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| **Psychological explanations for anorexia nervosa** | | | |
| **Cognitive Theory AO1** | | | |
| **Cognitive distortions**  According to the cognitive explanation, the core psychopathology of anorexia nervosa is cognitive distortions about body shape and weight. In the most significant of these, the AN sufferer has a disturbed perception of their own body image.  **Disturbed perceptions:-**Rebecca Murphy et al. (2010) argue that all other clinical features of AN stem from these distortions including preoccupations with thoughts of food, eating, weight, and body shape, and behaviours such as food restriction and checking (e.g. constantly looking in the mirror). People with AN become more and more critical of their own bodies. They misinterpret their emotional states as ‘feeling fat’, even as they get thinner and thinner.  Several research studies demonstrate that AN sufferers consistently overestimate their body size and weight. Different techniques are used to measure this, such as choosing from silhouettes of increasing size to match one’s own body shape. Don Williamson et al. (1993) carried out a study using this technique.  **Procedure** 37 participants diagnosed with AN used the Body Image Assessment to estimate their current body size and indicate their ideal size. A control group of 95 participants who did not having an eating disorder performed the same task.  **Findings** The participants diagnosed with AN were significantly less accurate in their size estimates than the control participants, with a marked tendency to overestimate their size. The ideal body shape for the AN participants was also significantly thinner than it was for the controls. | | | |
| **Irrational beliefs**  Researchers have noted that people with AN often express irrational beliefs and attitudes about their disorder that defy logic and rational sense. In Aaron Becks terms, these irrational beliefs become second nature and give rise to automatic negative thoughts. One example is *all-or-nothing thinking*: ‘If I’m not thin, I’m fat’; ‘if I don’t control my weight, I’m worthless’. Another is *catastrophizing*, putting the worst possible gloss on even the least important events: ‘I ate half a biscuit today; I’ve got no will power at all’. Another is *magical thinking* “If I reach size 8 then my life will be perfect.”  **Perfectionism:** A key irrational belief in AN is perfectionism, the view that the individual has to meet their most demanding standards all the time, and failure to do so is judged severely. This applies to all areas of the AN sufferer’s life – academic success, relationships, career aims – but especially to eating, body shape and striving for weight loss. Perfectionism is usually accompanied by intensive record-keeping, to make sure the individual is achieving their harsh goals. It makes some features of AN worse and more resistant to treatment, such as checking behaviours, excessive exercise and food restraint.  Paul Hewitt et al. (2003) claim that perfectionism is not satisfied when goals are achieved. In fact, as AN patients reach their exacting targets, they merely raise their standards still higher. So they are forever pursuing an unrealistic goal they can never attain, trapped in vicious cycle of irrational perfectionism and starvation. | | | |
| **Cognitive inflexibility**  Recent research has focused on the possibility that people with AN lack cognitive flexibility. Treasure and Schmidt (2013) have proposed a cognitive interpersonal maintenance model of anorexia which, among other things, suggests that AN sufferers experience problems with set-shifting. That is, they find it difficult to switch fluently from one task to another requiring a different set of cognitive skills. Instead, they tend to apply persistently the same skills in a changed situation where these skills are no longer useful.  This recent research indicates that this may be a significant cognitive deficit leading to the development of anorexia. Once a vulnerable individual gets started on the weight loss process, they rigidly persist with it and continue to perceive themselves as needing to lose weight. They find it hard to switch to a more adaptive way of thinking about their body shape and size. In effect, their weight loss is a solution to a problem that no longer exists, but they are unable to perceive this accurately. | | | |
| **Cognitive Theory AO3** | | | |
| **Research support for cognitive distortions**  **P:** A strength the cognitive theory as an explanation for anorexia nervosa is that it has supportive evidence.  **E:** For example, Sachdev et al. (2008) used fMRI with AN patients and healthy control patients. As the participants were having their brains scanned, the researchers showed them images of their own and other people’s bodies. The same brain areas were activated in both groups when they were shown non-self-images. However, the outcome was very different when the participants were shown images of themselves. Compared with the controls, the AN patients showed very little activation in parts of the brain thought to be involved in attention.  **E:** This is a very intriguing finding because it suggests that cognitive distortions do exist in AN, but they are limited to the individuals own body image and do not extend the body in general.  **L:** As a result this increases the credibility of the cognitive theory as an explanation for AN. | **Research support for perfectionism**  **P:** A strength the cognitive theory as an explanation for anorexia nervosa is that it has supportive evidence.  **E:** For example, Halmi et al (2012) studied 728 women over the age of 16 years, all diagnosed with AN. Each participant completed the EATATE Lifetime Diagnostic Interview. This measures AN symptoms and indicators of perfectionism in childhood. The researchers found that childhood perfectionism was a significant predictor of the later development of AN. The researchers concluded that perfectionism preceded onset of AN, so is a potential risk factor for development of the disorder.  **E:** This is a strength because it suggests that AN patients do have the irrational belief of perfectionism since childhood.  **L:** As a result the explanatory power of the cognitive theory as an explanation for AN is increased. | **Contradictory research**  **P:** However a weakness is that there is some contradictory research.  **E:** For example, Cornelissen et al (2013) compared AN patients with non-AN women on a morphing task – the participants had to adjust a computerised image of themselves until it matched their estimated body size. The researchers found no significant differences between the groups of women in the accuracy of their estimated body size. The researchers found no significant differences between the groups of women in the accuracy of their estimates. As it is not possible to distinguish between the body size estimates of healthy and AN women.  **E:** This suggests that over estimation is not pathological. This finding challenges the central role of body image distortion in cognitive theories of AN.  **L:** As a result, this reduces the credibility of the cognitive theory as an explanation for AN. | **Cause or effect?**  **P:** Although research shows that distortions and irrational beliefs are features of AN, it is not at all clear that they cause the disorder.  **E:** For example, Shott et al (2012) found that younger AN patients were no worse at set shifting than non-anorexic controls, but older patients were.  **E:** This suggest that cognitive inflexibility does not make an individual vulnerable to developing AN, but is instead a consequence of the disorder.  **L:** As a result, this reduces the credibility of the cognitive theory as an explanation for AN. |