PSY.OPT15 Psychological Explanations for Anorexia Nervosa

Total Marks

AQA 7182 · Calculators not allowed · about 75 minutes

Name: _____ Date: ____ / ____ / _____

Answer ALL questions. Show all your working.

1 Outline one key feature of family systems theory as an explanation for anorexia nervosa, referring to family interactions in the clinical context.

Outline one key feature of family systems theory as an explanation for anorexia nervosa, referring to family interactions in the clinical context.

(Total for Question 1 is 2 marks)

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

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(Total for Question 2 is 3 marks)

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3 Outline, in the context of social learning theory, how media modelling might contribute to the development of anorexic behaviour in adolescents.

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(Total for Question 3 is 2 marks)

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

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 4 is 3 marks)

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

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(Total for Question 5 is 2 marks)

6 Explain what is meant by cognitive distortions such as 'all-or-nothing' thinking about food and weight, and how such distortions may contribute to disordered eating in anorexia nervosa.

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(Total for Question 6 is 3 marks)

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7 Scenario for application: In a family meeting the mother constantly gives subtle praise when her daughter skips family meals, saying she 'looks great' and that others admire her discipline. The father is distant and avoids conflict, while the daughter reports that controlling her eating is the only way she feels she can make decisions for herself. Which psychological explanation for anorexia nervosa best accounts for this scenario? Explain your choice with reference to features in the scenario.

Scenario for application: In a family meeting the mother constantly gives subtle praise when her daughter skips family meals, saying she 'looks great' and that others admire her discipline. The father is distant and avoids conflict, while the daughter reports that controlling her eating is the only way she feels she can make decisions for herself. Which psychological explanation for anorexia nervosa best accounts for this scenario? Explain your choice with reference to features in the scenario.

(Total for Question 7 is 6 marks)

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8 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.

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(Total for Question 8 is 4 marks)

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9 Identify one limitation of social learning theory as an explanation for anorexia nervosa and explain how empirical evidence or other explanations challenge it in a clinical research context.

Identify one limitation of social learning theory as an explanation for anorexia nervosa and explain how empirical evidence or other explanations challenge it in a clinical research context.

(Total for Question 9 is 4 marks)

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10 Suggest one treatment implication derived from cognitive explanations of anorexia nervosa, and explain briefly how it targets cognitive distortions in a clinical therapy setting.

Suggest one treatment implication derived from cognitive explanations of anorexia nervosa, and explain briefly how it targets cognitive distortions in a clinical therapy setting.

(Total for Question 10 is 4 marks)

11 Identify one ethical issue for researchers studying psychological explanations of anorexia nervosa in clinical samples, and suggest how researchers can address it in a hospital or university study.

Identify one ethical issue for researchers studying psychological explanations of anorexia nervosa in clinical samples, and suggest how researchers can address it in a hospital or university study.

(Total for Question 11 is 3 marks)

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12 Explain one methodological limitation common to research supporting psychological explanations for anorexia nervosa, and explain why this limits the strength of conclusions drawn in clinical research literature.

Explain one methodological limitation common to research supporting psychological explanations for anorexia nervosa, and explain why this limits the strength of conclusions drawn in clinical research literature.

(Total for Question 12 is 4 marks)

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13 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.

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 13 is 16 marks)

Mark scheme · PSY.OPT15 Psychological Explanations for Anorexia Nervosa

Question 1

- **B1** identifies a relevant feature, e.g. enmeshment, overprotectiveness or rigid family boundaries as present in families of someone with anorexia oe
- **B1** explains the feature in context, e.g. enmeshment means family members are overly involved, which may limit the adolescent's autonomy and contribute to eating disorder behaviour oe
- **Answer: Example: Enmeshment or overinvolvement in family relationships; family members are overly close or intrusive, reducing the young person's autonomy and meaning that controlling food intake becomes a way for the individual to assert independence.**

Question 2

- **M1** states the psychosomatic family concept: families with enmeshment, poor conflict resolution, overprotectiveness and rigid roles, linked to a child's physical symptoms oe
- **A1** 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
- **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

- **B1** identifies modelling from the media as a mechanism, e.g. adolescents imitate thin-ideal behaviours seen in celebrities, influencers or adverts oe
- **B1** briefly explains: seeing thin role models being rewarded or admired can encourage imitation of dieting or disordered eating as a route to social approval oe
- **Answer: Media modelling: adolescents observe thin role models in media and social media, and imitate dieting or restrictive eating because these behaviours appear rewarded by attention and admiration.**

Question 4

- **M1** states how reinforcement works: positive reinforcement (praise, attention) or negative reinforcement (avoidance of criticism) increases the likelihood of behaviour repeating oe
- **A1** 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
- **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 5

- **B1** 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
- **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 6

- **M1** defines all-or-nothing thinking: seeing situations in extremes, e.g. a single calorie as failure, rather than a continuum oe
- **A1** applies to eating behaviour: this thinking leads to rigid rules about food, so any minor deviation is treated as catastrophic and triggers stricter restriction oe
- **A1** explains contribution: cognitive rigidity maintains disordered patterns and makes flexible, healthy eating less likely oe
- **Answer: All-or-nothing thinking treats eating as black or white, for example viewing a small snack as total failure, which causes the person to double down on restriction and perpetuate disordered eating**

Question 7

- **M1** identifies the most relevant explanation: family systems theory with contribution from social learning theory via reinforcement, oe
- **A1** applies family systems features: father avoids conflict and mother is overinvolved/praise gives family pattern of enmeshment and poor boundaries oe
- **A1** links daughter controlling eating to control function: asserts autonomy within an enmeshed system oe
- **A1** applies reinforcement/SLT: maternal praise reinforces meal-skipping and models approval for thinness oe
- **A1** integrates both ideas to explain maintenance: the behaviour both serves a family function and is socially rewarded, maintaining anorexic behaviour oe
- **A1** clear conclusion that family systems explanation best fits, with SLT reinforcement as a proximate maintaining factor oe
- **Answer: Best account: family systems theory explains enmeshment and poor conflict management, with the daughter using control over eating to assert autonomy; social learning theory also applies because the mother praises weight loss, positively reinforcing restrictive eating. Together these explain onset and maintenance.**

Question 8

- **M1** identifies a genuine strength, e.g. directs attention to family therapy such as Maudsley or systemic approaches that involve the family in recovery oe
- **A1** 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
- **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 9

- **M1** identifies a relevant limitation, e.g. SLT cannot fully explain why only some exposed individuals develop anorexia despite widespread media modelling oe
- **A1** explains implication: individual differences such as genetics, temperament or cognitive vulnerabilities moderate risk, so SLT alone is incomplete oe
- **A1** refers to empirical challenge: correlational media studies show associations but not causation, and experimental evidence is limited oe
- **A1** concludes that SLT needs to be combined with other explanations to account for variance in clinical cases oe
- **Answer: Limitation: SLT overemphasises exposure to thin ideals but cannot explain individual vulnerability. Evidence shows many people exposed to thin ideals do not develop anorexia, and media correlations are not causal; individual cognitive and biological factors moderate risk, so SLT is incomplete on its own.**

Question 10

- **M1** identifies a relevant treatment implication, e.g. use of cognitive behavioural therapy (CBT) to challenge distorted thoughts about weight and food oe
- **A1** explains how CBT targets distortions: therapists use cognitive restructuring to identify and dispute all-or-nothing thoughts and body image misperceptions oe
- **A1** explains expected clinical effect: reducing cognitive distortions should reduce rigid dieting rules and improve willingness to follow nutritional plans oe
- **A1** links to practice: includes behavioural experiments and exposure to normal eating to test and disconfirm distorted beliefs oe
- **Answer: CBT focused on body image and eating-related cognitions; therapists use cognitive restructuring and behavioural experiments to challenge all-or-nothing thinking and distorted body images, reducing rigid rules and helping patients adopt healthier eating.**

Question 11

- **M1** identifies a genuine ethical issue, e.g. risk of psychological harm/distress when discussing eating behaviours and body image oe
- **A1** suggests a practical safeguard, e.g. careful screening, providing full debriefing, and signposting to clinical support services oe
- **A1** explains why this safeguards participants, e.g. reduces risk of harm and ensures help is available if distress increases during or after participation oe
- **Answer: Ethical issue: risk of distress when discussing eating and body image. Address by screening participants, obtaining informed consent, providing debriefing and immediate access to clinical support or referral, protecting participant wellbeing.**

Question 12

- **M1** identifies a methodological limitation, e.g. reliance on correlational designs or retrospective self-report data oe
- **A1** explains consequence: correlational data cannot establish causation between family dynamics/media exposure/cognition and anorexia onset oe
- **A1** further explains limitation: retrospective reports are vulnerable to bias and may reflect illness effects rather than causes oe
- **A1** concludes that these design limits mean psychological explanations need cautious interpretation and ideally triangulation with prospective or experimental evidence oe
- **Answer: Common limitation: much evidence is correlational or based on retrospective self-report. This limits causal inference because it cannot determine whether family patterns or cognitive distortions cause anorexia or result from it; recall bias may also distort associations.**

Question 13

- **Level 4** (13-16): 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.
- **Level 3** (9-12): 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.
- **Level 2** (5-8): 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.
- **Level 1** (1-4): 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.
- **Level 0** (0): No creditable content.
- **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.