic people expected harm to happen again. You will not be asked about this on the current syllabus.

Treatment 1: systematic desensitisation

Systematic desensitisation (SD) (Wolpe, 1958) is a **behavioural** therapy for any fear-related disorder. It **counter-conditions** the fear: the feared object becomes linked with relaxation instead.

1. **Relaxation training**: the therapist teaches **progressive muscle relaxation** (tensing then relaxing each muscle group) and slow breathing.
2. **Fear hierarchy**: therapist and patient list situations involving the feared object, from **least to most** frightening, often rating each (e.g. 0–100).
3. **Gradual exposure**: the patient meets the **lowest** item (imagined, **in vitro**, or real, **in vivo**) while relaxing, and stays until calm.
4. **Reciprocal inhibition**: you **cannot feel relaxed and afraid at the same time**, so the relaxation replaces the fear response.
5. Only when calm at one level does the patient move **up** to the next, over **several sessions**, until the top item causes no fear.

Treatment 2: cognitive-behavioural therapy (CBT)

CBT changes both the **thoughts** that keep the fear going and the **behaviour** (avoidance).

1. **Therapeutic alliance**: building a trusting, collaborative relationship.
2. **Psychoeducation**: teaching the patient about their disorder and how **thoughts, feelings and behaviour** affect each other (e.g. "avoiding the bus stops you learning that nothing bad happens").
3. **Self-monitoring homework**: a **thought diary** recording each anxious situation, the thought, the feeling and what the patient did.
4. **Challenging irrational thoughts**: the therapist uses **Socratic questioning** (open questions such as "What is the evidence? What actually happened last time?") so the patient tests the belief themselves.
5. **Replacing** them with balanced thoughts ("My heart races, but that is anxiety, not a heart attack").
6. **Exposure and behavioural experiments**: facing the feared situation, often up a hierarchy, to learn that the feared outcome does not happen. Relaxation skills may be added.

Treatment 3: applied tension for BII phobia

Relaxation **lowers** blood pressure, which would make a blood phobic **more** likely to faint. **Applied tension** does the opposite: it **raises** blood pressure to stop the sudden drop.

1. Sit comfortably and **tense the muscles** of the arms, torso and legs for about **10–15 seconds**, until the face feels warm.
2. **Release** (without relaxing completely) for about **20–30 seconds**.
3. **Repeat 5 times**; practise several times a day for a week, checking that blood pressure rises.

4. Then use it **during exposure** to blood and needles, working up a hierarchy, so the patient stays conscious long enough to lose the fear.

Key study: Chapman and DeLapp (2013)

Aim: to show how a manualised CBT programme, with **applied tension**, could treat a long-standing BII phobia. It is a **case study** of one man.

Participant: "T", a **42-year-old** white American man, **self-referred**, with fears of medical procedures for **over 20 years**: panic attacks at the doctor's and **fainting** (vasovagal syncope) when having blood taken. He could not be with his children at their medical appointments, and one of them needed frequent visits.

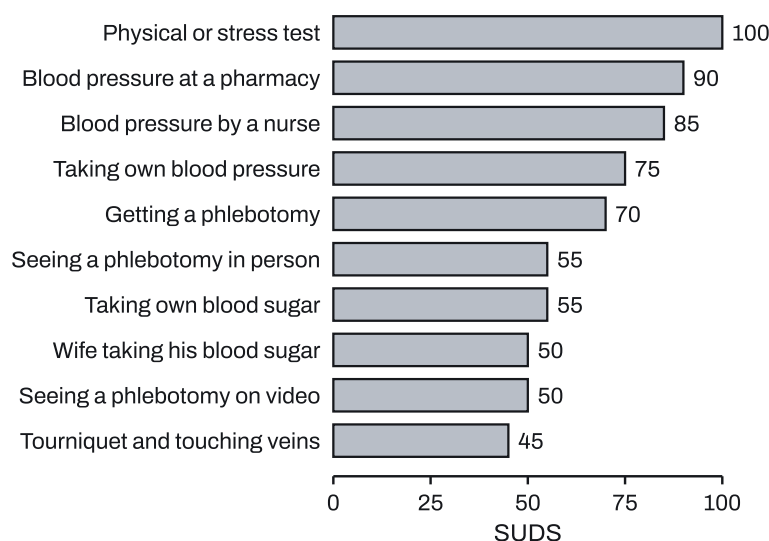
Measures at the start: the **Beck Anxiety Inventory (BAI)** (score **41**, severe anxiety), the Beck Depression Inventory, a quality of life questionnaire, a fear survey (blood rated 6, "terror"), and the **Blood-Injection Symptom Scale (BISS)**, where he reported **all 17** sensations.

Procedure: **9 sessions**, each with homework.

Sessions What happened

1–2	Psychoeducation (how common phobias are, the vagus nerve and fainting); where his fear came from; recording bodily sensations and a thought record ("I will die like my uncle and aunt at the doctor")
3	Cognitive restructuring : thinking errors such as catastrophising; treating thoughts as guesses to test, not facts; why exposure matters
4	Building an exposure hierarchy of 10 situations, each rated on the Subjective Unit of Discomfort Scale (SUDS) , 0–100
5	Learning applied tension (tense 10–15 s, release 20–30 s, 5 times, practised 5 times a day)
6–9	Exposure up the hierarchy, using applied tension when needed

T's exposure hierarchy: initial SUDS (0–100)



Results: T worked from the bottom of the hierarchy to the top. Examples of his SUDS falling:

Situation (initial SUDS)	What happened
Tourniquet and touching veins (45)	on his own, peaked at only 40: "it was fine"
Seeing a phlebotomy on video (50)	about 35–40 at the needle, using applied tension, falling to 15–20
Taking own blood sugar (55)	began at 45, then 20 with barely any tension needed
Seeing a phlebotomy in person (55)	65 waiting, then 45, 30 and finally 5; a second time from 30 to 0, with no applied tension
Getting a phlebotomy (70)	peaked at 40, then "nothing", with only a little applied tension at the start
Taking own blood pressure (75)	55, then 45, 35 and 20

After treatment he had his blood pressure taken by a nurse and a full physical without needing applied tension. Follow-ups at **4, 10 and 12 months** showed the gains had lasted: his BAI fell from **41 to 7**, and he reported only **4** of the 17 BISS sensations.

Conclusion: CBT combined with applied tension, in only 9 sessions, can successfully treat severe BII phobia, including the fainting.

Evaluation: a **case study** gives rich detail about one real patient and shows change session by session, and the **12-month follow-up** makes it **longitudinal**; but one man cannot be generalised to everyone, and it cannot show which part (CBT, applied tension or exposure) did the work. **Self-reports** (SUDS, BAI) are **quantitative** and easy to compare, but T might have under-rated his anxiety to please the therapist (**demand characteristics**). The standardised questionnaires are **nomothetic**, while the personal hierarchy and SUDS are **idiographic**.

Evaluating the explanations and treatments

Issue	Explanations	Treatments
Nature versus nurture	Genetic is nature ; behavioural is nurture ; psychodynamic is both (everyone passes through the stages, but experience decides whether a conflict is resolved). Öst's family link could be either.	SD, CBT and exposure assume fear can be unlearned (nurture); applied tension works with an inherited body response (nature).
Determinism versus free will	All three are deterministic : genes, conditioning or the unconscious cause the phobia, and the person did not choose it.	The patient chooses to enter therapy and to face the fear, so treatment involves free will .

Issue	Explanations	Treatments
Case studies	Albert and Hans give rich detail but are one child each ; Hans's data came through his father, who supported Freud's ideas, so may be biased.	Chapman and DeLapp is one man; detailed, but hard to replicate.
Longitudinal studies	Both cases followed a child over months or years, showing a phobia develop (Albert) and resolve (Hans) without relying on memory; but they took a long time and a lost participant ends the study.	Follow-ups (12 months in Chapman and DeLapp) show whether treatment lasts.
Validity	Albert's crying was easy to observe and a baby shows no demand characteristics; but deliberately conditioning a phobia is artificial. The unconscious cannot be observed or measured, so Freud's account is hard to test.	SUDS and questionnaires depend on honest self-report.
Generalisations from findings	Freud's theory claims to apply to everyone, but much rests on one boy.	Exposure-based treatments work for most patients in many studies, but some drop out because facing the fear is distressing; applied tension only suits BII phobia.
Idiographic versus nomothetic		Each hierarchy is personal (idiographic); treatment manuals and questionnaires apply the same rules to all (nomothetic).

Key facts and formulas

There is no formula list in the 9990 exam. "Learn it" means you must remember it.

Fact	Status
ICD-11 GAD: free-floating apprehension or excessive worry about many everyday things, more days than not, for at least several months, with symptoms such as muscle tension, restlessness, poor concentration, irritability and poor sleep	Learn it
ICD-11 agoraphobia: marked fear of several situations where escape is hard or help unavailable (public transport, crowds, being outside alone), fearing panic, so avoided; at least several months	Learn it
ICD-11 specific phobia: marked, out-of-proportion fear every time a particular object or situation is met or expected, so avoided; at least several months. BII phobia: blood, injections, injury; diphasic response and fainting	Learn it

Fact	Status
GAD-7: 7 items over the last 2 weeks, each 0 (not at all), 1 (several days), 2 (more than half the days), 3 (nearly every day); total 0–21; 0–4 minimal, 5–9 mild, 10–14 moderate, 15–21 severe; a screening tool	Learn it
BIPI: 18 situations, 27 cognitive, physiological and behavioural responses, rated 0 (never) to 3 (always). Mas et al. (2010): 174 Spanish-speaking participants, alpha 0.98	Learn it
Öst (1992): 81 blood phobics and 59 injection phobics; 61% against 29% had a first-degree relative with the same phobia	Learn it
Little Albert (Watson and Rayner, 1920): white rat (NS, then CS) paired with a loud noise (UCS) 7 times; fear generalised to furry objects	Learn it
Little Hans (Freud, 1909): Oedipus complex, castration anxiety, fear of father displaced onto horses (moustache, blinkers)	Learn it
Systematic desensitisation (Wolpe, 1958): relaxation, fear hierarchy, gradual exposure, reciprocal inhibition	Learn it
Applied tension: tense arms, torso and legs 10–15 s, release 20–30 s, repeat 5 times; raises blood pressure to prevent fainting	Learn it
Chapman and DeLapp (2013): T, 42, 9 sessions of CBT with applied tension; SUDS 0–100 hierarchy of 10 items; BAI 41 to 7; follow-ups at 4, 10 and 12 months	Learn it
Percentage change = $\frac{\text{new} - \text{old}}{\text{old}} \times 100$	Learn it

How to do it

We have tagged 45 questions on this topic, from 2021 to 2026 (Papers 3 and 4; 32 different questions, as variants repeat them). 25 of them have parts of more than one type, so the counts add up to 83. Questions before 2024 sometimes use the old syllabus (the cognitive explanation, Öst et al. (1989) and Öst and Westling (1995) as treatment studies): learn the current content and use those questions for the skill they test.

Question type	Questions
Describe an explanation of phobias (behavioural, psychodynamic, cognitive)	12
Evaluate an explanation of phobias	9
Apply a treatment to a named patient (SD, CBT, applied tension)	8
Describe or apply a measure (GAD-7, BIPI)	8
Evaluate a measure (GAD-7, BIPI, rating scales)	8
Describe treatments (SD, CBT, applied tension)	7
Evaluate treatments	6

Question type	Questions
Define an issue/debate and link it to this topic	6
"To what extent" essay	5
Design or plan a study	5
Chapman and DeLapp (2013) key study: recall and evaluate its method	3
Suggest another way to measure/diagnose, or how to test validity	3
Characteristics of a disorder (GAD, a specific phobia, blood phobia)	3

1. Describe an explanation of phobias (behavioural, psychodynamic, cognitive) (12 questions)

- **Behavioural** (2 marks): learned by association (1); NS paired with a UCS that causes fear until the NS alone (now the CS) produces fear (CR), e.g. Albert and the rat (1). Naming "classical conditioning" or "Little Albert" alone earns nothing.
- **Psychodynamic** (4 marks): id-superego conflict in childhood (1); repressed into the unconscious to protect the ego (1); displaced onto an object (1) that symbolises the real fear, e.g. Hans's horses standing for his father (1). Describe the **explanation**; retelling the Hans story without it, or the horse accident he saw, is not credited (June 2023 report).
- **Applied to a named child** (4 marks): use the details. A girl with a phobia of a long, thin creature: an unresolved **Electra complex**; the creature as a **phallic symbol** of her repressed penis envy; ashamed of the wish, she represses it and **displaces** the fear onto the creature rather than feeling it towards her mother.
- **Essay (6 marks, AO1)**: when two explanations are named, describe both; one only is capped at 4. Give each mechanism with its study.
- **Two case studies of a child with an animal phobia**: Albert (white rat, classical conditioning) and Hans (horses, Oedipus complex).
- **Cognitive** (old syllabus): irrational thoughts that overestimate danger after a bad experience, expecting it to recur; DiNardo et al. if linked to the explanation, not Albert or Hans (June 2021 report).

2. Evaluate an explanation of phobias (9 questions)

2 marks a point: the weakness or strength (1) explained in context (1).

- **Psychodynamic**: the childhood conflict cannot be remembered; the **unconscious, id, ego and superego cannot be measured** scientifically; data from therapy talk, dream analysis or hypnosis is **qualitative and subjective**; it rests on one case (Hans) reported by his father. **Incomplete**: a frightening real event (Hans saw a horse fall) may explain it better. It is hard to see how a phobia of the dark or heights could come from repressed id urges (June 2023 report).
- **Behavioural**: Albert shows phobias can be learned, but many people have a frightening experience and never develop a phobia, and some phobics recall no such event.

- **Genetic: reductionist and deterministic**; it cannot explain unusual phobias of harmless things (cotton wool, a type of food), which seem learned.
- "Unethical" is not a weakness of an **explanation**; and Hans's father had consented (June 2023 report). "Ignores biology" earns credit only if you say the phobia could have been inherited.
- **10-mark essays** (AO3, levelled): go issue by issue, named issue first (e.g. **longitudinal studies**: change seen over time, no reliance on memory; but time-consuming and the researcher may lose objectivity, as Hans's father did), then nature/nurture, determinism, case studies, validity. Apply each issue to both explanations rather than listing many issues for one (June 2022 report).

3. Apply a treatment to a named patient (SD, CBT, applied tension) (8 questions)

4 marks, one per step, and full marks only if every step uses the patient's details.

1. **SD**: relaxation training; a hierarchy built with the patient, with **three examples from their phobia** (lowest, middle, highest); exposure to the lowest while relaxed (reciprocal inhibition, explained); up a level only when calm; over several sessions. Hierarchy and relaxation are essential (November 2022 report).
2. **CBT** (e.g. agoraphobia): therapeutic alliance; psychoeducation **named and defined**; thought diary; Socratic questioning of one **quoted irrational thought** ("If I get on the bus I'll panic and won't be able to get off" → "Have you ever been unable to get off a bus?"); replace with a rational thought; feared outcomes don't happen, so the fear fades. Describing SD or imaginal desensitisation instead is not CBT (March 2026 report).
3. **Applied tension**: tense arms, torso and legs 10–15 s, release 20–30 s, repeat; raises blood pressure so they don't faint; practise, then use it **while facing the trigger in their situation**. Relaxation alone earns nothing.

4. Describe or apply a measure (GAD-7, BIPI) (8 questions)

- **GAD-7** (4 marks): screening self-report; 7 items (quote one or two); last 2 weeks; 0–3 with the labels; total out of 21; bands. It measures generalised anxiety, not how severe a phobia is (November 2021 report).
- **Using it with a patient**: a **baseline** before therapy, repeated during (e.g. every few weeks) and after; say which items should fall (trouble relaxing, irritability) and what scores mean (above 15 severe, keep treating; below 10, nearing discharge). Just saying "before and after" without scoring earns little (March 2025 report).
- **Why a doctor would use it**: quick (7 items, a few minutes), one item may match the complaint (trouble relaxing), and a high score leads to referral.
- **BIPI** (4 marks): 18 situations, 27 responses (cognitive, physiological, behavioural), 0–3 never to always, severity of blood phobia; examples. Not a 5-point scale or 11 items, and it does not involve injecting anyone (June 2022 report).
- **Write a physiological response statement**: worded as "I ...": "My hands get cold and clammy."

5. Evaluate a measure (GAD-7, BIPI, rating scales) (8 questions)

2 marks a point: the point (1) tied to an item, the scale or the disorder (1). A bare "social desirability" or "quantitative" earns 1 (March 2025 and November 2021 reports).

- **Strengths:** quick and simple (same 0–3 scale for every item); **quantitative**, so scores can be compared over time and between people; items general enough ("trouble relaxing") for any anxiety; 4 points allow a range of answers; standardised.
- **Weaknesses:** only **how often**, not how severe or why; "several days" and "more than half the days" overlap; only the last 2 weeks; people may hide anxiety; a screen, not a diagnosis; no chance to explain in their own words.
- **Similarity and difference, BIPI and GAD-7:** both self-reports with 0–3 scales giving quantitative scores. The GAD-7 has 7 items about general anxiety over 2 weeks and screens; the BIPI has many items specific to blood and can support a diagnosis (June 2022 report).
- **"Four-point scale"** questions: answer about the 4-point scale itself, with a blood-phobia example (November 2022 report).
- **Old 5-mark "discuss ... with a conclusion":** two strengths, two weaknesses, then a reasoned judgement, not a summary.

6. Describe treatments (SD, CBT, applied tension) (7 questions)

- **SD (2 marks):** hierarchy (1) plus relaxing at each level before moving up (1). The relaxing is what earns the second mark (June 2021 report).
- **Essay (6 marks):** describe **each** named therapy and how it reduces the fear. Chapman and DeLapp can illustrate, but say which parts are CBT (psychoeducation, thought record, restructuring, hierarchy with SUDS) and which is applied tension (tensing to raise blood pressure).
- Keep applied tension and applied relaxation apart: relaxation **lowers** blood pressure, tension **raises** it (March 2021 and March 2023 reports).

7. Evaluate treatments (6 questions)

- **2-mark weakness of SD:** needs several sessions, so commitment, time and cost; facing the fear is distressing, so some quit; hard for phobias that can't be recreated safely. "Unethical" earns nothing: the patient chose treatment and the hierarchy is built to avoid distress. They are patients, not "participants" (November 2022 report).
- **Strengths:** no drugs or side effects; relaxation and tension can be used anywhere; long-lasting (12-month follow-up); CBT tackles the thoughts behind the fear, so gains spread to other situations.
- **10-mark essays:** issue by issue with the named issue first, e.g. **generalisations** (Chapman and DeLapp is one man, but BII phobia is common and the techniques are standardised, so they may apply widely), **idiographic versus nomothetic**, **self-reports** (SUDS), **longitudinal** follow-up, **determinism versus free will** (fear is determined, but the patient chooses to face it).

8. Define an issue/debate and link it to this topic (6 questions)

Paper 3, 2+2 marks: define the term (1) + an example from this topic (1); then a weakness or reason, explained (1) and linked (1). Naming "reductionist" alone earns nothing.

- **Nature versus nurture:** how far behaviour comes from inherited traits or from the environment. Nurture example: phobias learned by pairing an NS with a fear-causing UCS. Weakness of the nature side: genetics alone can't explain odd phobias (of a type of fabric, say), so it is reductionist (March 2026 report: give the example).
- **Determinism:** behaviour caused by forces outside our control. Psychodynamic example: the phobia comes from unconscious repression and displacement (not Albert, March 2025 report).
- **Cultural differences:** how shared beliefs and norms vary between groups. They affect diagnosis because what counts as excessive depends on the culture: fear of flying hardly disrupts life where few people fly; staying at home may be a norm, not agoraphobia.
- **Situational:** behaviour caused by the environment. SD is situational because the fear is unlearned through the situations met in therapy.
- **Problem investigating the psychodynamic explanation:** the unconscious can't be observed or measured, and childhood events are forgotten.

9. "To what extent" essay (5 questions)

Old Paper 4, 12 marks: argue **both sides** of the claim with research, then **conclude**. Describing every explanation in turn scores few marks (March 2021 report).

- "Measures like the GAD-7 give no useful information": **useful** (severity, comparisons over time, quantitative, quick screening) against **not** (no reasons, honesty, a clinical interview reveals more).
- "Freud's explanation generalises from Hans to everyone": the id, ego and superego apply to all, so it claims to be universal (few realised this, November 2021 report); but one boy, data via his father, other explanations fit better.
- "The cognitive explanation is best": outline it with DiNardo, then compare with behavioural, psychodynamic and genetic (November 2022 report).

10. Design or plan a study (5 questions)

Since 2024: (a) a plan [10] with the specific features of the named method, (b)(i) the psychology it is based on [4], (b)(ii) how two features shaped the plan [4], (c) reasons and weaknesses, each about **your** plan. See the research-methods note for method features.

- **Questionnaire on GAD:** technique (online, paper), open and closed questions with examples built from the GAD-7 ("How often in the last two weeks have you had trouble relaxing? 0–3" and "Describe what you worry about most"), scoring (coding open answers into categories, with two raters), sample, ethics (right to withdraw, sources of help).
- **(b)(i):** GAD's features and the GAD-7's items and scoring, in detail.

- **Old "long-term effectiveness" designs:** for applied tension, a sample with **BII phobia** only, comparing it with something that doesn't lower blood pressure, measured with the BIPI at follow-ups. Many wrote about phobias in general or compared it with SD (November 2021 report).

11. Chapman and DeLapp (2013) key study: recall and evaluate its method (3 questions)

New Paper 4 Question 1 (10 marks).

- **Exposure hierarchy** (2): the patient's own feared situations, each given an anxiety rating (SUDS for T) and ranked, so they can be faced one step at a time starting with the easiest.
- **Situations and results:** learn the bar chart and results table. For a result, give the situation **and** numbers, e.g. "taking his own blood pressure: 75 at the start, falling from 55 to 20 in session 9".
- **Diagnosing without rating scales, ethically:** a **clinical interview** about blood and injection situations, or a controlled overt **observation** of a mild, consented situation (watching a short medical clip). Anything harmful scores 0.
- **Validity of SUDS:** T might exaggerate improvement to please the therapist or be untruthful, so it may not measure his real anxiety.
- **Quantitative data:** precise, so progress can be tracked; repeatable each session; can be compared with other patients or analysed.
- **Case study:** rich detail about a real patient (not a volunteer), could guide others; but one man, unique history, can't be replicated.

12. Suggest another way to measure/diagnose, or how to test validity (3 questions)

- **Measure without a rating scale:** observation (what the person does when shown a picture of a wound: looks away, leaves) or a clinical interview, plus one weakness (thoughts can't be observed; people may not be honest). The GAD-7 uses a rating scale, so it doesn't count (November 2022 report).
- **Validity of the GAD-7:** give it with another anxiety measure and check the scores **correlate** (criterion validity), or check scores rise with how badly anxiety affects daily life.

13. Characteristics of a disorder (GAD, a specific phobia, blood phobia) (3 questions)

2 marks, one per characteristic. Say **extreme** or **irrational** fear, not just "fear" (June 2023 report).

- **GAD:** excessive, uncontrollable worry about many things on most days; physical symptoms such as muscle tension, restlessness or poor sleep; long-lasting.
- **Specific phobia:** extreme fear out of proportion to the danger; avoidance; panic or fainting on contact.
- **Blood phobia:** irrational, persistent fear of blood, injections or medical procedures (1); blood pressure drops and the person may faint, so they avoid treatment (1). "Fear of blood" alone is not enough (June 2022 report).

Worked examples

Example 1

Kofi works on the twelfth floor of an office block but is terrified of lifts. He climbs the stairs every day and has turned down a job in a taller building. His therapist suggests systematic desensitisation.

(a) Suggest how systematic desensitisation could be used to treat Kofi's phobia of lifts. [4]

(b) Explain one weakness of systematic desensitisation for Kofi. [2]

(a) The therapist first teaches Kofi progressive muscle relaxation and slow breathing so he can calm himself (1). Together they build a fear hierarchy: lowest, looking at a photo of a lift; middle, standing in an open lift on the ground floor; highest, riding alone to the twelfth floor (1). Kofi meets the lowest item while relaxing; because he cannot be relaxed and afraid at once (reciprocal inhibition), the lift becomes linked with calm instead of fear (1). Only when calm at one level does he move up, over several sessions, until he can ride to his floor without fear (1).

(b) It needs many sessions, so Kofi must commit time and money (1); if real lift rides feel too frightening, he may stop before the top of the hierarchy, and the fear would remain (1).

Example 2

Amara is being treated for generalised anxiety disorder. Her GAD-7 item scores were 3, 2, 3, 3, 2, 2, 3 before therapy, and 1, 1, 0, 1, 1, 1, 0 after twelve weeks.

(a) Calculate Amara's total before and after therapy and state the severity of each. [2]

(b) Calculate the percentage decrease in her score, to 1 decimal place. [1]

(c) Explain one weakness of using the GAD-7 to judge whether Amara's therapy worked. [2]

(a) Before: $3 + 2 + 3 + 3 + 2 + 2 + 3 = 18$, **severe** (15–21) (1). After: $1 + 1 + 0 + 1 + 1 + 1 + 0 = 5$, **mild** (1).

(b) $\frac{18 - 5}{18} \times 100 = 72.2\%$ (1).

(c) The GAD-7 records only how often each problem happened in the last two weeks, not how severe it was (1); Amara may worry on fewer days but still be overwhelmed when she does, which the score would hide (1).

Example 3

(a) Describe the genetic explanation and the behavioural explanation of fear-related disorders. [6]

(b) Evaluate the genetic explanation and the behavioural explanation of fear-related disorders, including a discussion of determinism versus free will. [10]

(a) Genetic. Some people inherit a greater tendency to develop a phobia, so phobias run in families. In blood phobia the inherited part may be the fainting response: blood pressure rises, then drops suddenly. Öst (1992) studied 81 blood phobics and 59 injection phobics: 61% of the blood phobics had a first-degree relative with the same phobia, against 29% of the injection phobics, and blood phobics more often feared fainting. This suggests a strong family link for the type of phobia most tied to fainting.

Behavioural. Phobias are learned by classical conditioning. A neutral stimulus is paired with an unconditioned stimulus that naturally causes fear; afterwards the neutral stimulus alone (now a conditioned stimulus) causes fear (a conditioned response). Watson and Rayner (1920) showed this with Little Albert: a white rat (NS) was paired with a loud noise (UCS) that made him cry (UCR); after 7 pairings the rat alone made him cry (CR), and the fear generalised to a rabbit, a dog and a fur coat. Avoiding the feared object reduces anxiety, which keeps the phobia going.

Why it reaches the top level: both explanations are described accurately, with the mechanism, correct terms and a study for each.

(b) Determinism versus free will (the named issue). Both explanations are deterministic. In the genetic explanation, a person's genes make the phobia likely, so they did not choose it; in the behavioural explanation, Albert became afraid because of what was done to him, not by choice. This removes blame from the patient. However, the behavioural explanation leaves room for free will in treatment: what was learned can be unlearned, and patients choose to enter systematic desensitisation. The genetic explanation offers less hope, since genes cannot be changed, although applied tension shows an inherited fainting response can still be controlled.

Nature versus nurture. The genetic explanation is nature and the behavioural is nurture, but Öst's family data cannot separate the two: a child of a blood-phobic parent may copy the parent's fear rather than inherit it. The best account may combine an inherited tendency with a frightening experience.

Validity of the evidence. Albert's crying was easy to observe and a baby cannot show demand characteristics, but he was one child, conditioned deliberately in a way that rarely happens in real life. Öst used self-reports about relatives, which may be inaccurate. The behavioural explanation also struggles with people who recall no frightening event.

Why it reaches the top level: issue by issue, the named issue first and in depth, both explanations compared within each issue, with evidence from (a) and a balanced judgement.

Common mistakes

- **Writing "fear" instead of "extreme" or "irrational" fear**, or "a fear of blood" with nothing more, when asked for characteristics (June 2022 and June 2023 reports).
- **Describing how a phobia develops when a treatment is asked for**, or naming the hierarchy without the relaxing at each step (June 2021 report).
- **Mixing up applied tension and applied relaxation:** tension raises blood pressure to stop fainting; relaxation lowers it (March 2021 and March 2023 reports). Applied tension is for blood-injection-injury phobia only (November 2021 report).

- **Retelling Little Hans without the explanation**, or giving the horse accident as the psychodynamic cause (June 2023 report); the June 2023 report also did not credit a conflict "between the ego and id", so describe the id's urges against the superego.
- **Calling SD or the Hans study unethical**, or treating patients as participants (November 2022 and June 2023 reports).
- **Saying the GAD-7 measures phobias**, or wrong BIPI details (5-point scale, 11 items, injecting people) (November 2021 and June 2022 reports).
- **Unlinked weaknesses**: "social desirability" or "quantitative" with no GAD-7 item or symptom (November 2021 and March 2025 reports).
- **Wrong treatment or no context**: SD or imaginal desensitisation when CBT is asked, or nothing about the patient (March 2026 report).
- **In essays, listing many issues for one explanation** instead of applying each issue to both (June 2022 report), or describing everything in a "to what extent" essay instead of arguing (March 2021 report).

How to get the marks

- **"Identify", "give"**: short exact facts (an item, a situation, a number).
- **"Outline"** (2 marks): the point plus a detail or example.
- **"Explain" or "suggest"** (2 marks a point): the point (1) applied to the disorder, measure or patient (1).
- **Patient questions**: the person's name, phobia and situations in every step.
- **"Describe" essays** (6 marks): both named items with terms (NS, UCS, CS, repression, displacement, reciprocal inhibition, psychoeducation, Socratic questioning) and how each causes or reduces fear.
- **"Evaluate"** (10 marks): issue by issue, named issue first, both items compared, context from (a), a judgement.
- **Study results**: give **numbers** (SUDS ratings, 61% against 29%).

Quick check

1. A patient's GAD-7 item scores are 3, 2, 3, 2, 3, 2, 2. What is the total, which band is it in, and what is the highest possible total?
2. Which ICD-11 diagnosis fits each person? (a) For eight months, worry most days about money, health and family, with muscle tension and poor sleep. (b) Avoids buses and crowded markets in case a panic attack starts and there is no way out. (c) Has fainted twice at the sight of blood in films and refuses blood tests.
3. Ken heard a deafening crash of thunder while swimming in the sea, which terrified him. Now he panics at the sight of the sea. Identify the NS, UCS, UCR, CS and CR.
4. In Chapman and DeLapp (2013), T's BAI score fell from 41 to 7. Calculate the percentage decrease to 1 decimal place. How many fewer BISS sensations did he report after treatment?
5. A patient practises applied tension, tensing for 15 seconds and releasing for 30 seconds, 5 times. How long does one practice take? Why would relaxation alone not help her?

Answers

1. $3 + 2 + 3 + 2 + 3 + 2 + 2 = 17$: **severe** (15–21). The highest possible is $7 \times 3 = 21$.
2. (a) **Generalised anxiety disorder**: many everyday worries, more days than not, for months. (b) **Agoraphobia**: several situations where escape is hard, fearing panic. (c) **Specific phobia (blood-injection-injury)**: one kind of trigger, with fainting.
3. NS: the sea. UCS: the thunder crash. UCR: fear. CS: the sea (after pairing). CR: panic at the sea.
4. $\frac{41 - 7}{41} \times 100 = 82.9\%$. $17 - 4 = 13$ fewer sensations.
5. $(15 + 30) \times 5 = 225$ seconds, **3 minutes 45 seconds**. Relaxation lowers blood pressure, which in blood phobia makes fainting more likely; tensing raises it.

Past questions to try

- [9990/33/O/N/24 Q1](#): systematic desensitisation for a patient's phobia.
- [9990/32/M/J/24 Q1](#): applied tension for a patient's blood and injection phobia.
- [9990/42/F/M/24 Q2](#): GAD-7 scoring, testing its validity, a strength and a weakness.
- [9990/33/M/J/24 Q4](#): essay on the behavioural and psychodynamic explanations with longitudinal studies.