13.3 Psychological Explanations for Anorexia Nervosa: 30-minute Pack

AQA 7182 · about 30 minutes

Total Marks

Name: _____ Date: ____ / ____ / _____

Answer ALL questions.

1 Outline one cognitive explanation for anorexia nervosa focusing on body image distortion in the clinical assessment context.

(Total for Question 1 is 2 marks)

2 Explain Minuchin's notion of the 'psychosomatic family' and how this idea was applied to cases of anorexia nervosa in clinical descriptions.

(Total for Question 2 is 3 marks)

3 Explain how reinforcement operates within social learning theory to maintain weight loss behaviour in someone with anorexia nervosa, giving a clinical example.

(Total for Question 3 is 3 marks)

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4 Identify one clinical strength of the family systems explanation for anorexia nervosa and explain why this strength is important for treatment planning in a hospital or outpatient clinic.

(Total for Question 4 is 4 marks)

5 Discuss psychological explanations for anorexia nervosa. In your answer include family systems theory, social learning theory and cognitive explanations. Refer to research evidence and clinical implications, and evaluate strengths and limitations of these psychological accounts.

(Total for Question 5 is 16 marks)

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Mark scheme · 13.3 Psychological Explanations for Anorexia Nervosa: 30-minute Pack

Question 1

identifies body image distortion as a cognitive factor, e.g. perceiving oneself as overweight despite being underweight oe	**B1**
briefly explains how it contributes: distorted perception of size motivates continued restriction and refusal to recognise the seriousness of weight loss oe	**B1**

Answer: Body image distortion: the person genuinely perceives their body as larger than it is, and this distorted perception drives continued restriction and resistance to weight gain.

Question 2

states the psychosomatic family concept: families with enmeshment, poor conflict resolution, overprotectiveness and rigid roles, linked to a child's physical symptoms oe	**M1**
applies this to anorexia: Minuchin suggested the disorder could be a symptom of family dysfunction where eating problems communicate distress or maintain family homeostasis oe	**A1**
explains why this matters clinically, e.g. eating disorder behaviour serves a social function within the family system oe	**A1**

Answer: Minuchin described a psychosomatic family as one with enmeshment, overprotectiveness, conflict avoidance and rigid roles; he suggested a child's anorexia can function as a symptom that expresses family conflict and maintains family stability by redirecting attention to the child's needs.

Question 3

states how reinforcement works: positive reinforcement (praise, attention) or negative reinforcement (avoidance of criticism) increases the likelihood of behaviour repeating oe	**M1**
applies to anorexia: e.g. weight loss receives compliments from peers or parents, which reinforces restrictive eating oe	**A1**
explains maintenance: repeated social reward makes the dieting behaviour persistent even when harmful oe	**A1**

Answer: Reinforcement maintains behaviour: for example, when a teenager receives praise from peers or parents for weight loss (positive reinforcement) or avoids parental criticism by losing weight (negative reinforcement), restrictive eating is reinforced and becomes persistent.

Question 4

identifies a genuine strength, e.g. directs attention to family therapy such as Maudsley or systemic approaches that involve the family in recovery oe	**M1**
explains why this is useful clinically, e.g. engaging family can address maintaining dynamics, improve support and reduce relapse risk oe	**A1**
further develops why it matters in a clinical setting, e.g. allows therapists to target communication/enmeshment rather than only treating weight gain as an individual problem oe	**A1**
shows consequence: better long term outcomes or reduced readmission if family factors are changed oe	**A1**

Answer: Strength: it leads to family-based interventions. This matters clinically because involving and changing family interactions can remove maintaining dynamics, improve carers' support skills and reduce relapse, so treatment addresses social causes as well as weight restoration.

Question 5

Level 4 Knowledge of psychological explanations is detailed and accurate. Evaluation is thorough and well balanced, using relevant evidence to support and challenge explanations and showing awareness of clinical implications. Different explanations are integrated and compared, and limitations in methods and generalisability are considered. Specialist terms are used accurately and the answer is coherent.	**13-16**
Level 3 Knowledge is accurate with some detail. Evaluation is clear but less comprehensive, with some relevant evidence and clinical implications. Explanations are compared and application is present but may lack depth. The answer is generally organised with appropriate terminology.	**9-12**
Level 2 Knowledge of explanations is present but partial or limited. Evaluation is superficial and may rely on assertion. Some clinical implications or evidence may be mentioned but not well linked. Organisation and use of terminology are inconsistent.	**5-8**
Level 1 Knowledge is minimal or fragmented. Evaluation is very limited or absent. Little or no use of evidence or clinical application. Answer lacks clarity and specialist terminology.	**1-4**
Level 0 No creditable content.	**0**

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Indicative content:

- AO1: Family systems theory explains anorexia in terms of dysfunctional family dynamics such as enmeshment, overprotection, poor conflict resolution and Minuchin's psychosomatic family idea, with anorexia serving a function in family homeostasis.
- AO1: Social learning theory explains onset and maintenance by modelling and reinforcement, where parents, peers and media provide thin role models and social approval that reward weight loss, encouraging imitation and maintenance.
- AO1: Cognitive explanations focus on distorted body image and cognitive distortions such as all-or-nothing thinking, attentional bias to weight-related cues, and overvaluation of weight and shape, which maintain restrictive eating.
- AO3: Support for family explanations includes clinical case studies and therapeutic results from family-based interventions, which can improve outcomes, but evidence is often clinical, non-experimental and may reflect selection bias.
- AO3: SLT is supported by correlational studies linking media exposure to body dissatisfaction, and by evidence that parental and peer attitudes predict disordered eating, but causal direction is unclear and many exposed individuals do not develop anorexia.
- AO3: Cognitive models are supported by experimental cognitive bias studies and by effectiveness of CBT in addressing dysfunctional thoughts, yet cognitive differences may be consequences of starvation rather than primary causes; prospective evidence is limited.
- AO3: Methodological limitations across the literature include correlational designs, retrospective self-report, small clinical samples and difficulty separating cause from effect in cross-sectional research; prospective and longitudinal designs offer stronger tests.
- AO3: Integration and interactionist stance: psychological explanations complement rather than exclude each other; family dynamics, modelling and cognitive vulnerability may interact with biological predisposition to produce anorexia in some individuals.
- AO3: Clinical implications include family therapy, psychoeducation to reduce reinforcing behaviours, and CBT to address cognitive distortions; evaluate the evidence base for each intervention and its practical constraints in service delivery.
- AO3: Consider generalisability and cultural change: many studies sample females in Western settings and may not generalise to males or non-Western contexts, so cultural and temporal validity should be discussed.

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