Abnormal Psychology Learning Outcomes

These are all essay questions. Choose ONE from three choices (Always Q1,2 or 3 on paper2)

These are OUTLINES only. You will have to add to these as part of your review.

**General framework**

* To what extent do biological, cognitive and sociocultural factors influence abnormal behavior Remember that these factors can be asked about individually or together. Read the type of disorder required VERY CAREFULLY -Biological came (2012) regarding anxiety OR eating disorders. Came up biological and sociocultural (May 2011) regarding all 3 disorders
* Evaluate psychological research (that is, theories and/or studies) relevant to the study of abnormal behavior

*This is a VERY general ERQ. If the command term is ‘Evaluate’ then you must select theories or research that have many strengths and weaknesses. Below is only a suggestion. Make sure research methods are introduced clearly and evaluated*

Possible ERQ Outline

Introduction: The abnormal perspective seeks to ultimately help those with disorders by aiming to identify causes and looking at the effectiveness of treatment. In order to achieve this, a variety of research methods and studies from a variety of perspectives have been utlilised.

**Biological Approach.** Explain the main principles related to abnormality.

**Genetic factors**:

Correlational studies ie Twin studies See textbook p52

Description Measures the relationship between two or more variables. There is no manipulation of an IV so no cause and effect can be established. To establish a correlation between a behavior and genetic inheritance, twin studies are used. Monozygotic twins (MZ) come from one fertilized egg which split therefore they are genetically identical (share 100% genetic material). Dizygotic twins (DZ) come from two different fertilized eggs and therefore are like siblings who share 50% of their genetic material.

How A behavior is chosen, for example Major Depressive disorder (MDD) and the rate at which the behavior is found in both twins is measured. This usually expressed as a % and is called the **concordance** rate.

Why (also strengths) It can easily quantify observational data. No manipulation of behavior is required. Strong correlations can indicate areas for further research.

Weaknesses No cause and effect can be inferred

Example **Nurnberger and Gershon** (1982) review of 7 twin studies on major depression

Meta analysis using **Sullivan et al** (2000) See study guide p54. **Meta-analysis** is a statistical technique in which the results of two or more studies are mathematically combined in order to improve the reliability of the results. Studies chosen for inclusion in a meta-analysis must be sufficiently similar in a number of characteristics in order to accurately combine their results.

Advantages of meta-analysis include:

* Combines all the research on one topic into one large study with many participants therefore allows for generalization to the population of studies.
* Ability to control for between-study variation
* Including moderators to explain variation

Weaknesses of Meta Analysis

* Sources of bias are not controlled by the method
* A good meta-analysis of badly designed studies will still result in bad statistics.
* Dangers of Agenda Driven Bias: From an integrity perspective, researchers with a bias should avoid meta-analysis and use a less abuse-prone (or independent) form of research

Gene mapping using **Caspi et al 2003**. Attempts to determine the effect of a particular gene on behavior. This is at the cutting edge of research and may be significant in the future. There may be a way of identifying faulty genes that give people a predisposition to depression and potentially change them. There are many ethical implications of genetic research.

**Neurotransmitters**

The serotonin hypothesis, Coppen, 1967 **This links to the main form of treatment available from the biological approach.**

MDD is caused by low levels of Serotonin

+ Antidepressant drugs reduce the symptoms of Major depressive disorder. One group of antidepressants drugs is selective serotonin reuptake inhibitors (SSRI’s). These block the re-uptake process for serotonin. This increases the levels of serotonin in the synapse and therefore more is available at the receptor site. *Serotonin is found in areas of the brain involved with emotional behaviour.*

+ SSRI drugs such as Prozac and Zoloft are the most common for treatment of depression.

- You cannot make assumptions on the causes of MDD based on how people respond to treatment. This is backward reasoning, **Lacasse and Leo** (2005).

- The serotonin hypothesis needs to be revised because experiments that reduced serotonin levels in healthy individuals, did not lead to depressive symptoms. **Henninger et al (**1996)

- Publication bias. The placebo effect can account for 80% of all research carried out into SSRI effectiveness, published and non-published. We have to bear in mind that the drug companies fund a lot of the research into SSRI’s. **Kirsch et al 2008** – Meta analyais: Medical treatment was not more effective than a placebo and that depressed patients can improve without biochemical treatment

(-) **Leuchter and Witte 2002** – Brain function: Placebo is equally good as drug treatment

(-) Drugs have side effects

(-) Drugs are not a cure

Overall:

+ There is some evidence that serotonin may be involved in MDD. This may be linked to stress and stress hormones.

- Scientific research has failed to show a clear link between serotonin levels and MDD. Just because SSRI’s can regulate serotonin levels and produce an effect does not mean that low serotonin levels cause depression. Indeed, MDD may itself

**Cognitive Approach**

* *Beck (1967)*
  + Cognitive theory of depression: depressed people think differently about themselves and the world around them
  + The theory is based on schema processing where schemas about the self are negative (depressogenic schemas)
  + Depressogenic schemas lead to errors in thinking such as arbitrary inference, selective abstraction and overgeneralisations
  + These negative thoughts and errors then produce a triangle of negative thoughts of the self, the future and the world
* Alloy et al (1999)
  + Longitudinal study of young Americans in their 20s for 6 years
  + Participant’s thinking styles were tested and were either classified as “positive thinkers” or “negative thinkers”
  + After 6 years, only 1% of those in the positive thinkers group developed depression while 17% of those in the negative thinkers group had developed depression
  + Indicates a link between cognitive style and the development of depression

**Treatment**

**Luty et al 2007-** Trial of IPT and CBT. In severe depression more patients responded to CBT compared to IPT

(+) Lowers relapse rate

(+) No side effects

influence the production of neurotransmitters.

**Sociocultural-More linked with causes as these factors are hard to treat.**

* + Mental disorders found more frequently in lower socioeconomic groups – true for depression
  + Social causation is the idea that low socio-economic status (SES) causes psychopathology, whereas social drift is the idea that individuals and families with mental disorders tend to drift into lower-socioeconomic groups.

Brown and Harris (1978)

**Aim**

Investigate the link between depression and both current and past life events in the lives of sufferers (from MDD)

**Procedure**

A complex structured interview called the life events and difficulties scale (LEDS) was developed - Interviewers were trained in the use of LEDS

539 women in Camberwell, London were interviewed using LEDS.

Interviewers obtained details of what stressful events had occurred in the previous year, along with the background circumstances in which they occurred.

LEDS aimed to uncover stressful childhood events too.

Interviewers prepared a written account of each event of source of stress, which would be rated by a panel of researchers for how stressful it would be for a typical person. To avoid bias, these raters had no knowledge of whether the person they were looking at had suffered depression, until later.

Researchers then looked for associations between who suffered depression and who had recently had a stressful life and who had had stressful events in their childhood.

**Findings**

High levels of stress and having suffered a stressful childhood event left people particularly vulnerable to depression.

80% of women who suffered depression had had a major stressful life event in the previous year, as opposed to 40% of those who did not suffer depression.

3/4 factors that had the strongest associations with depression involved recent levels of stress.

These were the lack of an intimate relationship, lack of paid employment and the presence of three or more children in the home. However, childhood events were also important, especially the death of the woman’s mother before she reached the age of 11.

**Conclusions**

There was a link between recent negative life events and the onset of depression.

Loss in childhood, especially of the mother, also made women more vulnerable to depression.

**Overall Evaluation of Socio-Cultural Factors**

•    + A lot of the factors indicate that stress leads to depression which links to the cortisol hypothesis from the biological etiology

•    + Has strong empirical evidence from studies and observations

•    + Links in with Beck’s cognitive theory of depression since those people under social stress might develop a negative world perception

•    - Only shows correlation, not causality between factors and the onset of MDD

•    - A lot of the results are had to generalise to the overall population

•    - A lot of studies does not account for cultural differences in the social causes of MD

**Conclusion:** The abnormal perspective seeks to ultimately help those with disorders by aiming to identify causes and looking at the effectiveness of treatment. However, abnormal behavior is complex and there is no clear-cut cause or cure. Psychologists within this perspective now acknowledge that there are a variety of causes of abnormal behavior-**diathesis stress model.** They also favour an eclectic approach to treatment (using a variety of techniques) –**Pampallona et al meta analysis**.

**Concepts and Diagnosis**

* Examine the concepts of normality and abnormality (easy question)
* Discuss validity and reliability of diagnosis DO NOT ATTEMPT (2012) (Nov 2011)
* Discuss cultural and ethical considerations in diagnosis. DO NOT ATTEMPT (May 2011)

**Psychological disorders**

* Describe symptoms and prevalence of one disorder from two of the following groups: As a parted ERQ. Read the type of disorder required VERY CAREFULLY

Anxiety disorders DO NOT ATTEMPT

Affective disorders- Major depressive disorder (shorten to MDD)

Eating disorders- Bulimia Nervosa

**Describe the symptoms and prevalence of one affective disorder**

* Describe MDD – affective disorder
* Symptoms
  + 2 key symptoms - Depressed mood, loss of pleasure or interest
  + 4 secondary symptoms - Hypersomnia/Insomnia, weight loss/increase, suicidal thoughts, worthlessness/guilt
  + Symptoms must be concurrent in the same 2 week period
* Prevalence
  + Kessler et al (2005) – general vs gender
  + Andrade and Caraveo (2003) found prevalence for depression varies across cultures.
    - 3% in Japan to 17% in US

**Describe the symptoms and prevalence of one eating disorder**

* State that eating disorder described is bulimia nervosa
* Symptoms
* Psychological: Nutritional deficiencies and hormonal changes could lead to disturbances in the menstrual cycle, fatigue, digestive problems, muscle cramping
* Cognitive: Distorted body image, low self-esteem, sense of lack of control during binge-eating episodes
* Emotional: Fear of becoming fat, body dissatisfaction, and depressed mood
* Behavioural: Self-starvation in combination with recurrent binge eating episodes and compensatory behaviour such as vomiting and misuse of laxatives to avoid weight gain.
* Definition of prevalence: a statistical concept in medicine (or psychiatry). It refers to the percentage of individuals within a population who are affected by a specific disorder at a given time.
* Studies
* Keel and Klump (2003)
* They performed a meta-analysis of research on bulimia nervosa and found an increase in people diagnosed with bulimia from 1970 to 1993. There are no incidence data for bulimia prior to 1970. The diagnostic criteria for blimia have become more stringent over the years and this has resulted in the increase of incidences. According to the researchers, self-report surveys tend to produce higher estimates of bulimia nervosa prevalence than structured clinical interviews.
* Fairbun and Beglin (1990)
* They found that bulimia nervosa affected between 1 and 2% of young women in the USA and the UK. APA (200) estimated 1-3% of young adult females to have Bulimia, The disorder occurs much less frequently in men.
* Analyse etiologies (in terms of biological, cognitive and/or sociocultural factors) of one disorder from two of the following groups: Remember that these etiologies can be asked about individually or together.

Anxiety disorders DO NOT ATTEMPT

Affective disorders- Major depressive disorder (shorten to MDD)

Eating disorders- Bulimia Nervosa

**Analyze etiologies (biological, cognitive, sociocultural) of one affective disorder**

**You will need to add more detail to evidence to the information below**

* Describe MDD – affective disorder

### Difficult to investigate origin of an affective disorder and as such there is no simple answer. A combination of factors is usually the cause.

* Symptoms
  + 2 key symptoms - Depressed mood, loss of pleasure or interest
  + 4 secondary symptoms - Hypersomnia/Insomnia, weight loss/increase, suicidal thoughts, worthlessness/guilt

Symptoms must be concurrent in the same 2 week period

### Biological Investigates genetic factors and biochemical factors (neurotransmitters and hormones).

### Possible Causes

### Genetic Vulnerability, Neurotransmitters malfunctioning, Changing Hormones

### Genetic Factors – MDD being affected by genetic component

### Twin studies establish a genetic cause using MZ and DZ twins Measures degree of similarity or concordance of characteristics such as MDD, between twins. Twins are likely brought up in similar environments hence concordance comparison between MZ and DZ indicates possibly genetic cause. However living environment is likely to affect personality and likelihood of developing the disorder, the adoption study attempts to control this. Nurnberger and Gershon and Sullivan et al.

### Family –Closer relation in family means more likely to share diagnosis of MDD 100% MZ, 50% DZ, 50% parent or sibling, 25% aunt uncle niece nephew. Similarly to the twin study, families live in similar environment which may affect their likelihood of getting affective disorders together. Oruc et al First degree relatives of people diagnosed with depression are 2-3 times more likely to receive a similar diagnosis than first degree relatives of those who have not received a diagnosis of depression.

### Adoption – Attempts to control similar environments that most related individuals share. Concordance in MZ twins living in different environments suggests strong genetic evidence. Harrington et al 20% of biological relatives compared with 5-10% of adoptive relatives

### Biochemical Factors – MDD being affected by chemicals produced in the body

### Neurotransmitters – Neurons transmit information within the brain. Neurotransmitter travel the gap of neurons and either excite or inhibit the next neuron. It is unclear however, how a change in neurotransmitter such as serotonin affects the likelihood of developing or recovering from depression. Coppen The serotonin hypothesis. Lacasse and Leo, Henninger et al.

### Hormones – Endocrine glands secrete hormones into blood which can affect behaviour. Cortisol (stress) associated with depression, released by adrenal glands and controlled by pituitary gland. The cortisol hypothesis

**Sociocultural**

* + Mental disorders found more frequently in lower socioeconomic groups – true for depression
  + Social causation is the idea that low socio-economic status (SES) causes psychopathology, whereas social drift is the idea that individuals and families with mental disorders tend to drift into lower-socioeconomic groups.

**Brown and Harris** (1978)

**Aim**

Investigate the link between depression and both current and past life events in the lives of sufferers (from MDD)

**Procedure**

A complex structured interview called the life events and difficulties scale (LEDS) was developed - Interviewers were trained in the use of LEDS

539 women in Camberwell, London were interviewed using LEDS.

Interviewers obtained details of what stressful events had occurred in the previous year, along with the background circumstances in which they occurred.

LEDS aimed to uncover stressful childhood events too.

Interviewers prepared a written account of each event of source of stress, which would be rated by a panel of researchers for how stressful it would be for a typical person. To avoid bias, these raters had no knowledge of whether the person they were looking at had suffered depression, until later.

Researchers then looked for associations between who suffered depression and who had recently had a stressful life and who had had stressful events in their childhood.

**Findings**

High levels of stress and having suffered a stressful childhood event left people particularly vulnerable to depression.

80% of women who suffered depression had had a major stressful life event in the previous year, as opposed to 40% of those who did not suffer depression.

3/4 factors that had the strongest associations with depression involved recent levels of stress.

These were the lack of an intimate relationship, lack of paid employment and the presence of three or more children in the home. However, childhood events were also important, especially the death of the woman’s mother before she reached the age of 11.

**Conclusions**

There was a link between recent negative life events and the onset of depression.

Loss in childhood, especially of the mother, also made women more vulnerable to depression.

**Overall Evaluation of Socio-Cultural Factors**

•    + A lot of the factors indicate that stress leads to depression which links to the cortisol hypothesis from the biological etiology

•    + Has strong empirical evidence from studies and observations

•    + Links in with Beck’s cognitive theory of depression since those people under social stress might develop a negative world perception

•    - Only shows correlation, not causality between factors and the onset of MDD

•    - A lot of the results are had to generalise to the overall population

•    - A lot of studies does not account for cultural differences in the social causes of MD

**Cognitive**

* *Beck (1967)*
  + Cognitive theory of depression: depressed people think differently about themselves and the world around them
  + The theory is based on schema processing where schemas about the self are negative (depressogenic schemas)
  + Depressogenic schemas lead to errors in thinking such as arbitrary inference, selective abstraction and overgeneralisations
  + These negative thoughts and errors then produce a triangle of negative thoughts of the self, the future and the world
* Alloy et al (1999)
  + Longitudinal study of young Americans in their 20s for 6 years
  + Participant’s thinking styles were tested and were either classified as “positive thinkers” or “negative thinkers”
  + After 6 years, only 1% of those in the positive thinkers group developed depression while 17% of those in the negative thinkers group had developed depression
  + Indicates a link between cognitive style and the development of depression
* Boury et al (2001)
  + Investigated Beck’s theory and found a significant correlation between the amount of automated negative thoughts the severity of depression
  + Found that the duration of the depression was influenced by the frequency of negative cognitions
  + However it is hard to demonstrate causality between negative cognitions and depression. Could be the result rather than cause

**Analyse etiologies (biological, psychological, sociocultural factors) of one eating disorder**

**Introduction**

* Define etiologies
* One eating disorder I will be focusing on is bulimia nervosa
* Bulimia nervosa: a serious psychological disorder characterisied by binge eating episodes and compensatory behaviours (i.e. dieting, vomiting…)

**Biological factors**

* Genetic vulnerability in bulimia nervosa
* Kendler et al (Aim, Method, Results, Conclusion)

**Evaluation of the study**

* Gynocentric, cannot generalize findings to men
* Study does not take environmental factors into account
* Difficult to find out the relative importance of genetic inheritance and environmental factors

**Evaluation of biological factors as a whole**

* Genetic vulnerability may predispose an individual, but other factors also trigger the disorder
* It’s important to investigate environmental factors

**Cognitive factors: short studies 🡪 name drop**

* Body-image distortion hypothesis
* **Bruch** (conclusion)
* **Fallon Rozin** (Aim, method, findings
* Weight-related schemata model
* **Fairburn**

**Evaluation of cognitive factors as a whole**

* For some ppl, their concerns and prioritization of weight control may reflect a wider lack of self-esteem and a vulnerability to cultural messages about body weight.
* They think that they will feel better if they lose weight but this obsession with weight control may lead to depression and intensified feelings of low self-esteem because weight control is the major way of maintaining self-worth

**Sociocultural factors**

* Perceptions of the perfect body are influenced by cultural ideals to a large extent. In west, the ideal body shape for women has changed from an hourglass to a slimmer shape.

**Supporting studies**

**Levine et al** (Aim, method, findings, conclusion, evaluation)

**Jaeger et al** (Aim, method, findings, conclusion, evaluation)

Evaluation of sociocultural factors as a whole

* Discuss cultural and gender variations in prevalence of disorders
* You will need a definition of prevalence
* You still need to identify the disorders you will discuss. You will need at least two.
* You need to identify the disorders and describe the symptoms in terms of PEBC (Physiological, Emotional, Behavioural and Cognitive).
* The disorders you write about will have different gender and cultural variations. It is probably best to deal with gender variations first and then cultural variations.

Affective disorder: Major Depressive Disorder

Gender variations in prevalence

* Re-cycle
* The National Institute of Mental Health in the USA found the lifetime prevalence of depression for Males was 13.2% and Females was 20.2% **(Kessler et al 2005)**
* **Nolen-Hoeksema** (2001) Women are about twice as likely as men to develop depression. However there is no single variable that can account for this.
* **Weisman et al** found women had a higher prevalence of depression than men in 10 different countries

You will need to provide explanations for the gender differences

* What are the biological explanations for women’s higher prevalence?
* Historically it was thought that the hormones oestrogen and progesterone could cause women to be vulnerable to depression BUT there is little scientific evidence to support this**. Nolen-Hoeksema** (2001)
* Weiss et al suggested that women have a dysregulated response to stress because they are more likely to have been exposed to regular episodes of trauma.
* What are the sociocultural explanations for women’s higher prevalence?
* **Nolen Hoeksema** (2001) Women’s low power and status. This may lead to constrained choices and make women feel like they have a lack of control
* The role strain hypothesis. Women may have to rely on the role of housewife for identity and self esteem. **Brown and Harris’s** study also supports the idea that women’s social roles carry a number of strains like childcare. Bebbington home/small children=depression

Cultural variations in prevalence

* There are some similarites across cultures. According to the World Health Organisation, identified common symptoms of major depression in Iran, Japan, Canada and Switzerland? Sad effect, loss of enjoyment, lack of energy. An etic approach showing universal symptoms.

However there are many differences

* Re-cycle
* **Andrade and Caraveo** (2003) found the lifetime prevalence of depression varies across cultures. 17% in USA and 3% in Japan.
* What do you think the key findings are according to **Weisman et al** (1996)? Varying rates of depression worldwide. Beirut 19%, Taiwan 1.5%. Different risk factors, social stigma and cultural reluctance to endorse mental symptoms may account for the differences.

You will need to provide explanations for the cultural differences

* Historically, depression was common in western culture and appeared to be absent in Asian cultures. This has been explained in many ways.
* **Rack** (1982) Asians only consult their doctor for physical problems (tiredness, insomnia). Emotional issues are sorted out within the family.
* **Klienman** (1982) Neurasthenia in China. 100 patients with neurasthenia were interviewed using DSM III criteria. 87% of the patients could be classified as suffering from depression. 90% complained of headaches, only 9% complained of depressed mood.
* Marsella (2003) argues that in individualistic cultures depression takes a primarily emotional form (loneliness). Whereas in collectivist cultures physiological symptoms (headaches) dominate.
* **Marsella** (1995) Urban settings are associated with increased stress (housing problems, underemployment, limited education).
* **Dutton** (2009) People in some countries have much harder lives due to war, economic changes, unemployment. They are exposed to different social stresses.
* Reporting Bias Rates are based on figures from hospital admissions which may not reflect true prevalence rates. **Rack** (1982) found that there is a great stigma attached to mental illness in China. Therefore only psychotics are labelled.

Even within culture there are differences (this is an added extra)

* Re-cyle
* **Poongothai et al** (2009). Overall prevalence for MDD in the city of Chennai, South India was 15.9%. Similar to the USA. Self report study of 25,455 participants. Depression rates were higher in the low income group-19.3% compared to the higher income group-5.9%. Also rates among divorced-26.5% were higher than currently married-15.4% Evaluate the use of self study.
* This shows that factors other than culture are responsible for differing prevalence rates.

Use terminology correctly

* Individualistic
* Collectivist
* Emic-one culture, culturally specific
* Etic (the t represents together)-across cultures, universal behaviours

Eating disorder: Bulimia Nervosa

Gender variations in prevalence

**Fairburn and Beglin** (1990) bulimia nervosa affected between 1 and 2% of young women in the USA and the UK, APA(200) estimated 1-3% of young adults females to have bulimia. The disorder occurs much less frequently in men.

Makino – reviewed studies from 11 cultures. Found that more femals had eating problems then males.

IN the uk out of 100 cases of bulimia 5 are.

You will need to provide explanations for the gender differences

Less socially acceptable for men to come out with bulimia and different issues.

Cultural variations in prevalence

**Jaeger et al. (2002)**

Cross cultural  investigation of relationships between body dissatisfaction and the development of bulimia nervosa.

A cross cultural sample of 1,751 female medical and nursing students from 12 nations participated.

10 body silhouettes designed to be culturally neutral to measure body dissatisfaction. Participants BMI was taken and they answered questions on self dissatisfaction with body shape and dieting behavior.

Most extreem dissatisfaction was found in northern Mediterranean countries followed by northern european. COuntries in process of westernization showed an intermediate amount of dissatisfaction. Non-western cultures showed the lowest levels.

Results indicated that the body shapes represented in the media could encourage dissatisfaction with body shape and dieting behavior

**Nasser** (1994) – Ideal body weight in Egypt is much higher as it shows wealth, Still evidence of Bulimia in Egypt.

You will need to provide explanations for the cultural differences

**Jaeger et al. (2002)**

**Cross cultural  investigation of relationships between body dissatisfaction and the development of bulimia nervosa.**

**A cross cultural sample of 1,751 female medical and nursing students from 12 nations participated.**

**10 body silhouettes designed to be culturally neutral to measure body dissatisfaction. Participants BMI was taken and they answered questions on self dissatisfaction with body shape and dieting behavior.**

**Most extreme dissatisfaction was found in northern Mediterranean countries followed by northern European. Countries in process of westernization showed an intermediate amount of dissatisfaction. Non-western cultures showed the lowest levels.**

**Results indicated that the body shapes represented in the media could encourage dissatisfaction with body shape and dieting behavior**

**Implementing treatment**

* Examine biomedical, individual and group approaches to treatment. Include more than one disorder. (May 2011 biomedical and individual) (Nov 2011 individual and group)

**Introduction**

* three kinds of approaches to treatment
* patients experience disorder to different degree

**Biomedical:**

* based on the assumption that biological factors are involved in disorder
* drugs typically operate by affecting transmission in nervous system of neurotransmitters 🡪 to increase/decrease the level of available neurotransmitter in the synaptic gap
* can help change a person’s mood in a positive direction

selective serotonin reuptake inhibitors (SSRI)

* interfere with serotonin levels and affect mood and emotional responses positively in most people
* take 7-14 days to relieve depressive symptoms
* most drugs are SSRI
* increase serotonergic nerve activity leading to improvement in mood
* fewer side effects (headache, sleeplessness)

Neale et al (2011)

* meta-analysis of published studies on the outcome of anti-depressants vs placebo
* 1) antidepressants 🡪 placebo 2) placebo 3) antidepressants
* Finding: antidepressants -> 25% risk of relapse, stopped medication 🡪 42%
* Conclusion: depressants interfere with the brain’s natural self regulation and increase the risk of relapse

**Individual treatment**

* One of the most widely used individual therapies in cognitive behavioral therapy
* Beck’s explanation automatic negative thinking is assumed to cause depression.
* 12-20 weekly sessions combined with daily practice exercises.

How cognitive behavioral therapy (CBT) works

1. Identity and correct faulty cognitions and unhealthy behavior
2. Increase activity and learn alternative problem solving strategies

Paykel et al (1999) controlled trial of 158 patients suffered from major depression.

The patients received antidepressant medication but some of them also received cognitive therapy. The CBT group had a relapse rate of 29% compared to only medication patients.

Cognitive therapy appears to be effective to prevent relapse, particularly in combination with medication.

How CBT works in treating bulimia

**Fairbum** 1997

CBT best psychological treatment for bulimia involves

* Replacing binge eating with a pattern of regular eating and trying to aviode vomiting or other compensatory behaviors
* Therapy sessions with the client and later with important friends and relatives who will support
* Therapy sessions that address both behavior and cognitive distortions
* Maintenance of the program and considerations of strategies to prevent relapse.

**Hay et al** (2004)

* Aim: effectiveness of CBT in the treatment of bulimia and binge eating.
* Showed that CBT was an effective treatment for eating disorders.
* CBT was effective in group settings.

Interpersonal psychotherapy (IPT)

**Klerman et al** 1984

* Developed IPT as a short term, structured psychotherapy for depression
* Aim: help clients identify and modify current interpersonal problems that maintain the eating disorder.
* Does not focus directly on eating disorder symptoms

**Group treatment**

In group therapy, the therapist meets with a group of people (family or a group of individuals suffering from the same disorder). Group therapy is generally less expensive than individual therapy. Group therapy based on mindfulness is becoming increasingly popular and studies indicate that it may be a useful approach.

**McDermut et al 2001**

Aim: To review the effectiveness of the group approach in the treatment of depression.

Method: Meta Analysis of 48 studies

Results: 43 showed statistically significant reductions in depressive symptoms after group therapy, 9 showed no difference between group and individual therapy, 8 showed individual CBT to be more effective than group therapy.

Evaluation

+ Sound evidence through the study that group therapy is effective for relieving depression.

-78% of the patients were women. The results may be more applicable to females.

- The group did not include severely depressed and suicidal patients so it is not possible to conclude anything about its effectiveness within those groups.

-It is hard to evaluate the effectiveness of group therapy because the group dynamic presents more variables than individual therapy, Yalom (2005). For example, Group cohesion-there needs to be a sense that all people belong. Confidentiality-people must trust that they can speak freely.

**Mindfulness based cognitive therapy (MBCT) Segal, Williams and Teasdale (2001)**

Aim: to prevent people becoming relapsing depression after successful treatment for major depression

**How MBCT works**

* MBCT is based on Buddhist meditation and relaxation techniques. These help people to direct their focus and concentrate so they are able to observe intrusive thoughts and gradually become more able to prevent the escalation of negative thoughts
* Goal: teach people to recognize the signs of depression and adopt a decentered perspective, where people see their thoughts as mental events rather than something central to their self-concept or as accurate reflections of reality

**Mindfulness based treatment of depression.**

**Kuyken et al (2008)**

The study investigated the effectiveness of MBCT in a randomized controlled study with 123 participants with a history of three of more episodes of depression. All participants received anti-depressive medication.

Participants were randomly allocated to two groups. Over the 15-month study, the control group continued their medication and the experimental group participated in an MBCT course and gradually diminished their medication.

People in the control group who received anti-depressive medication had a relapse rate of 60% compared to the experimental group of 47%. Participants in the MBCT group overall reported a higher quality of life, in terms of enjoyment of daily living and physical well-being. Anti-depressive medication was significantly reduced in the MBCT group and 75% of the patients stopped taking the medication.

**Mindfulness based treatment of bulimia**

**Prolux (2008)**

* Eight-week mindfulness based intervention to treat six college age women suffering form bulimia.
* Patients were interviewed individually before and after treatment.
* Reported that they could control emotional and behavioral extremes better after the treatment and had reached a greater self-acceptance.
* They felt less emotional stress and were more able to manage stress and the symptoms of bulimia.

**Overall evaluation of a group approach to treatment**

+ It is less expensive compared to individual therapy

-/+Group therapy may be used to treat depression but it may not be appropriate as the only therapy (**Kuyken** supports this)

-It may only be effective when the group dynamic is right and patients must feel positively about the treatment.

-It may only be suitable for patients/clients who are not severely depressed.

* Evaluate the use of biomedical, individual and group approaches to the treatment of one disorder Remember that these treatments can be asked about individually or together. Read the type of disorder required VERY CAREFULLY. (2012 Group approaches)

Introduction

Establish use of affective disorder MDD

Give a description of symptoms (PEBC) and prevalence

Many approaches but I will be focusing on…

Biomedical Overview

Define. Assumptions of the approach

Use of drugs in general in terms of neurotransmitters.

Explain how SSRI’s are now widely used, how they work , Example (Prozac)

Strengths of Biomedical (mostly in terms of effectiveness)

(+) **Bernstein et al 1994** Help 60-80% of people

(+) Long term control/Prevent suicide

(+) Less hospitalization so cheaper

Weaknesses of Biomedical (mostly in terms of effectiveness)

(-) **Leuchter and Witte 2002** – Brain function: Placebo is equally good as drug treatment

Supported by

(-) **Kirsch et al 2008** – Meta analyais: Medical treatment was not more effective than a placebo and that depressed patients can improve without biochemical treatment

(-) Drugs have side effects

(-) Drugs are not a cure

Individual Treatment Overview

Define. Assumptions of the approach

Focus will be on cognitive therapy

Outline CBT in terms of how it is carried out. (Cognitive and behavioural aspect)

Strengths of Individual (mostly in terms of effectiveness)

(+) **Riggs et al 2007** Adolescents – combination of placebo/drugs andCBT gives a big improvement **OR Luty et al 2007-** Trial of IPT and CBT. In severe depression more patients responded to CBT compared to IPT

(+) Lowers relapse rate

(+) No side effects

Weaknesses of individual (mostly in terms of effectiveness)

(-) **Elkin et al 1989** IPT drugs and CBT are equally effective

(-) More expensive than drugs (may be cost effective compared to other IP

(-) Focus on symptoms not causes

Conclusion

It is a concern that it is not clear exactly how SSRI’s work. They are however effective in treating depressive patients with a range of severities. It is still hard to establish just how effective drug treatments are when compared. with other methods. If drugs are equally effective as CBT, then surely it would be better to offer a treatment that is long term and with few side effects.

* Discuss the use of eclectic approaches to treatment. Include more than one disorder

Introduction

Define eclectic approaches: an approach that incorporates principles/techniques from various systems/ theories

State that eclectic approaches recognize the strengths and limitations of various systems and tailors sessions to the needs of individuals

This is a widely practiced approach practiced

This is supported by Klerman who claims that a combination of psychotherapy Is more successful than either psychotherapy or drugs alone

Supporting Study 1: **Pampallona et al (2004)**

Meta-analysis of efficiency of drug treatment alone vs drug treatment and psychotherapy

The aim of the study was to analyse whether combining anti-depressants and psychotherapy was more effective in the treatment of depression

16 randomized controlled studies were conducted including 932 patients taking antidepressants only had 910 receiving combined treatment

The patients had all been randomly allocated to the treatments

The results showed the patients in combined treatment improved significantly more compared to those receiving drug therapy alone

This was particularly true in studies that ran over more than 12 weeks and there was also a significant reduction in dropouts

Significance of study: shows that eclectic approach is more effective

Evaluation of Study 1:

+: Use of meta-analysis gives a strong supporting evidence to the effectiveness of eclectic approach as it uses many studies for evidence

+: Is a representative sample

-: Too many different variables may have influenced this as different studies many not have the same controlled variable (such as the drugs used)

-: Meta-analysis does not take into account of those patients who have received group psychotherapy (or ambiguous as to which psychotherapy is used)

Supporting Study 2: **Klerman et al (1974)**

Treatment of depression by drugs and/or psychotherapy

The aim of this controlled study was to test the efficacy of treatment with anti-depressants and psychotherapy, alone or in combination

Participants were 150 females diagnosed with depression

Patients were divided into 3 groups:

1. Anti-depressants alone
2. Anti depressants and psychotherapy
3. No medication but more psychotherapy
4. Placebo and no psychotherapy

The results showed that relapse rates were highest for patients in the placebo group alone (36%)

The group with anti depressants alone had a relapse rate of 12%

The psychotherapy (IPT) alone had a relapse rate of 16.7%

Combination of drug and IPT had a relapse rate of 12.5%

This shows that combination does have a lower relapse rate but there was no significant difference between drug therapy alone or drug therapy in combination with psychotherapy

Significance of study: shows that there are studies that show eclectic approaches are not always more effective than just drug therapy or psychotherapy alone

Discussion on why eclectic approaches could be more efficient than medication alone:

* Patients might stop taking their medication
* **Pampallona** et al (2004) meta-analysis provides strong evidence that the combination of drugs and psychotherapy generally leads to greater improvement. The study showed that psychotherapy helps to keep patients in treatment

Conclusion

Eclectic approach is useful in treating depression

Researchers have shown this as a combination of treatment is usually more effective than just one approach alone (this is because one treatment might not be enough)

However this is not always the case as there are different studies that provide different evidence to its effectiveness

But overall, it is a good approach that should be considered as it is tailored to the needs of individuals and is specific to help their needs

* Discuss the relationship between etiology and therapeutic approach in relation to one disorder (Nov 2011)

1st part

• Introduction; MDD, characteristics of MDD

• 1st paragraph; **Coppen’s** (1967) serotonin hypothesis

• 2nd paragraph; How serotonin works and the effect of SSRI

• 3rd paragraph; Positives (cheap, works, highly recommended by psychiatrist)

• 4th paragraph; Negatives, **Lacasse & Leo** (2005) shows how SSRI’s are an example of backwards reasoning. **Kirsch et al** (2002) showing publication bias regarding the effectiveness of SSRI

• Conclusion; works, tends to be short in effectiveness. It treats the symptoms rather than cause.

2nd part

• 1st paragraph; Cognitive etiology, **Beck’s cognitive theory of depression** (1967)

o Support with **Alloy et al** (1999)

• 2nd paragraph; CBT’s aims and principles to correct an individuals way of thought

• 3rd paragraph; Evaluation

• + no down sides, cheap, permanent

• - ethical concerns, some people can’t commit to therapy

• Conclusion; both treatments are effective at different things, short term vs. long term solutions. Results in an eclectic approach being used most of the time.

**Never been used**

* Evaluate psychological research (that is, theories and/or studies) relevant to the study of abnormal behavior
* Examine the concepts of normality and abnormality (easy question)
* Describe symptoms and prevalence of one disorder from two of the following groups: As a parted ERQ. Read the type of disorder required VERY CAREFULLY
* Analyse etiologies (in terms of biological, cognitive and/or sociocultural factors) of one disorder from two of the following groups:
* Discuss cultural and gender variations in prevalence of disorders
* Discuss the use of eclectic approaches to treatment. Include more than one disorder