Abnormal psychology

To what extent do biological, cognitive and sociocultural factors influence abnormal behavior?

Biological factors

**Genetic predisposition (e.g. depression, schizophrenia, anorexia nervosa)**

**Imbalance of neurotransmitters (anorexia nervosa and depression – serotonin, schizophrenia - depression**

**Hormones (anorexia nervosa: cortisol, orexin)**

**(Caspi 2003)**

Aim: To investigate the relationship between the 5-HTT gene (The serotonine transporter gene) and depression  
Participants: 847 Caucasian New Zeelanders  
Dependent variable: Self report on depression  
Controls: Checked that participants were honest in self report by cross checking with friend, same levels of stressful life events  
Findings: Having a short allele of the 5-HTT gene correlated with increased vulnerability for depression between ages of 21 to 26

Cognitive factors  
  
Cognitive theorists believe that abnormality is caused by unrealistic, distorted or irrational understanding, perceptions and thoughts about oneself, others or the environment. Abnormal behavior is also caused by difficulty in controlling thought processes or using them to control actions

- A depressed mood can lead to depressed thoughts

  - Depressed cognitions, cognitive distortions, and irrational beliefs produce disturbances in mood

Goldapple (2004)

**Aim:** To investigate how cognitive behavior therapy affects brain changes

**Research method:** Experiment

**Procedure:** PET scans were used to document brain activity before and after 15 to 20 therapies of cognitive therapy over seven weeks in 14 patients. PET scans from a previous study on participants taking antidepressants were used as a control group. Participants were screened to ensure that they had no substance problems or antidepressant treatment one month prior to the study. Some of the participants reported reported previous negative experiences with drug therapy

**Findings:** there were significant changes in glucose metabolism in prefrontal-hippocampal pathways. The changes on the brain were the same as with antidepressants.

Lyon & Woods (1991)

Compared 70 Cognitive Therapy outcone studies with behavior therapy and other psychotherapies.

Cognitive therapy demonstrated better improvement than other groups

Effect size was related to therapist experience and duration of therapy

There were some methodological flaws: attribution rates (some participants dropped out) and lack of follow updata.

These studies show that cognitive factors influence abnormal behavior because they can affect a persons thoughts or cognition.

They're mood changes after the therapy, which aims to change their thought patterns.

Since their moods have improved after therapy, we can assume that their mood is affected by negative thoughts

**Weakness:** It ignores the other factors and only focuses on one factor. Does not take into account the biological and sociocultural factors

**Strengths:** It is testable and applicable- it is supported by studies.

**Sociocultural factors**

-       Members of society that break social and cultural norms are defined as abnormal

-       Labeling people as abnormal establish clear norms of reality and appropriate behaviour (*conformity*)

-       In order to keep their definition of reality, the family, general practitioners and psychiatrists conspire against the “insane” by imprisoning and degrading them as human beings

-       Social identity theory: People who are not included in the in-group are defined as abnormal

-       Abnormal behaviour violates moral or ideal standards or differs from commonly accepted beliefs or ways of thinking. It is a way to find a dispositional cause of disruptive behaviour instead of situational factors *(fundamental attribution error).* Instead of saying “evil”, “bad” or “crazy”, we say “anti-social personality disorder” or “schizophrenia”.

-       What is abnormal in one culture (e.g. *strange visions, speech and behaviour*) might be regarded as special or sacred in another culture (e.g. *shamanism*)

**Supporting evidence**

•Different countries have different tools for diagnosis (e.g. DSM IV-TR in United states, CCMD-3 in China)

•Homosexuality was considered to be abnormal until DSM-III (1980). It is still considered abnormal in many countries.

•Unmarried mothers in Britain and political dissidents in the Soviet unions were once confined to institutions for abnormality. The tendency for American black slaves in the 1800s to try flee captivity was considered to be a mental illness. It is claimed that psychiatry also have been used to silence political dissidents in China (e.g. t*he Falungong movement*)

•The existence of culture-bound syndromes (*emics*)

•Gender differences in mental health (which may be due to differences in social expectations)

•Cultural variations in the prevalence of certain disorders

**Challenging evidence**

•The universality (*etics*) of some disorders (e.g. eating disorders, depression and behaviours associated with psychosis – e.g. delusions and hallucinations)

•Inuit tribes have linguistic distinctions between “shaman” and “crazy people” in their society (Murphy 1976)

•Many people voluntarily seek help because of their problems

**Research example: Anorexia nervosa**

Warin 2001: Culture & Anorexia  
Aim: how people dealt with anorexia in the context of their everyday lives  
Participants: 46 women and men with anorexia in Australia, Canada and Scotland  
Findings:   
-participants did not always experience anorexia as a mental disorder  
-some actually saw it as "an empowering process that opened up a whole new way of relating to the world"  
-patients joined together in treatment settings to form highly secretive "cults" or "clubs" with others who shared their diagnosis

Evaluate psychological research (that is, theories and/or studies) relevant to the study of abnormal behaviour.

Biopsychosocial model explanation

The biopsychosocial model is a general model or approach that conceives that biology, psychology and social factors all play a significant role in human functioning (in the context of diseases of illness). It is understood however that health is best explained in terms of a combination of biology, psychology and social factors, rather than just merely in biological terms.

* The biological component of the biopsychosocial model seeks to understand how the cause of the illness stems from the functioning of the individual's body.
* The psychological component of the biopsychosocial model looks for potential psychological causes for a health problem such lack of self-control, emotional turmoil, and negative thinking.
* The social part of the biopsychosocial model investigates how different social factors such as socioeconomic status, culture, poverty, technology, and religion can influence health.
* The biopsychosocial model implies that treatment of disease processes, for example type two diabetes and cancer, requires that the health care team address biological, psychological and social influences upon a patient's functioning.
* In a philosophical sense, the biopsychosocial model states that the workings of the body can affect the mind, and the workings of the mind can affect the body. This means both a direct interaction between mind and body as well as indirect effects through intermediate factors.
* Psychosocial factors can cause a biological effect by predisposing the patient to risk factors.
  + An example is that depression by itself may not cause liver problems, but a depressed person may be more likely to have alcohol problems, and therefore liver damage.

**Evaluation of the biopsychosocial model**

**Weaknesses**

* Some critics point out this question of distinction and of determination of the roles of illness and disease.
  + This may be exploited by medical insurance companies or government welfare departments eager to limit or deny access to medical and social care.
* Epstein and colleagues describe six conflicting interpretations of what the model might be, and proposes that "...habits of mind may be the missing link between a biopsychosocial intent and clinical reality."
* Psychiatrist Hamid Tavakoli argues that the BPS model should be avoided because it unintentionally promotes an artificial distinction between biology and psychology, and merely causes confusion in psychiatric assessments and training programs, and that ultimately it has not helped the cause of trying to destigmatize mental health.
* From an epistemological (theory of knowledge) stand there can be no model of mental disorder without first establishing a theory of the mind.
* Problems with testability: difficult to test empirically (with experiments)
* Unclear how exactly the factors interact

**Strengths**

* A BPS model focuses attention on the diversity of client needs, reinforcing the importance of client-centered clinical practices.
* A BPS model includes traditional addictions models as therapeutic options. It provides a broad and flexible framework for conceptualizing the nature of the problem and for selecting from a wide range of potentially effective responses to it.
* The BPS model is amenable to empirical scrutiny and supports a broad range of empirically tested "best practices".
* Commonsensical, palpable. Has provided a framework for treatment and future research.
* Less reductionist. Emphasize an interaction of several factors.

**Diathesis-stress model explanation**

The diathesis-stress model is a way of explaining how people end up suffering from mental disorders by assuming that mental disorders come from the interaction of two factors. These factors includes a person’s genetics (nature) and their life experience (nurture). The premise underlying the “diathesis-stress” model is that a person is more likely to suffer an illness if he or she has a particular *diathesis* (i.e., vulnerability or susceptibility) and is under a high level of stress. Diathesis factors that have been studied include family history of substance abuse or mental illness; individual psychological characteristics such as hostility or impulsivity; biological characteristics (e.g., cardiovascular reactivity, hypothalamic-pituitary-adrenal responsivity); and environmental characteristics such as childhood maltreatment or low socioeconomic status. Diathesis factors are generally assumed to be relatively stable but not necessarily permanent

**Stress vulnerability model (new version of diathesis-stress model)**

The new version of the diathesis-stress model states that the onset and symptoms of mental disorders is influenced by three interacting factors

1. *Vulnerability factors*: Biological factors, such as genes, that may predispose an individual to a disorder

2. *Environmental factors:* Stressors and events in life that may influence the symptoms and onset of the disorder

3. *Protective factors*: Factors that may protect the individual against development of a disorder (e.g. social support, medicatio**n)**

**Evaluation of the stress-vulnerability model**

**Weakness:**

* model is very fuzzy
* unclear

**Strengths:**

* categorizes reasons for mental disorder into three categories/factors (vulnerability, environmental, protective)
* explain how the three factors play roles in causing a mental disorder

Examine the concepts of normality and abnormality.

**The social and cultural norms criterion:**

Normality: Being within limits of “normal” functioning.

Abnormality: Marked strangeness as a consequence of being “abnormal”.

-          People who are not included in the in-group are defined as abnormal

* Abnormal behaviour violates moral or ideal standards
* Abnormal behaviour differs from commonly accepted beliefs or ways of thinking
* What is abnormal in one culture (e.g. *strange visions, speech and behaviour*) might be regarded as special or sacred in another culture (e.g. *shamanism*)

o   **Laing’s (1967) conspirational model:** In order to keep their definition of reality, the family, general practitioners and psychiatrists conspire against the “insane” by imprisoning and degrading them as human beings

-          **Supporting evidence:**

•          Different countries have different tools for diagnosis (e.g. DSM IV-TR in United states, CCMD-3 in China)

•          Homosexuality was considered to be abnormal until DSM-III (1980). It is still considered abnormal in many countries.

•          Unmarried mothers in Britain and political dissidents in the Soviet unions were once confined to institutions for abnormality. The tendency for American black slaves in the 1800s to try flee captivity was considered to be a mental illness

•          The existence of culture-bound syndromes (*emics*)

•          Gender differences in mental health (which may be due to differences in social expectations)

•          Cultural variations in the prevalence of certain disorders

•          Rosenhan’s (1973) study showed that psychiatrists had difficulties distinguishing the sane from the insane

-          **Challenging evidence:**

•          Murphy’s (1976) research on Inuit tribes has indicated that there are linguistic distinctions between “shaman” and “crazy people” in their society

**The mental illness criterion/biomedical model/disease model:**

o   Normality depends upon a properly functioning physiology and nervous system and no genetic predispositions to inherit mental disorder

**Supporting evidence:**

•          Studies on the relationship between physiology, genetic make-up and abnormal behaviour (e.g. Caspi 2003, Kendler 1991, Carraso 2000,

•          The universality (*etics*) of some disorders (e.g. eating disorders, depression and behaviours associated with psychosis – e.g. delusions and hallucinations)

•          Sex differences in the prevalence of mental illness (*which may be due to physiological differences between men and women*)

**Challenging evidence:**

•          Different countries have different tools for diagnosis (e.g. DSM IV-TR in United states, CCMD-3 in China)

•          The existence of culture-bound syndromes (*emics*)

•          Cultural variations in the prevalence of certain disorders

**Caspi et. al. (2003)**

Aim: To investigate relationship between 5-HTT gene and depression

Participants: 847 Caucasian New Zealanders

Experiment: Had participants give self-reports on depression (cross-check with their friends)

Results: People with short allele for this gene correlated with more vulnerability to depression

Conclusion: Certain diseases based on behavior are caused by genes. In this case, depression is found to be related to the length of the 5-HTT gene. The shorter the 5-HTT gene is; the tendency of getting depression rises. This experiment is one of the few experiments that have supported the theory that the biological function of the body is interrelated with the cognitive aspect of human beings.

Discuss validity and reliability of diagnosis.**Validity:** *pertains to if the diagnosis reflects a genuine disorder*

**Reliability:***means that different diagnosticians agree on the same diagnosis*

Validity: 2 studies showing how diagnoses don't always show a genuine disorder

1. **Chapman & Chapman (1967):**

*Procedure:*

Beginning clinicians observed draw-a-person test drawing randomly paired (unknowingly to participants) with symptom statements of patients.

Results:

Although the relationship between symptoms and drawings were absent, participants rated a high associative strength between symptom and drawing characteristics (e.g. paranoia and drawing big eyes)

This study therefore shows how diagnoses don't always reflect genuine disorders. They also depend heavily on dispositional instead of situational factors.

1. **Rosenhan (1973)**

*Procedure:*

Eight ‘sane’ people (3 women & 5 men from a variety of occupational

backgrounds) arranged appointments at various hospitals and complained that they had been hearing voices. The voices were unclear, unfamiliar, of the same sex and said single words like empty, hollow and thud.

The pseudo-patients did not change any aspect of their behaviour, personal history or circumstances (apart from their names). On admission to the hospital ward every pseudo-patient immediately stopped simulating any symptoms and responded normally to all instructions (except that they did not swallow any medication) and said they were fine, experiencing no more symptoms and would like to be released.

*Results:*

All but one pseudo-patients were admitted to a hospital with a diagnosis of schizophrenia and their ‘sanity’ was never detected by staff although many other patients did become suspicious! Length of stay ranged from 7 days to 52 days with an average of 19 days. All except one were released with a diagnosis of ‘Schizophrenia in remission’ supporting the view that they had never been detected as ‘sane’ at all.

A follow up study was conducted to check the poor reliability of diagnosis, whereby a teaching hospital was told to expect pseudo-patients over a three month period. Not a single pseudo-patient ventured near the hospital, but 41 genuine patients were suspected of being fakes, 19 of these were suspected by a psychiatrist and another member of staff.

Reliability: 2 studies showing how diagnostic classification systems can easily be unreliable

**1.     Cooper et al (1972)**

Found New York psychiatrists were twice as likely to diagnose schizophrenia than

London psychiatrists, who in turn were twice as likely to diagnose mania or depression

when shown the same videotaped clinical interviews.

**2.      Beck et al (1962)**

Found that agreement on diagnosis for 153 patients between two psychiatrists was

only 54%. This was often due to vague criteria for diagnosis.

Discuss cultural and ethical considerations in diagnosis *(for example, cultural variation, stigmatization).*

**Cultural considerations**

**--> Cultural differences in the display of certain disorders**

-          The way in which people perceive certain disorders may differ from culture to culture. People in various cultures define disorders differently, depending on their social and cultural backgrounds. In individualistic cultures, people may define disorders as a mental illness, because of their background of depending on themselves to solve their own problems. On the contrary, people in collectivistic cultures define disorders as something having to do with physical illness, because they are less willing to admit to having a mental illness.

**CASE STUDY: Elialilia Okello and Solvig Ekblad (2006)**

**Method:** Individual Interviews

**Participants:** Clans in Uganda (extended family, hierarchy, collectivistic)

**Procedures:** Use *vignettes* to explore perception of depression

**Findings:** see treatment as *help-seeking behavior*. Depression = “illness of thoughts” not emotional illness. Therefore, do not need medicine, unless chronic                        or recurring

**Strength:** High ecological validity because of researchers are able to gain insights directly from the locals without having to manipulate them.

**Weakness:** There could be extraneous/confounding variables. Participants may not answer truthfully.

**--> Cultural variations in the prevalence of disorders**

-          Different cultures also differ in the widespread of these disorders. The statistics vary because of the willingness to be diagnosed with mental illnesses, and being labeled as abnormal. The statistics are much higher in individualistic cultures which have individuals whom are more eager to express themselves and have less fear of being different. They are more willing to admit to having the disease and seeking treatment. For collectivistic cultures however, the statistics are much lower, out of the fear of being different and dishonoring their families. People in collectivistic cultures are more afraid of being labeled as abnormal, and aren’t as willing to be diagnosed and treated.

**CASE STUDY: Hwu and Compton**

**Method:** Statistic

**Procedures:** Studied prevalence lifetime depression using Diagnostic Interview Schedule (DIS)

**Findings:** Korea 3.3%, Iran 6.24%, New Zealand 12.6%

**Strength:** The result supports the theory because Korea, a collectivistic country, has a lower report rate than individualistic country like NZ. This suggests that less people are willing to admit.

**Weakness:** The result differs for some countries. This could result from different sensitivity of the measurement tool.

**Ethical consideration: labeling**

**Self fulfilling prophecies:** People may act as they are expected to (similar to stereotype threat)

**Prejudice/stereotyping/discrimination:** People with psychological disorders may be discriminated

       Patient may think the “cure” is around the corner

**STUDY:**Rosenhan

Aim: Rosenhan conducted two studies, both of which tested acclaimed psychologist’s abilities to distinguish between sanity and insanity.

Procedure:

In the first study, Rosenhan sent 8 pseudopatients, who were, in actuality, healthy associates, to 8 different mental hospitals across the United States; each pseudopatient had called beforehand and created a scenario in where they had been experiencing brief periods of auditory hallucinations – immediately certifying their places within these institutions as patients with schizophrenia. After their admission, the pseudopatients carried on with their lifestyle as normally as they could under the given environment. Weeks went by as the hospital staff failed to distinguish these pseudopatients from their real patients – with some of the hospital staff believing that all these pseudopatients were abnormal, though they were behaving normally, than the patients with the same mental illness. The pseudopatients were later then released, several weeks later, with the term that their mental illness was in remission. Ensuing the first study, a doctor from a mental institution, who felt the circumstances under which they had been deceived were unjustifiable, felt that he needed to disprove Rosenhan’s claim that psychiatrists could not distinguish the sane from the insane; he challenged Rosenhan to send more associates. After a few weeks, hospital staff falsely identified multiple patients as imposters, when, in actuality, Rosenhan had not sent any pseudopatients at all.

Findings: In mental institutions, it is difficult to distinguish the sane from the insane and that it is dangerous to label people with a mental illness as it dehumanizes them from society.

Methodological strengths:

High ecological validity- this experiment has a high ecological validity due to the fact that the participants, in this case, the pseudopatients, were in a natural environment – the mental institutions; they were expected to behave normally while under a realistic environment that patients with mental illnesses are placed in.

Methodological limitations:

Generalizability- this experiment has problems with generalizability because it is difficult to generalize the results of this experiment to persons of older ages as the symptoms of a particular mental illness may be more lucid that ones in patients of younger ages.

Describe symptoms and prevalence of one disorder from two of the following groups: anxiety disorders, affective disorders, eating disorders  
  
**Anorexia – Symptoms**

**Behavioural symptoms:** Will not maintain normal weight for their age and height, 85 % of an appropriate weight

**Emotional symptoms:** Extremely fearful of gaining weight or being fat, even the person is already underweight

**Cognitive symptoms:** Has a distorted view of body shape and weight

**Somatic symptoms:** A female that misses three menstrual cycles in a row

**Depression – Symptoms**

* **Affective:** Feelings of guilt and sadness, lack of enjoyment or pleasure in familiar activities or company
* **Behavioural:** Passivity, lack of initiative
* **Cognitive:** Frequent negative thoughts, faulty attribution of blame, low self esteem, suicidal thoughts, irrational hopelessness, difficulties in concentration and inability to make decisions
* **Somatic:** Loss of energy, insomnia, or hypersomnia, weight loss/gain, diminished sex drive
* One or two major depressive depressive episodes
* At least two weeks of depressed mood or loss of interest accompanied with at least four additional symptoms of depression

**Prevalence of anorexia nervosa and major depression**

    -approximately 95% of those affected by anorexia are female

    -Lifetime prevalence of Anorexia nervosa in females is 0.5%

    -10 times more likely in females than in males

    -Onset age is usually between ages 14-18

    -caucasians are more affected than people of other background

    - More common in western societies, middle and upper socioeconomic groups but is increasing in eastern societies because of globalization

    -models, dancers, and actors/actress are careers that have higher risk of anorexia nervosa

Major depression:

Biological Factor: Genes and neurotransmission

Caspi et al. (2003)

- **Aim:** To investigate the relationship between the 5-HTT gene (The serotonine transporter gene) and depression

- **Participants:** 847 Caucasian New Zeelanders

**- Method:** interview, correlation method

- **Dependent variable:** Self report on depression

- **Controls:** Checked that participants were honest in self report by cross checking with friend, same levels of stressful life events

- **Findings:** Having a short allele of the 5-HTT gene correlated with increased vulnerability for depression between ages of 21 to 26

- **Evaluation:**

 - Use of controls

  - Findings has been confirmed with animal and brain research (*greater neuron activity in the amygdala in response to fearful stimuli if short allele*)

  - Short alleles are more common in Japanese sample

Social and cultural Factors: Relationships, number of children

**EA Campbell, SJ Cope and JD Teasdale** **(**Brown and Harris's model)

    - Aim: investigate rather the vulnerability factors are risk factors for depression

    - Participants: 110 of working class women and children in Oxford

    - Experiment, correlation study/ survey : Using the samemethodology as Brown and Harris, the role of provoking agents in the onsetof affective disorder was found to be very similar to that which theyoriginally described. Lack of an intimate relationship with a husband orboyfriend was found to act as a vulnerability factor, increasing the risk of psychiatric disorder in the face of a provoking agent.

    - Findings: There was a trendfor women with three or more children aged 14 or under to have an increasedvulnerability. However, unemployment was not found to be a vulnerabilityfactor. These results provide general support for Brown and Harris's causalmodel.

Anorexia:

Southgate (2008)

Aim: Investigate preferential information processing style in eating disorder (ED)

Participants: sixty nonmedicated female participants 26 with health diet, 20 with anorexia, and 14 with bulimia

Experiment:  We compared the performance of participants with EDs against healthy controls in a task that measures cognitive style (reflection–impulsivity) and cognitive efficiency (inefficient–efficient).Sixty non-medicated female participants (healthy controls n=26, anorexia nervosa n=20, bulimia nervosa n=14) took part in the Matching Familiar Figures Test (MFFT), a difficult visual search paradigm with high response uncertainty. Participants with anorexia scored significantly higher on the efficiency dimension score than the control group. No significant differences were found across groups on the dimension ‘reflection–impulsivity’.

Finding: Participants with anorexia are more efficient (quicker response latencies in conjunction with fewer errors) in this visual search task that requires an analytic approach. This supports the hypothesis that individuals with anorexia have a positive bias toward local detail processing, indicative of weak central coherence.

Evaluation : Lack ecological validity because the investigation was conducted in a controlled lab and lacks generalizability because the experiment focus on only female patients with anorexia the result cannot be apply to males patient

Mazzeo & Bulik (2009)

**Aim:**The authors’ goal was to explore the relationbetween perfectionism and psychopathology, including eatingdisorders.

**correlation method/survey:**Using logistic regression, the authors calculatedodds ratios for the associations between perfectionism subscalescores and psychiatric disorders in 1,010 female twins who completedthe Multidimensional Perfectionism Scale and participated indiagnostic interviews.

**Finding:**Elevated concern over mistakeswas associated with anorexia and bulimia nervosa but not withother psychiatric disorders. Doubts about actions was associatedwith eating and anxiety disorders. Multivariable models confirmedthat higher scores on the subscales for concern over mistakesand doubts about actions were most strongly associated witheating disorders.

**conclusion:**The aspect of perfectionism capturedby scores on a subscale measuring concern over mistakes maybe particularly associated with eating disorders and not genericallypredictive of psychopathology.

Analyse etiologies (in terms of biological, cognitive and/or sociocultural factors) of one disorder from two of the following groups: anxiety disorders, affective disorders, eating disorders  
Etiology is the study of the causes or origins of a disease.  
  
**Major Depression**

**Biological**  
There are several genetic and biochemical factors in depression. There are certain genes that have found to have links with depression such as the short allele of the 5-HTT gene (Caspi 2003).

There is a study that supports the existence of this factor. That study is Caspi et. al. (2003) The aim of this study was to investigate the relationship between the 5-HTT gene (Seretonin transporter gene) and depression. The participants were 847 Caucasian New Zealanders. The study went by having participants give self-reports on depression and cross-check it with their friends (To check the honesty of the participants). The results show that having a short allele of the 5-HTT gene correlated with increased vulnerability for depression between the ages of 21-26. The results of this study clearly shows that biological factors such as genes can be the underlying causes of many diseases such as depression. This study is high in external reliability but is rather difficult to replicate. The study though is valid although may not be generalizable because only the participants were only New Zealanders. Ecological validity is also not very high because the study is not very realistic.  
  
**Cognitive**

There is several cognitive factors in depression. Firstly, a depressed mood may lead to depressed thoughts. On the other hand, depressed cognitions, cognitive distortions and irrational beliefs can produce disturbances in the mood.

There are many studies that support the existence of this factor in depression. One of those is Goldapple (2004). The aim of this study was to investigate how cognitive therapy affects brain changes. In this study, the brain activity before and after 15-20 therapies of cognitive therapies over seven weeks of fourteen different patients were documented using a PET scan. PET scans from a previous study on participants taking antidepressants were used as a control group. Other controls were that participants were screen to ensure that they had no substance problems or antidepressant treatment within one month prior to the study. The results were fascinating as there were significant changes in glucose metabolism in prefrontal-hippocampal pathways. The changes to the brain were similar as those patients who took antidepressants. This experiment is difficult to replicate. However, it is highly valid and high in ecological validity because PET scans are used in everyday life.

**Sociocultural**

Social and cultural factors affect the prevalence and manifestation of the disorder

There are many studies that support the existence of this factor. One of those is Brown and Harris (1978). In this study, Brown and Harris examined the relationship between social factors and depression in a group of women from Camberwell in London. They studied women who had recieved hospital treatment for depression or consulted a doctor about depression. They also studied a general population sample of 458 women aged between 18-65 years old. They found that on average, 82% of those who became depressed recently had encountered a traumatic life event. In the normal group however, only 33% of the women had encountered a serious life event recently. The study also found that working women were at a greater risk of depression than women who stayed at home. It was also found out that women with children have a greater risk of depression as well. Women that were recently widowed, divorce or separated also have a relatively higher chance of suffering from depression. Nevertheless, not all women who have had life difficulties became depressed. In fact, only about 20% of women who experienced life difficulties became depressed. This suggested that people differ in their vulnerability and there are many 'vulnerability factors' such as a lack of confidante, early loss of mother or being unemployed. One of the most protecting factors against depression was found to be the presence of a partner. Another study is Cutrona et al, (2006):

|  |  |
| --- | --- |
| Aim | To investigate how environment, personality and life stressors contribute to depression |
| Sample | 720 Afro-American women |
| Procedure | Survey |
| Findings | Negative life events may lead to depression, neighborhood affects depression (Rich areas less likely to become depressed than poor areas), personality was not a factor |
| Methodological Considerations | Generalizability problems, very large sample, maybe demand characteristics |
| Ethical Considerations | Highly ethical, unanimity was kept |
| Conclusion | There are many environmental and life stressors that can lead to depression |

**Anorexia Nervosa**

Biological:

Dispositional (genetic) factors, such as personality (perfectionism) may contribute to the disorder. Possible appetite and weight regulation imbalance in the hypothalamus, neurotransmitters (serotonin)

Mazzeo & Bulik (2009)

|  |  |
| --- | --- |
| Aim | To investigate how genes and environment interact for eating disorders |
| Sample | Unknown |
| Procedure | Literature review of correlation studies |
| Findings | Several types of gene-environment-interactions contribute to eating disorders  A)    Situational-Social environment, parents  B)    Dispositional-Girls with high levels of perfectionism may have demands on themselves and to be more susceptible to media influence |
| Methodological Considerations | Considers more than one factor for the disorder, cause and effect is not clear |
| Conclusion | Several types of gene-environment-interactions contribute to eating disorders |

Cognitive

Attentional biases and cognitive styles that distort reality/body image

Southgate (2008)

Aim: Investigate preferential information processing style in eating disorder (ED)

Participants: sixty nonmedicated female participants 26 with health diet, 20 with anorexia, and 14 with bulimia

Experiment:  We compared the performance of participants with EDs against healthy controls in a task that measures cognitive style (reflection–impulsivity) and cognitive efficiency (inefficient–efficient).Sixty non-medicated female participants (healthy controls n=26, anorexia nervosa n=20, bulimia nervosa n=14) took part in the Matching Familiar Figures Test (MFFT), a difficult visual search paradigm with high response uncertainty. Participants with anorexia scored significantly higher on the efficiency dimension score than the control group. No significant differences were found across groups on the dimension ‘reflection–impulsivity’.

Finding: Participants with anorexia are more efficient (quicker response latencies in conjunction with fewer errors) in this visual search task that requires an analytic approach. This supports the hypothesis that individuals with anorexia have a positive bias toward local detail processing, indicative of weak central coherence.

Evaluation : Lack ecological validity because the investigation was conducted in a controlled lab and lacks generalizability because the experiment focus on only female patients with anorexia the result cannot be apply to males patient

Social cultural

Media exposure, social learning

Becker Study (1993-1995):

AIM: to investigate the influence of cultural factors on the incidence of anorexia nervosa by taking advantage of cultural change when television was first introduced to the island of Fiji to see what effects western TV would have on attitudes towards eating and the incidence of anorexia nervosa

PROCEDURE: In 1993 when TV was first introduced to the island of Fiji, 63 native Fijian girls were asked to complete a questionnaire on attitudes towards eating and were questioned about their TV viewing habits. 2/3 years later, a further sample of 65 girls aged 17 years on average were re-questioned to assess the impact of TV on their eating habits. Girls were also interviewed about their views on eating and television.

FINDING: % of girls who reported vomiting in order to control weight changed from 3% in 1993 to 15% in 1995. Girls with a high score on the eating questionnaire (indicating a risk of disordered eating) changed from 13% in 1993 to 29% in 1995

CONCLUSION: The findings indicate a strong link between exposure to western ideals of thinness and changed attitudes towards eating.

Such changed attitudes are likely to lead to the development of eating disorders such as anorexia nervosa

EVALUATION: The findings do not necessarily demonstrate a cause (Validity low). This was a natural experiment during which the investigators had no control over extraneous variables (Credibility low). Changed attitudes may not lead to eating disorders - we do not all show signs of eating disorders even if we are all exposed to the same cultural influences, there may well be a biological vulnerability. Low generalizability, as study was conducted in only country.

Discuss cultural and gender variations in prevalence of disorders  
  
**Major Depression**

More common in individualistic than collectivistic cultures

**Seattle, Washington:** 6.3 %

**China:** 4 %

**Verona, Italy:** 4.7 %

**Groningen, Germany:** 15.9 %

**Manchester, United Kingdom:** 16.9 %

**Ankara, Turkey:** 11.6 %

**Nagasaki, Japan:** 2.6 %

       Possible cause: Collectivistic cultures may share their feelings and since group interest is important, people may help each other get through personal issues. Also, there might be a lower rate of depression in collectivistic cultures because of somatization. They report other bodily symptoms instead of feeling depressed.

**Anorexia Nervosa**

More common in western societies but is increasing in eastern societies because of globalization

Possible cause: There are more expectations of how you look in the west. Women are sometimes pressured to look thin and model-like. Eastern societies are starting to experience anorexia nervosa due to globalization from the west.

**Major Depression**

**Life time prevalence for the disorder:** Women – 10-25% Men – 5-12%

Possible cause: violence and abuse against women could make them more prone to depression than men. Another possible cause is that, although men and women may have similar rates of depression, more women are diagnosed correctly as having the depression due to gender bias.

**Anorexia Nervosa**

10 times more likely in females than in males

Possible cause: Females are more aware about their body weight, while men are less afraid of gaining weight. Females are usually more expected to have a thin body shape, since female models must be thin but this is not always the case for males.

**Major Depression (Weissman et al. (1996)):**

AIM: To estimate the rates and patterns of major depression and bipolar disorder based on cross-national epidemiologic surveys.

DESIGN AND SETTING: Population-based epidemiologic studies using similar methods from 10 countries: the United States, Canada, Puerto Rico, France, West Germany, Italy, Lebanon, Taiwan, Korea, and New Zealand.

PARTICIPANTS: Approximately 38000 community subjects.

OUTCOME MEASURES: Rates, demographics, and age at onset of major depression and bipolar disorder. Symptom profiles, comorbidity, and marital status with major depression.

RESULTS: The lifetime rates for major depression vary widely across countries, ranging from 1.5 cases per 100 adults in the sample in Taiwan to 19.0 cases per 100 adults in Beirut. The annual rates ranged from 0.8 cases per 100 adults in Taiwan to 5.8 cases per 100 adults in New Zealand. The mean age at onset shows less variation (range, 24.8-34.8 years). In every country, the rates of major depression were higher for women than men. By contrast, the lifetime rates of bipolar disorder are more consistent across countries (0.3/100 in Taiwan to 1.5/100 in New Zealand); the sex ratios are nearly equal; and the age at first onset is earlier (average, 6 years) than the onset of major depression. Insomnia and loss of energy occurred in most persons with major depression at each site. Persons with major depression were also at increased risk for comorbidity with substance abuse and anxiety disorders at all sites. Persons who were separated or divorced had significantly higher rates of major depression than married persons in most of the countries, and the risk was somewhat greater for divorced or separated men than women in most countries.

CONCLUSIONS: There are striking similarities across countries in patterns of major depression and of bipolar disorder. The differences in rates for major depression across countries suggest that cultural differences or different risk factors affect the expression of the disorder.

EVALUATION: The findings do not necessarily demonstrate a cause (Validity low). This was a natural experiment during which the investigators had no control over extraneous variables (Credibility low). Can people of all cultures be diagnosed with major depression as defined by Western psychiatric manuals? There are ethical and cultural concerns for diagnosis (Credibility low). Large sample size is good. Lots of countries is a good representative of differing cultural factors (questionable Asian sample though).

<http://www.ncbi.nlm.nih.gov/pubmed/8656541>

**Anorexia Nervosa (Becker Study (1993-1995)):**

AIM: to investigate the influence of cultural factors on the incidence of anorexia nervosa by taking advantage of cultural change when television was first introduced to the island of Fiji to see what effects western TV would have on attitudes towards eating and the incidence of anorexia nervosa

PROCEDURE: In 1993 when TV was first introduced to the island of Fiji, 63 native Fijian girls were asked to complete a questionnaire on attitudes towards eating and were questioned about their TV viewing habits. 2/3 years later, a further sample of 65 girls aged 17 years on average were re-questioned to assess the impact of TV on their eating habits. Girls were also interviewed about their views on eating and television.

FINDING: % of girls who reported vomiting in order to control weight changed from 3% in 1993 to 15% in 1995. Girls with a high score on the eating questionnaire (indicating a risk of disordered eating) changed from 13% in 1993 to 29% in 1995

CONCLUSION: The findings indicate a strong link between exposure to western ideals of thinness and changed attitudes towards eating.

Such changed attitudes are likely to lead to the development of eating disorders such as anorexia nervosa

EVALUATION: The findings do not necessarily demonstrate a cause (Validity low). This was a natural experiment during which the investigators had no control over extraneous variables (Credibility low). Changed attitudes may not lead to eating disorders - we do not all show signs of eating disorders even if we are all exposed to the same cultural influences, there may well be a biological vulnerability. Low generalizability, as study was conducted in only country.

http://docs.google.com/viewer?a=v&q=cache:\_K--L4YoUvkJ:www.poorlad.com/psychology/studies/Abnormality%2520-%2520Becker.pdf+becker+anorexia+study&hl=en&pid=bl&srcid=ADGEESi4kVIKYHIsTxJ5fdopP73b4cdapBHGl7mGJkaxv0UYDJ9MwiPifaxELiZGU4KXAey7jngSKRcHpyV7VmC7eastqcn7qC7zr2l5QhIcMLSovIYG2IzzqG4\_YoMZUeqGdM\_tNpcA&sig=AHIEtbTA59HZLSzHx\_C4ICLlti\_NTgKCJA>

Two studies of gender variations in prevalence of major depression and anorexia nervosa

**Name of study and year:** The National Comorbidity Study

**Procedure:**A large survey of adult in the United States released, followed by other countries such as Canada, Brazil, Germany and Japan, with the same procedures. Questions such as social life leading to depression

**Findings:** 1.7 women for every man had experienced at least one episode of depression. Roughly the same ratio has been found in recent studies in nine other countries, including Canada, Brazil, Germany and Japan

**Sample:** adults (both male and female)

**Methodological strength/limitation:** strength: generalizability & credible / weakness: possible response bias

**Name of study and year:**Dr. George Zubenko

**Aim:**Identification on 19 regions of chromosomes that were especially common and, therefore, likely to contain genes that promote depression.

**Procedure:**scanning the genomes of people with major depression in 81 family.

**Findings:**four of these regions showed up only in women and one only in men. For example CREB1 which has an unknown affect on estrogen receptor, but still might have affect on the reproductive hormone itself, therefore might lead to a certain level of depression.

**Conclusion:**the sex difference in depression is most pronounced in women during their reproductive years, when sex hormone levels are highest. Before puberty, boys and girls have roughly equal rates of depression. The incidence of depression climbs in both sexes during puberty, but the climb is steepest for girls.

**Sample:**81 family

**Methodological strength/limitation:** strength: reliable, scientific, controlled / weakness: generalizability, disregards other influences on depression

Explanation on cultural variations in prevalence of major depression; differences in symptoms

Centre for Addiction and Mental Health (CAMH)   
Aim: to test the following hypotheses  
East-Asian participants will emphasize somatic or physical symptoms of depression more than North American participants  
North American participants would emphasize psychological symptoms of depression (e.g. report feeling sad, crying spells, or a loss of self-confidence) more than East-Asian participants   
wanted to examine the role stigma and alexithymia (difficulty using words to describe emotions) play in how each culture presented and expressed depression symptoms  
Participants: 100 Chinese out-patients and 100 North American patients  
Method: spontaneous report of problems during unstructured discussion with doctor; clinician-rated symptoms in a structured clinical interview; and a symptom rating scale in questionnaire Findings:   
1. East-Asian participants did report a significantly higher level of somatic symptoms   
2. Western cultures emphasize psychological symptoms of depression   
Conclusion: people who do not frequently focus on their internal emotional state are more likely to notice somatic symptoms.  
Evaluation  
+ Application: help clinicians be more aware of how culture can impact how people talk about their illness  
- Data might not be representative: all east-asian participants are from China

Examine biomedical, individual and group approaches to treatment  
Evaluate the use of biomedical, individual and group approaches to the treatment of one disorder  
Explanation: The biomedical approach to treating anorexia nervosa and major depression is to stabilize brain chemistry of the patient; psychiatrists in this field believe that the brain chemistry is the cause to many mental disorders.

Anorexia Nervosa

* Hospitalization to prevent death, suicide, and medical crisis.
* Weight restoration to improve health, mood, and cognitive functioning. Note: An anorexic's fear of weight gain, especially forced weight gain in hospital, is a huge obstacle to treatment and recovery. Nevertheless, it is clear that the closer to normal weight is at the end of treatment, the better the chances of complete recovery. In study after study, low body weight is strongly correlated with treatment failure and relapse
* Medication to relieve depression and anxiety
* Dental work to repair damage and minimize future problems
* Nutrition counseling to debunk food myths and design healthy meals

Major Depression

Electroconvulsive Therapy

Electroconvulsive therapy is a therapy which inputs electric currents into the patient’s brain. The electric currents then induce seizure towards the patients, which makes neurons fire rapidly, increasing metabolism within the brain. This process may be painful, but modern day doctors use anesthetics and sedatives so patients won’t feel any pain.

 Doctors do not actually know how this process works, but patients with severe depression who do not respond to other therapies usually experience some recovery through this process.

-Side effects that may occur to some patients are loss of memory prior to the ECT and headaches but usually recovers a couple of hours after the therapy.

-Describe and evaluate two studies on the effectiveness of the biomedical approach to treatment of either major depression or anorexia nervosa

For Major Depression

|  |  |
| --- | --- |
| **Name and year of study** | Kirsch et al (2002) |
| **Aim** | To find out whether new generation anti-depressants Selective Seratonine Reuptake Inhibitors (SSRI) is effective in treating depression or not. |
| **Research method** | Experimental |
| **Procedure** | Using the Hamilton Scale for Depression on patients of different severity of depression taking the SSRI and placebo to see if the SSRI is effective or not. |
| **Findings** | The effects on the SSRI did not seem effective on patients with mild and moderate symptoms of depression; only severe depression patients experience some positive effects. |
| **Conclusion** |
| **Methodological strength** | -          Make people more aware of the real effects of the new generation drugs.  -          Ecological validity is high as drugs are being tested for their real effects. |
| **Methodological weakness** | -          Employed too many participants of the milder depression with fewer participants with severe depression. Creates a bias. (Low generalizability.  -          Some drugs experimented were still in the experimental phase, and not yet approved by the FDA. |
| **Ethical considerations** | -          Requires human testing on drugs, but consent was given. |

 For Anorexia Nervosa

|  |  |
| --- | --- |
| **Name and year of study** | Kaye Et Al (UCSD) |
| **Aim** | The aim of this study is to find out whether Anorexia Nervosa is caused by abnormal brain functioning. |
| **Research method** | Study |
| **Procedure** | 13 women with anorexia in remission and 13 women with no eating disorder were instructed to play a computer quiz with quizzes that activate different parts of the brain. The functioning of the brain is observed with fMRI. |
| **Findings** | -          A region in the brain called the anterior ventral striatum becomes more active in healthy women when they winning a game, whereas in anorexic women, the differences of the activity of the AVS was quite low.  -          Another region in the brain called the caudate became more active in women with anorexia in remission when quizzes appeared. They were more anxious with their decision making and tried to find rules when the quizzes themselves had none. This symptom, if more severe, may become OCD. |
| **Conclusion** | Anorexia nervosa is considered abnormal brain activity, therefore considered a mental illness. This means it is not only contributed by only cognitive processes of the brain, but more of the biological processes. |
| **Methodological strength** | -          Paves a new aspect of biomedical study in the anorexic field  -          Use of a controlled, scientific method: biological processes in the brain using advanced technology. |
| **Methodological weakness** | -          Sample size only consisted of women in remission or was healthy, but does not contain women who were still having anorexia, therefore low on generalizability. |

-Explain individual approach to treatment of anorexia nervosa and major depression, using two therapies (e.g. cognitive therapy, client-centered therapy)

Rational Emotive Behavior Therapy (REBT)

- Pioneered by Albert Ellis, REBT focuses on the belief that all disorders are based on an irrational belief on an event and that they should be cured with a rational argument which will relive the individual of the consequences of irrationality.

- The ABCDE Model

    - A - activating event that causes the problem

    - B - beliefs that are irrational

    - C - consequences of such beliefs

    - D - disputing the belief with a more rational and healthy belief

    - E - effort of disputing the belief, putting things into action

Major Depression

- Tackle the source of the problem by pointing out the flaws in the thought process (the irrational belief), and suggest a more rational, logical belief to replace the irrational one. The disputing belief, however, have to be tailor-made for different client because the activating event for varies from patient to patient.

Anorexia Nervosa

- Dispute the irrational perception of the client's body image by offering a more rational one by methods such as showing the patients a photograph of an actual model and compare the model to the patient in order to change their beliefs that they are "too fat" when they are actually too skinny in reality.

Cognitive therapy

-          Treatment of thoughts and thought process

-          CT believes that people with depression have negative thoughts of the self, world environment, and the future.

-          CT helps people get rid of self-defeating thoughts and to solve problems.

-          Process: analyzing the patient then trying to change thinking that is unfounded or negative because they may lead to depression, phobias, obsessions or other disorders.

o   Such as…meditation/mindfulness, thought stopping, self distancing.

-          How CT is used to treat patients with depression

*Cognitive restructuring –* replacing faulty thinking with more accurate beneficial ones: involves the patient to gain awareness of bad thoughts/habits, learn to challenge the bad thoughts/habits, and change their life style to one that enhances thoughts and believes.

-          How CT is used to treat anorexia nervosa

The therapist must develop accepting and warm relationship with the patient since most anorexic patients do not want treatment. The therapist will have to accept the patients’ belief about their body image. They can question the patients and giving suggestions on how to deal with problems in life and let them experiment with them.

 In the 2004 Goldapple Study, PET scans of 14 cognitive therapy patients before and after then therapy were taken over the course of 7 weeks, 15-20 therapies were involved. PET scans of participants taking antidepressants were used as a control group. Goldapple concluded that cognitive therapy yields a similar result to that of the antidepressants where activities in the prefrontal-hippocampal pathways increased.

Goldapple’s study is quite systematic, but the patients might develop some uncontrolled level of stress when they are being scanned with the PET machine which might have distorted the findings slightly.

 Similarly, the 1991 Lyon and Woods study compared the effectiveness of 70 cognitive therapy reults with other types of psycho therapies. The study showed the cognitive therapy showed the greatest improvement of the patient’s conditions, however, the effectiveness also depends largely on the therapists’ experience as well as the duration of the therapy.

 The study has a few flaws that should be addressed, such as possible researcher bias, since the results are based mainly on observations. Secondly, the study is quite reductionistic; it focuses on only one factor, the cognitive factor.

Cognitive-behavioral therapy (CBT) : treatment for adult/children with depression

-          Focuses on current issue/symptoms

-          12-20 weekly session, daily practice (to help client use new skills on a day-to-day basis)

-          CBT is based on cognitive therapy + behavioral modification

 -

Riggs et al (2007)

-          Aim: Study of effectiveness of CBT in combination with placebo or an SSRI

-          Sample: Randomized double blind study with 126 adolescents (13-19) who suffered from depression/ substance use disorder

-          Participants recruited from juvenile justice systems/ social service

-          Problem: could not follow 6, 12 could not complete (got into jail), 2 withdrew

-          Procedure: cognitive-behavioral therapy with placebo was given to a group of participants while CBT and SSRI (a type of medicine) was given to the other group of participants

-          Findings: CBT + placebo = 67% “very much improved”, “much improved”

-          CBT + SSRI  = 76% “very much improved”, “Much improved”

-          Self report of participants showed that their depression has increased and their other behavioral problems too

-          Conclusion: CBT + drugs is effective, CBT is almost as effective

-          CBT techniques helped them manage negative thoughts and feelings that can trigger substance use

-          Treatment could start with CBT alone, if the participants does not response a drug use from the SSRI group should be added

Strenght: Cost-effective – does not involve a long treatment   
- found that they CBT + drug most effective for chronic depression (caused by childhood experiences)

Weaknesses:

-          Focus on symptoms rather than causes

-          Provide clients with strategy for self help : less manipulative than other treatment

-          Therapist could make judgment about which thoughts are acceptable

-          Personal information of client could be leaked

Group treatment of major depression and anorexia nervosa

-group participants with the same experience

-meet every week

-share experiences

-support and motivate each other to comply with treatment

Depends on the type of the group, they can be classified into 4 types:

**Classification of group methods**

|  |  |  |
| --- | --- | --- |
|  | Highly specific therapeutic goals | Non-specific therapeutic goals |
| High level of leader activity | -structured group programs in centers for drink and drug dependence  -activity groups, including occupational therapy  = activity groups | -problem-solving and psycho-educational groups for homogeneous populations  = problem-solving and psycho-educational groups |
| Low level of leader activity | -psychodrama, drama and music therapies  -short-term dynamic groups  -systems-centered groups  =  psychodynamic groups | -support groups, art therapy groups  -psychotherapy groups, interpersonal therapy, Tavistock groups, group analytical therapy  = support groups |

Activity groups (opposite of support group)

-engaging patients in a form of focused activity or work

\*help to develop social skills and address hidden anxieties and also create a sense of togetherness

Problem-solving and psycho-educational groups

-group made up of individuals with similar problems working towards clearly defined aims

\*the emphasis is on shared learning; with some modeling of the group leader; unconscious dynamics are not explored and the group itself is not viewed as a therapeutic force for change

Support groups (opposite of activity group)

-provide a psychosocial network and offer opportunities for problem-sharing

-patients with chronic mental and physical illness for whom a more exploratory dynamic form of therapy would not be indicated

-aim is to maintain homoeostasis: change is not expected and any that occur is gradual

Psychodynamic groups

-aim to create a lasting personality change brought about through non-directive free association (the therapist will not ‘lead’ the group in an obvious way – the stance of the therapist allows unconscious dynamics between group members to be examined and personality change to be achieved in the working through of new understandings within the transference (redirection of feelings) and counter-transference material

Two studies on the effectiveness of the group approach to treatment of either major depression or anorexia nervosa

|  |  |
| --- | --- |
| Name and year of study | Can group therapy help treat depression among HIV/AIDS patients? (By counselors from World Vision, and researchers from Johns Hopkins University, Columbia University - 2004) |
| Aim | Can group therapy help treat depression among HIV/AIDS patients? |
| Research method | Comparative study |
| Procedure | -classified patients with HIV/AIDS into 15 groups with 12 people each group (total of  144)  - patient with extreme suicidal thoughts were not  -created another control group of patients (do not participate in the group therapy)   allowed in the study  -group therapy which last 90 minutes once per week for 4 months |
| Finding | -6.5% of the group therapy still had major depression  -54.7% that did not participate in the group therapy still had major depression |
| Methodological strength | -supports how group therapy is effective  -no ethical issue, participants participate on their willing nesses |
| Methodological weakness | -the degree of depression in each group was different (could cause the data to be inaccurate)  -participant might lie or else they would feel bad that they ruined the doctor’s therapy  -difficult to replicate and time consuming  -might be other factors during the 9 months that changed the patients’ thinking  -group therapy relies on the patients to confront to their problems, support each patients in the group, and develop themselves  -required experienced psychologist to perform a well structured group therapy |
| Ethical considerations | -friendly environment, participants can talk openly |

|  |  |
| --- | --- |
| Name and year of study | Wilson, G.T., Fairburn C.G. & Agras W.S. (1997) |
| Aim | Compare the effectiveness of group therapy versus individual therapies for anorexia patients |
| Research method | Comparative study |
| Procedure | -3 types of individual therapies were used; cognitive therapy, psychodynamic therapy and behavioral therapy on patients with anorexia for 5 years  -group therapy was used  on patients with anorexia for 5 years |
| Finding | -group therapy had a higher success than the 3 individual therapies  -18 months, 68% of patients stopped binge eating and purging  -Compare to other therapies  Behavioral therapy = fast effect but short-lived  Cognitive therapy = slow effect but improvements did not deteriorate  - 48% of patients in behavioral therapy dropped out due to lack of improvement after 1 year  After 5 years, percentage of self denial to binge eating and purging were:  Cognitive Therapy: 44% Psychodynamic Therapy: 52%  Behavioral Therapy: 18% |
| Methodological strength | -supports how group therapy is effective  -no ethical issue, participants participate on their willing nesses |
| Methodological weakness | -the degree of depression in each group was different (could cause the data to be inaccurate)  -participant might lie or else they would feel bad that they ruined the doctor’s therapy  -difficult to replicate and time consuming  -might be other factors that changed the patients’ thinking during the period of the experiment  -group therapy relies on the patients to confront to their problems, support each patients in the group, and develop themselves  -required experienced psychologist to perform a well structured group therapy |
| Ethical considerations | -friendly environment, can talk openly |

Discuss the use of eclectic approaches to treatment.

Definition: An approach that combines two or more techniques for treatment. The treatment is adapted to suit the needs of the individual or group

Examples :

Combining drug therapy and cognitive therapy for treatment of depression

Combining cognitive and behavioral therapy (CBT) for treatment of depression

Combining Chinese herbal medicine and antidepressants for treatment of depression

Types of  eclectic approaches :

**Simultaneous use:** Use of the therapies at the same time

**Sequential use:** Either therapy is used at one time

**Stage-oriented use:** One therapy is used during the critical stage, the other therapies are used at the maintenance stage

Notes:

-          The use of a combination of approaches or theoretical orientations.

-          Therapist able adapt to each client’s individual needs.

-          a recognition that individuals may benefit from a variety of techniques.

-          eclectic approach can be flexible and adaptive and avoid forcing treatment into one size fits all limitations.

-          necessary that the therapist be well grounded in several of the more orthodox  approaches to treatment rather than using bits and pieces through a lack of familiarity.

-          eclectic approach in therapy is to view an individual from a psychodynamic perspective, but to use more active interventions, such as you might find in a cognitive-behavioral approach.

            there is no one right or guaranteed way of approaching any given problem.

-          Each problem is tainted and changed by that individual's own history and way of viewing or perceiving his or her own problem.

-          Can sometimes involve elements of several different types of therapy, for example, a combination of behavioral therapeutic techniques and psychodynamic therapeutic techniques, becoming what is                 referred to as an “eclectic approach” to therapy.

**Eclectic Approach**

Strengths

-         Doesn’t confine the researcher to only one perspective, which allows them to have bigger base of information.

-         More flexible, allow each patient to be treated with method produced best effect for them.

-         Allow generation of better treatment and wider range of patient to be treated by combining two or more treatments.

-         Less bias in choosing type of treatment fit with each patient.

-         Allowing patient to decide their own type of therapy can be considered as more ethical

-         Contain the strength of all therapy involved.

-         Broaden the view in which the subject can be pursue and give more understanding by utilizing all relevant information from other approaches.

Weaknesses

-         Required skill and knowledge to be applied efficiently, since the clinician need to have knowledge of various approaches.

-         Different views of each approach can create confusion and difficulty in determining a combined method of treatment.

-         The value of each approach in an explanation can be hard to determine.

-         The lack of clear direction and back up study cause the approach to sometime unreliable.

-         Contain the weakness of all approaches involved

**Timothy (2006)**

Aim: show that there are many good reasons for using drug/psychotherapy combination treatments

Procedure: Examined research on drug and psychotherapy combination when they were used in different ways. The first combination is the *simultaneous* use of drugs and psychotherapy. The second is when drug and psychotherapy are combined *sequentially* (one or the other is use in addition to the first as to control symptoms). The third is *stage-oriented* use of antidepressant and psychotherapy.

Findings:

1)      The strongest evidence is the stage-oriented combination treatment. Antidepressants are the most beneficial treatment during the phase, after patients symptoms go away. Psychotherapy either alone or combined with antidepressants is the most effective way to prevent relapse.

2)      Research on the simultaneous use of drugs and psychotherapy during the acute phase of depression shows only a moderate increase in the reduction of symptoms.

3)      Some evidence that the sequential use of drugs and psychotherapy is beneficial. (Frank 2000) found that women with chronic depression were best treated first with IPT. Thos who still needed help to reduce symptoms were given SSRIs to supplement the IPT

4)      Agrees that Good apple’s neuroimaging study shows that both drug therapy and CT cause changes in the brain.

**Liu Jing-feng and Zhang Hong-xue (2002)**

Aim: to test the effectiveness of combing antidepressants and Chinese herbal medicine to treat’ depression.

Procedure: one hundred twenty participants were assigned to receive either a Chinese herbal formula/ antidepressant combination treatment or antidepressants alone. The combination treatment used 11 Chinese medicinal herbs thought to “calm the spirit” plus others if the participant also had other symptoms. The group also took chlorpromazine and amitriptyline. The comparison took a larger dose of the chlorpromazine and amitriptyline.

Findings: 41 participants in the combination treatment group were said to be cured, and return to work and live a normal live. 12 participants had showed improvement and tried to regain their normal lives. 7 had symptoms ended but couldn’t return to their normal lives. All the participants in the combination group shown improvement. In the comparison group where only drugs where give 36 participants were cure and 8 had shown great improvement. 14 of the participants had improved a little and 2 didn’t change at all.

**Advantages:**

-          Is supported by the biopsychosocial & stress-vulnerability models

-          Offers a greater flexibility in treatment

-          Treatment can be modified to suit individual needs

-          Less reductionist, more likely to address more facets of a problem

-          Empowers the patient. Patient can choose his treatment (*more ethical*)

-          Share the strengths of both therapies

**Limitations:**

-          Requires more of the therapist. The therapist needs to be an expert of several therapies

-          Share the weaknesses of both therapies

-          May be unsystematic and unfocused

Discuss the relationship between etiology and therapeutic approach in relation to one disorder.  
  
**Biological etiology of depression**

Genetic predisposition: can partly explain depression  
Twin studies: Nurnberger and Gershon (1982)  
reviewed the results of 7 twin studies and found that the concordance rate for major depressive disorder was consistently higher for MZ twins than for DZ twins   
genetic factors might predispose people to depression  
Average concordance rate for MZ twins was 65%, while for DZ twins it was 14%. The fact that the concordance rate is way below 100 indicates that depression may be the result of genetic predisposition/genetic vulnerability.   
  
Duenwald (2003), Caspi et al  
short variant of the 5-HTT gene may be associated with higher risk of depression. This gene plays a role in serotonin pathways which scientists think are involved in controlling mood, emotions, aggression, sleep, and anxiety.   
  
**Biological etiology of Anorexia**

Research suggests that a genetic predisposition to anorexia may run in families. If a girl has a sibling with anorexia, she is 10 to 20 times more likely than the general population to develop anorexia herself. Brain chemistry also appears to play a significant role. People with anorexia tend to have high levels of cortisol, the brain hormone most related to stress, and decreased levels of serotonin and norepinephrine, which are associated with feelings of well-being.  
Studies at the University of Pittsburgh found that unusually high levels of serotonin in the brains of anorexics. It seems strange at first because normal levels of serotonin are associated with happiness and a sense of well-being. High levels of serotonin, however, may be linked to anxiety and obsessional thinking. These are typical traits of anorexics.  
 **Biological treatment of depression**

The biological depression treatments are familiar to many people in that they usually include antidepressant medications and ECT (electroconvulsive therapy) or shock treatments. Antidepressant medications have grown significantly in their level of effectiveness and have an improved side effect profile over the earlier medication treatments.  The earliest antidepressants included tricyclic antidepressants which are now increasingly being replaced by the SSRI's (selective serotonin reuptake inhibitors) which include Prozac, Paxil and Zoloft.  These medications are reviewed extensively on separate pages of this web site.

One of the most controversial forms of depression treatment is electroconvulsive therapy or ECT.  These treatments for depression have been around for several decades but have improved significantly over the years in terms of both safety and effectiveness.  These depression treatments will also be reviewed extensively on other pages of this web site.

For Major Depression

|  |  |
| --- | --- |
| **Name and year of study** | Kirsch et al (2002) |
| **Aim** | To find out whether new generation anti-depressants Selective Seratonine Reuptake Inhibitors (SSRI) is effective in treating depression or not. |
| **Research method** | Experimental |
| **Procedure** | Using the Hamilton Scale for Depression on patients of different severity of depression taking the SSRI and placebo to see if the SSRI is effective or not. |
| **Findings** | The effects on the SSRI did not seem effective on patients with mild and moderate symptoms of depression; only severe depression patients experience some positive effects. |
| **Conclusion** |
| **Methodological strength** | -          Make people more aware of the real effects of the new generation drugs.  -          Ecological validity is high as drugs are being tested for their real effects. |
| **Methodological weakness** | -          Employed too many participants of the milder depression with fewer participants with severe depression. Creates a bias. (Low generalizability.  -          Some drugs experimented were still in the experimental phase, and not yet approved by the FDA. |
| **Ethical considerations** | -          Requires human testing on drugs, but consent forms are given. |

**Cognitive etiology of Anorexia Nervousa**

-          People with Anorexia have distorted image of themselves

-          Emotional disorder focused on food

-          Cognitive mind: trying to deal with **perfectionism**, control things by strictly controlling amount of food intake and weight

-          Self esteem is tied to their weight (how thin they are)

-          Could be caused by emotional stress or severe trauma (sexual abuse, death of loved ones) during times before or during puberty

-          It is an **Attentional biases and cognitive styles that distort reality/body image**

-          **“Body-image distortion hypothesis” :** 1962, Brucg

o   Overestimation of body size

o   1994, Slade and Brodie : those who suffer from an eating disorder are UNCERTAIN about the size /shape of their body

* Make judgment in which results in overestimation of body size

**Cognitive etiology of Major Depression**

A depressed mood may lead to depressed thoughts

Depressed cognitions, cognitive distortions, and irrational beliefs produce disturbances in mood

Ellis 1992 “cognitive style theory”

Depression from illogical and irrational thinking

On doubtful evidence about the meaning of an event, people draw false conclusion which could cause depression

E.g. “My report must be perfect”  “I did not get an A” leads to self-defeating conclusion  “I am a failure, I am very stupid,  I will fail at life”

Beck 1976 “cognitive distortion theory of depression”

Schema processing : store schemas about the self interfere with information processing

By observing depressive patients he found out that patients receives a negative cognitive triad characterized by

1.      Overgeneralization : based on negative evens

2.      Non-logical interference :about self

3.      Dichotomous thinking: “black and white thinking”, only recalling the negative consequences

-          Negative cognitive schemas are activated by stressful events and patients overreact

-          If a person has negative expectations about the future then the depression will go in a cycle

-          \*Most people who suffer from depression have irrational beliefs and cognitive biases such as harsh self-criticism and pessimism

**Sociocultural etiology of anorexia nervosa**

* More common in western society, but it is increasing in the eastern societies because of globalization
* Media exposure
* Social learning that people mimicking the action of their parents and low self-esteem
* Family interaction
* Places(social or environment) where they take the importance on physical appearance
* Places where people who area thin achieve success

**Cognitive Treatment of Depression:**

-          Beck’s cognitive therapy

-          Beck states: depressed people acquired negative schema of the world in childhood and adolescence through negative events

-          When those people faces situation that represents the original condition of the learned schema/negative schema activated (read more above)

-          Beck’s cognitive triad (patients have negative thoughts of) : SELF, WORLD, FUTURE

Way to treat :

-          **COGNITIVE RECONSTRUCTURING**

-          Replace wrong thoughts with accurate and beneficial ones

-          Gain awareness of bad thought habits challenge the habits change life enhancing thoughts and beliefs

-          E.g. “I failed my test” “I will do better next time,” “I can definitely pull my grades up.” “I hated the class anyway, now I know what course to take next year”

STUDY:

 Goldapple (2004)

**Aim:** To investigate how cognitive therapy affects brain changes

**Research method:** Experiment

**Procedure:** PET scans were used to document brain activity before and after 15 to 20 therapies of cognitive therapy over seven weeks in 14 patients. PET scans from a previous study on participants taking antidepressants were used as a control group. Participants were screened to ensure that they had no substance problems or antidepressant treatment one month prior to the study. Some of the participants reported reported previous negative experiences with drug therapy

**Findings:** there were significant changes in glucose metabolism in prefrontal-hippocampal pathways. The changes on the brain were the same as with antidepressants.

Lyon & Woods (1991)

Compared 70 Cognitive Therapy outcone studies with behavior therapy and other psychotherapies.

Cognitive therapy demonstrated better improvement than other groups

Effect size was related to therapist experience and duration of therapy

There were some methodological flaws: attribution rates (some participants dropped out) and lack of follow updata.

These studies show that cognitive factors influence abnormal behavior because they can affect a persons thoughts or cognition.

They're mood changes after the therapy, which aims to change their thought patterns.

Since their moods have improved after therapy, we can assume that their mood is affected by negative thoughts

Weakness: It ignores the other factors and only focuses on one factor. Does not take into account the biological and sociocultural factors

Strengths: It is testable and applicable- it is supported by case studies.

Lyon & Woods (1991)

Compared 70 Cognitive Therapy outcome studies with behavior therapy and other psychotherapies.

Cognitive therapy demonstrated better improvement than other groups

Effect size was related to therapist experience and duration of therapy

There were some methodological flaws: attribution rates (some participants dropped out) and lack of follow-up data.

These studies show that cognitive factors influence abnormal behavior because they can affect a persons thoughts or cognition.

They're mood changes after the therapy, which aims to change their thought patterns.

Since their moods have improved after therapy, we can assume that their mood is affected by negative thoughts

Weakness: It ignores the other factors and only focuses on one factor. Does not take into account the biological and sociocultural factors

Strengths: It is testable and applicable- it is supported by case studies.

***Also, see group approach to treatment***