Rewarding Learning

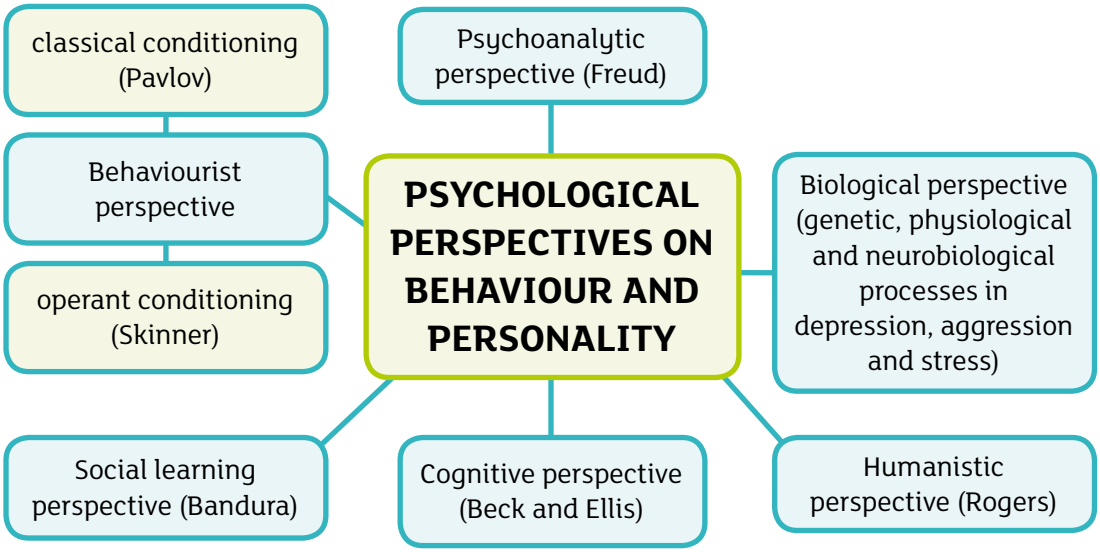
eGUIDE//

Health and Social Care

Unit A2 6: Understanding Human Behaviour

Content Page

Psychological perspectives on behaviour and personality



The diagram highlights the six major perspectives in psychology; the names of theorists and other information shows what you need to know about each perspective. The perspectives are described in detail in CCEA's fact file 'Psychological Perspectives on Behaviour and Personality'.

Treatments and therapies

Each perspective has associated therapies and treatments which professionals, such as psychologists, psychiatrists, mental health nurses and GPs, can use to help individuals.

Psychoanalytic therapies

Psychoanalysis

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Freud's therapy was **psychoanalysis**, which aims to uncover unconscious conflicts and anxieties resulting from past experiences. The aim is to gain insight into the causes of current problems, rather than focusing on changing conscious thoughts or behaviours. A number of techniques are employed, including:

- **free association** – clients are encouraged to relax and freely talk about anything that comes into their heads;
- **word association** – clients are encouraged to respond to words called out by the therapist with the first words that come to mind;
- **dream analysis** – clients tell the therapist what they can remember about their dreams;
- **transference** – this is the redirection of feelings and desires, especially those buried in the unconscious from childhood, towards new objects or people; and
- **projective tests** – clients are asked to respond to ambiguous stimuli by saying what they think they can see.

The purpose of all these techniques is to allow the therapist to gain access to the unconscious and the therapist interprets the meaning of what is revealed. The therapist then helps clients to work through their conflicts and fears so that they can achieve catharsis, which is the release of negative energy from the unconscious.

Play therapy

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In this psychoanalytic technique for children, play is used to communicate with them to allow feelings and conflicts to emerge from their unconscious minds, in a similar way that free association, dream analysis and other techniques are used with adults. Toys are provided, for example dolls, cars, houses, bricks, and drawing materials, to allow children to act out scenes, which can uncover unconscious thoughts and feelings. The actions and interactions that take place during play can be interpreted by a therapist to get a better understanding of a child's problems. The therapist can then help the child to work through his/her feelings, which will help the child to experience catharsis and therefore cope better with any trauma that has negatively affected their behaviour.

Evaluation of psychoanalytic therapy

Strengths

- These are well-established therapies that are still popular and widely used with lots of published case studies to help therapists in their own development;
- Clients are able to express their feelings and conflicts in a safe environment;
- They can be applied to dealing with a whole range of behaviours ,for example depression, aggression, eating disorders;
- They recognise that negative early experiences can negatively affect an individual's ability to cope with life; and
- The therapies can be applied to children as well as adults – play therapy can help children who may otherwise find it difficult to explain how they are feeling.

Weaknesses/limitations

- Psychoanalytic therapy tends to be expensive, as it is a one-to-one approach and it can take a lot of sessions before any progress is evident;
- The childhood conflicts that are uncovered may be very distressing for clients, so they may feel worse than ever whilst undergoing therapy;
- Clients' memories may be inaccurate – these are referred to as 'false memories';
- An analyst's interpretations, for example of dreams or of what a client says during free association, may be inaccurate;
- It may be difficult to establish a therapeutic relationship as some clients may be very resistant to exposing their thoughts; and
- The whole approach has been criticised as being totally unscientific, for example there is no evidence for the existence of the 'unconscious'.

Humanistic therapies

Client-centred therapy

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In Rogers' client centred therapy, also known as person centred therapy (PCT), the role of the therapist is to provide unconditional positive regard for the client. This will allow the client to work towards self-actualisation as he/she is freed from trying to satisfy other people's 'conditions of worth' in order to achieve positive regard. There is a need for warmth, genuineness and empathy in the therapeutic relationship to allow positive regard to be experienced by the client. The focus of this therapy is on dealing with the present rather than the past. The therapy is non-directive, meaning that the client, not the therapist, should decide how to work towards self-actualisation, so that his/her behaviour becomes congruent with his/her self-concept. The therapist employs the Q-sort technique to determine the discrepancy between the client's self – image and ideal self. This involves cards which contain statements that the client can sort into piles to represent the self and the ideal-self. This technique can be repeated to measure progress in the therapy. Here is a clip of Carl Rogers' talking about his therapy and working with his client, Gloria.

Encounter Groups

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Clients in group therapy can provide positive regard for each other. Rogers' encounter groups have the same purpose and effect as his one-to-one therapy described above.

Evaluation of humanistic therapies

Strengths

- As the therapy is non-directive, that is it does not have the therapist telling the clients what to do, clients are given the chance to work out what they need to do to address their own needs which gives them a sense of control;
- Clients can develop the motivation and power to help themselves which adds to their sense of achievement;
- Encounter groups allow clients to express problems openly in a group and gain feedback from others who may have similar problems so they feel accepted; and
- Being in an encounter group can help the clients to see they are not the only ones with problems so they don't feel so alone or isolated.

Weaknesses/limitations

- As the facilitator does not offer an overall judgement on the clients' problem some clients may be left feeling the therapy was a waste of time;
- Some clients may feel the need for an authority figure to tell them what to do rather than a facilitator who expects them to work out their own path in life; and
- Some clients have difficulty discussing problems in encounter groups and also forming a trusting relationship with the therapist in client-centred therapy.

Therapies linked to the behaviourist perspective

In therapies linked to the behaviourist perspective, the focus is on changing problem responses or behaviours, as opposed to trying to understand reasons for them. The aim of these therapies is to replace negative or inappropriate responses with more positive and appropriate ones, for example a behaviour therapy may attempt to replace a fear response with a more relaxed response in clients with phobias, whilst behaviour modification might be used to replace aggressive behaviours in a child with more positive co-operative behaviours when in the presence of other children.

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Behaviour therapies, based on Pavlov's theory of classical conditioning through learned associations, are used to help clients with phobias. **Systematic desensitisation** is a therapy in which clients are asked to draw up a 'hierarchy of fears' from the least to the most threatening. For example, a client with a fear of rodents might have looking at a photograph at the bottom of the hierarchy and actually holding a live animal at the top. The therapist teaches the client to use relaxation techniques and the client works gradually through the hierarchy of fears, replacing the conditioned fear response with relaxation. The therapy starts with least threatening situation and gradually works up the hierarchy. It may not be necessary to achieve relaxation at the very top of the hierarchy for the client to live a more normal life for example. a client with a phobia of rodents may not necessarily need to be able to hold a live animal, as long as the fear reduces enough for the client to be able to live a normal life. In exposure therapies, which include **flooding** and **implosion**, clients are required to remain with the feared stimulus, despite high levels of anxiety. It is physiologically impossible for the body to maintain an anxiety state like the 'fight or flight' response, so it subsides and fear is extinguished as a result. In flooding the clients are directly exposed to the object of their fear and made to confront it, whilst in implosion therapy clients are never brought into direct contact with the object or situation they fear, but they are asked to imagine or visualise coming in contact with it again and again until the fear is reduced. You can see an example of a phobia of snakes being cured in this video.

Behaviour modification techniques are based on Skinner's theory of operant conditioning and in particular his concept of reinforcement; these techniques can be used by parents and teachers as well as by psychologists. Behaviour modification starts with measuring and quantifying the behaviours to be reduced for example, observing and counting acts of aggression. Inappropriate behaviours are then ignored, where possible, or they can be punished using 'time out' though such punishments must be immediate to be effective. Appropriate behaviours are positively reinforced, for example by a child gaining

adult attention. A common form of behaviour modification is the use of star or reward charts; children can accumulate stars by producing the desired behaviour, for example playing co-operatively with others, and this allows the children to earn treats or rewards. Behaviour is measured to check for change and progress. For children, all the adults they come into contact with, as consistency is essential, should follow through this type of programme both at school and at home.

Time management techniques, based on operant conditioning, can also be used for stress. This involves setting and meeting realistic targets for tasks so they are more likely to be completed. This, in turn, removes the stressor of lack of time (i.e. the environmental stimulus that elicits the learned stress response) and improves the individual's sense of control. It focuses on changing the behaviours that have become associated with the stress response for example, rushing to complete tasks at work. In behaviourist terms, it extinguishes the stress response caused by not having enough time to complete tasks and replaces the stress response with more relaxed behaviours, which are reinforcing for the individual.

Evaluation of therapies based on the behaviourist perspective – behaviour therapies, behaviour modification and time management

Strengths

- These therapies can be more effective than counselling therapies for some people as they take a more direct and practical approach to solving problems rather than just talking about them and they don't depend on the client and therapist developing a positive therapeutic relationship;
- They tend to be much quicker than talking therapies like psychoanalytic therapy because of the focus on changing behaviour rather than trying to find out the root cause;
- Research has shown that behaviour therapies can be just as effective as medication for conditions like anxiety, as clients can learn to produce new behaviours in anxiety-producing situations;
- These therapies can provide long-term protection against relapse as clients have learnt techniques to help them cope that they can reproduce in the future;
- Behaviour modification techniques can easily be adopted by non-psychologists, for example parents and teachers using star charts to encourage positive behaviours;
- Time management is easily understood by clients and they can be quickly trained or even just given literature so they can try to help themselves, which is cost effective compared to talking therapies.

Weaknesses/limitations

- Behaviour therapies do not suit everyone, as clients must be committed to tackling their problems and often are required do 'homework' between sessions, which requires determination and some discipline;
- Some theorists argue that these therapies fail to tackle the underlying problems as they try to change behaviour without getting to the bottom of why an individual is displaying it in the first place;
- Behaviour modification techniques are better suited to children than adults ,for example the token economy in which adults in settings like mental hospitals were given tokens for good behaviour, which they could collect and trade for privileges, was regarded as patronising.

Cognitive therapies

These focus on changing irrational or inappropriate thoughts that may be having a negative impact on an individual.

Beck's cognitive therapy is referred to as **Cognitive Restructuring** and aims to change cognitive distortions and negative thoughts by challenging them in therapy over a series of sessions, usually by considering the evidence for negative statements. The therapist will ask the client questions, such as:

- What is the evidence supporting the conclusion currently held by the client?
- What is another way of looking at the same situation but reaching another conclusion?
- What will happen if, indeed, the current conclusion/opinion is correct?

The aim is to move the client away from negative cognitive processes and towards positive cognition.

Here is a video of Aaron Beck talking about one of his patients as an example to illustrate the process of restructuring a client's negative cognitions stemming from the client's dysfunctional automatic thoughts.

Ellis's **Rational Emotive Therapy (RET) and Rational Emotive Behaviour Therapy (REBT)** also aim to challenge irrational beliefs, but the therapist is more active and directive than in Beck's therapy. Techniques include challenging clients to prove unrealistic statements and role-playing different situations during therapy. REBT also addresses behaviour change with behavioural tasks set by the therapist between sessions. These therapies are often referred to as cognitive behavioural therapies. You can watch a useful role play here.

Evaluation of Cognitive Therapies

Strengths

- They take account of clients' thinking behaviour and how they view the world;
- The treatment has clear goals – to change maladaptive thinking to more positive;
- They teach clients how to try to think differently, which they can use to recognise and change their own negative thoughts in the future;
- They are relatively quick compared to other talking therapies like psychoanalysis with many clients showing more positive thinking after just a few sessions; and
- They work well for a range of problems as shown by outcome studies, for example they have been used successfully to treat general anxiety, depression, eating disorders and stress.

Weaknesses

- They are only useful for clients who are well enough to have insight and reflect on their own thoughts, so those who are very unwell may not benefit;
- They ignore hidden reasons for problems, like unconscious thoughts, so don't really get to the root of some problems;
- Changing thinking patterns may not be enough to remove some severe problems ,for example they are less successful than behavioural techniques for agoraphobia; and
- Individuals have to be determined to address their problems and for REBT they have to be willing to do 'homework' and practise new behaviours, which can require a considerable commitment of time and effort.

Therapies based on the social perspective

Modelling therapy

This therapy is based on Bandura's Social Learning Theory and aims to change problem behaviours. The theory is that, if you can get someone with a psychological disorder to observe someone dealing with the same issues in a more productive fashion, the first person will learn by modelling the second. A client will be shown examples of people behaving in a desired way and perhaps see them being rewarded or alternatively being punished for undesired behaviour, for example an aggressive child could see a film of someone being given sweets for being co-operative and of an aggressive child being scolded. The models can be live and actually present or observed indirectly as on TV. Bandura's original research on this involved herpephobics, people with a neurotic fear of snakes. Clients watched another person, an actor; go through a slow and painful approach to a caged snake. He acts terrified at first, but shakes himself out of it, tells himself to relax and breathe normally and take one step at a time towards the snake. He may stop in the middle, retreat in panic, and start all over. Ultimately, he gets to the point where he opens the cage, removes the snake, sits down on the chair, and drapes it over his neck, all the while giving himself calming instructions. After the clients saw all this they were invited to try it themselves. They knew that the other person was an actor – there was no deception involved, only modelling! And yet, many clients, lifelong phobics, were able to go through the entire routine first time around, even after only one viewing of the actor!

Social skills training

Social skills are those communication, problem solving, decision-making, self-management, and peer relations abilities that allow people to initiate and maintain positive social relationships with others. Many clients never learned appropriate behaviour in social settings Perhaps they did not have good role models in the home to promote appropriate behaviour, or if they did have they did not pick up these skills as well as others.

Social skills training is a general term for instruction that promotes more productive/ positive interaction with others. Social skills are taught to clients who are socially unskilled in order to promote acceptance by others. A social skills training programme might include:

- "Manners" and positive interaction with others
- Appropriate behaviour, for example in the classroom
- Better ways to handle frustration/anger, for example counting to 10 before reacting, distracting oneself, learning an internal dialogue to cool oneself down and reflect upon the best course of action
- Acceptable ways to resolve conflict with others ,for example using words instead of physical contact or seeking the assistance of others to resolve a conflict

Family therapy (for eating disorders)

- The therapy aims to help the whole family learn about eating disorders and how they are treated, in particular to help parents realise that a young person with an eating disorder cannot control his or her thoughts and behaviour. The idea is to help parents to understand and support the client more effectively
- The therapy aims to help everyone in the family to understand that the family is not the cause of the illness, but the family can help overcome it.

- It aims to help parents take control of their child's eating until he or she has put on weight. For example, the therapist might suggest that parents monitor meals and limit exercise for a child who has anorexia. In return, parents might give the child choices over things like whether or not to tidy their room.
- It tries to focus on how the family members get along together to see if anything is making it hard for parents and the client to work towards improving the eating problems. For example, the family might be encouraged to consider the rules they have, how decisions are made and how limits are set.

Evaluation of therapies based on the social perspective

Strengths

- These therapies take account of the important effect role models can have on the behaviour of individuals;
- Family therapy helps those who are most often with the clients to understand their condition and to help them;
- Social skills training can be delivered to a group of clients, for example in a school setting; and
- Modelling therapy is a powerful therapy that has a proven record of working well with phobias.

Weaknesses/limitations

- These therapies don't really focus on finding out the root cause of the problem;
- Clients with eating disorders may feel that including the family is an invasion of privacy, so they may hold back on saying things they would discuss with a therapist on a one-to-one basis because of the presence of family members;
- One drawback to modelling therapy is that it isn't easy to get the rooms, the snakes, the actors, etc., together.

Therapies based on the biological perspective

The biological perspective aims to treat the physical causes of psychological problems.

Drug therapy

Some of the main drugs used to treat psychological problems are:

Anti-depressants of which there are 3 main types:

- Monoamine Oxidase Inhibitors (MAOIs) – these block the action of the enzyme monoamine oxidase which normally breaks down the neurotransmitters noradrenaline and serotonin in the brain, therefore increasing levels of serotonin and noradrenaline, making the individual feel happier.
- Tricyclics (TCAs) – these help to prevent the neurotransmitters noradrenaline and serotonin from being re-absorbed after use, thus increasing the available levels of these neurotransmitters, making the individual feel happier
- Selective Serotonin Reuptake Inhibitors (SSRIs) – these increase the level of the neurotransmitter serotonin slowing down the process of them being used up by the brain, again helping the individual to feel happier.

Minor tranquilisers, for example, benzodiazepines reduce the activity of the brain (Central Nervous System) by helping to enhance the effect of its own anxiety-relieving chemical GABA (gamma-amino-butyric acid) which slows down the activity of neurones, thus sedating clients, so these drugs are used to reduce aggression and anxiety.

Beta-blockers reduce the activity of the Sympathetic Nervous System and so reduce heart rate, blood pressure and levels of the hormone cortisol. They work by blocking the action of the neurotransmitter noradrenaline at receptors in arteries and the heart muscle, causing arteries to widen and slowing the action of the heart, resulting in falling blood pressure and reduced work by the heart, and thus reducing the physiological experience of stress.

Anxiolytic (anxiety reducing) drugs depress activity in the Central Nervous System, which in turn reduces activity in the Sympathetic Nervous System, which is responsible for physiological changes, such as the increase in heart rate associated with experiencing stress.

Electro-convulsive therapy (ECT)

This involves the passage of an electrical current through the brain producing unconsciousness and seizure – this is used for severe depression when drug therapies are not having the desired effect. Watch this video of a patient being given ECT. You can read more about ECT and its advantages and disadvantages in this leaflet by the Royal College of Psychiatrists.

Biofeedback

Biofeedback involves clients using a machine that provides information about autonomic functions, such as heart rate, muscle and blood pressure. The client is then taught to use a psychological technique such as relaxation to reduce the readings on the machine. The improved readings can be regarded as positively reinforcing the behaviour. You can view a biofeedback session here.

Meditation

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Meditation involves getting into a comfortable position and repeating a mantra of a single syllable – this can reduce oxygen consumption and induce electrical activity in the brain indicative of a calm mental state; it also reduces blood pressure.

Relaxation

One physiological symptom of stress is muscle tension – progressive muscle relaxation involves tightening and relaxing muscles until the whole body is relaxed and muscle tension and blood pressure are reduced. Have a go at progressive muscle relaxation by listening to the audio here.

Evaluation of therapies based on the biological perspective

Strengths

Drugs

- Are effective for most patients in dealing with the physical symptoms of psychological conditions, for example reducing the physiological reactions to stress;
- Usually have reasonably quick results for example. most patients who are prescribed anti-depressants start to feel better within 3 weeks ;
- Are more cost effective for the health service than patients spending long periods in talking therapies; and
- Are free for patients on the NHS.

Other physical treatments

- ECT has helped very extreme cases of depression where other techniques have failed when used for drug resistant patients;
- Using biofeedback, meditation and relaxation can give clients a sense of control over their symptoms;
- Biofeedback, meditation and relaxation have no side effects; and
- Meditation and relaxation techniques can be managed by clients once they have been learned so are very cost effective.

Weaknesses

In general these therapies treat the symptoms of the problem not the underlying cause.

Drugs

- Drugs can have minor side effects like dizziness or more serious side effects like blurred vision; SSRIs have been shown to suppress appetite;
- Some drugs for example, benzodiazepines can be addictive and so their use is often time limited to avoid this problem;
- Withdrawal symptoms can be very unpleasant, for example anxiety, tremors and

headaches can be experienced;
- Patients may refuse to take drugs because they fear addiction;
- Patients may forget to take their medication – this problem can be exacerbated by their condition, for example the lethargy associated with depression; and
- There may be reactions with other drugs the client uses.

Other physical treatments
- ECT has some serious side effects like memory problems for up to 6 months, reading difficulties and painful headaches – it has been described as 'electrical head injury' by some patients' groups;
- It is not clear how ECT works and because of this some people regard it as unethical;
- Patients sometimes perceive ECT as a punishment for being different – they report that it is a frightening experience;
- Biofeedback needs specialist equipment and expert supervision which makes it expensive, especially compared to meditation and relaxation; and
- Meditation and relaxation are unsupervised so clients may feel unsupported and may give up using the techniques.

The application of perspectives to understanding and treating individuals

The major perspectives help to explain human behaviours such as depression, aggression, stress, eating disorders and phobias, and the associated therapies and treatments can be used.

Depression

Depression is a very common mental illness experienced by many people at some point in their lives; it has signs and symptoms that distinguish it from simply feeling a bit 'down' for a few days, as described by the NHS.

From the psychoanalytic perspective, depression results from unconscious processes and problems buried in the unconscious mind as a result of childhood experiences. Throughout childhood, the libido concentrates its energy on a particular sequence of body parts, or erogenous zones. Stimulation at each stage must be exactly right to avoid fixation, where some of the energy of the libido is left behind at a particular stage to deal with unresolved conflicts. It is this fixation that determines adult personality characteristics. The first stage is the oral stage, age 0 – 1 year, when the erogenous zone is the mouth. Freud argued that that too little stimulation of the mouth at this stage would lead to a pessimistic, depressive adult personality. Thus depression can occur due to fixation during the oral stage. Depression can also occur due to the failure of defence mechanisms such as repression and denial to protect the ego so that childhood experiences like neglect or abuse may enter the conscious mind and cause depression.

From this perspective the treatments for depression are psychoanalysis for adults and play therapy for children.

From the humanistic perspective, individuals who are depressed are failing to self-actualise because they are not receiving or have not received unconditional positive regard. They have been influenced by **conditions of worth**, which means parents, teachers, peers and others only gave them positive regard when they showed they were 'worthy'. In other words, these individuals got love and affection only if they behaved as others wanted them to, so they experienced **conditional positive regard** rather than the unconditional positive regard people need to be true to themselves and self-actualise. Because people need positive regard they bend themselves into a shape determined by others' wishes. Over time, this leads individuals to have **conditional positive self-regard** as well. They begin to like themselves only if they meet the standards others have applied to them, rather than if they are truly self-actualising, making it difficult to maintain self-esteem, and so depression sets in.

If an individual is forced to live with conditions of worth that are out of step with self-actualising and receives only conditional positive regard, he develops instead an **ideal self** with high standards that are always out of reach. A gap develops between the real self and the ideal self, the "I am" and the "I should be". This is called **incongruity**, meaning the two do not match, and so depression results from being 'out of synch' with your own self.

When there is incongruity between the ideal and the real self the individual is in a **threatening situation** and will feel **anxiety**. To reduce this the individual uses two defences: denial and perceptual distortion. Unfortunately for the depressed individual, by using these defences, he puts a greater distance between the real and the ideal self, creating more incongruence, more threat, and greater levels of anxiety, and therefore the individual uses defences more and more frequently. It becomes a vicious cycle that the person eventually is unable to get out of, at least on his own. More serious depressive episodes or mental breakdown occurs when a person's defences are overwhelmed, and their sense of self becomes 'shattered'.

From this perspective the treatments for depression are client-centred therapy and encounter groups.

The cognitive perspective argues that irrational thoughts and beliefs cause depression. As maladjusted thinking causes depression, it is necessary to examine an individual's thought processes to understand his or her depression.

Beck described the **irrational and maladaptive assumptions and thoughts** that lead to depression as **cognitive errors**. Beck claims mental disorders like depression are rooted in the maladaptive ways people think about:

- Themselves for example, I can't succeed at anything;
- The world ,for example it's a bad place and nothing in it can make me happy ; and
- The future, for example nothing will change.

Beck referred to this as a '**cognitive triad**' of negative, **automatic thoughts**. These **negative schemas** dominate thinking and depression is the result.

Ellis also argued that irrational thoughts are the main cause of depression as they lead to a self defeating **internal dialogue** of negative self statements ,for example depression is caused by **catastrophising self statements** like 'I'll never be a happy person, my life may as well be over'. He identified 11 basic irrational beliefs that are emotionally **self-defeating** and commonly associated with depression for example:

- I must be loved and accepted by absolutely everybody
- I must be excellent in every respect and never make mistakes – otherwise I'm worthless

Sometimes referred to as the '**ABC model**', Ellis claims disorders begin with an **activating event (A)** (for example, a failed exam) leading to a **belief (B)**, which may be rational (for example, I didn't work hard enough) or irrational (for example, I'm too stupid to pass). The belief leads to **consequences (C)**, which can be **adaptive** (appropriate) for rational beliefs (for example, I'll do more revision) or **maladaptive** (inappropriate) for irrational beliefs (for example, getting depressed).

From this perspective, treatments for depression are Beck's cognitive restructuring and Ellis's RET and REBT.

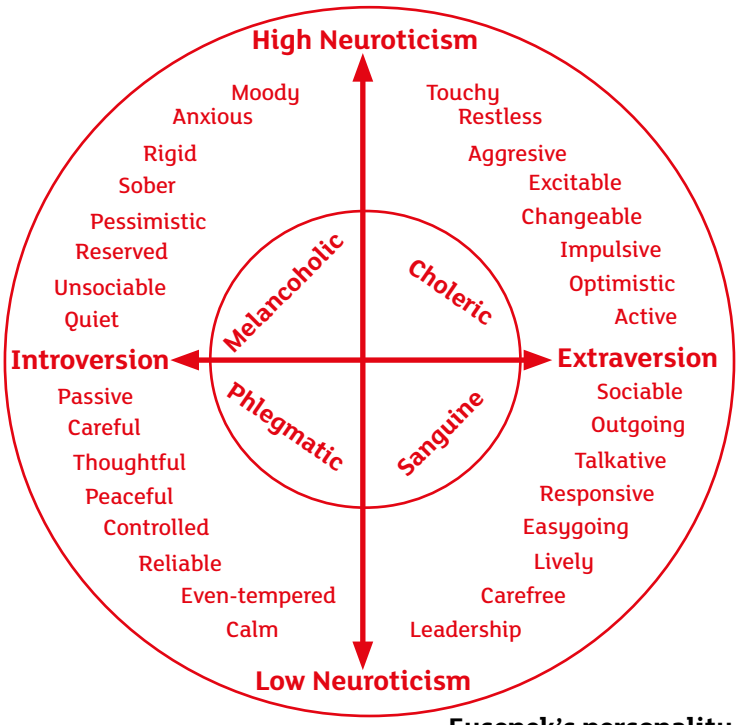
From **the biological perspective**, depression results from genes and neurochemistry. This perspective points to evidence of the increased risk of depression for first-degree biological relatives (parents, siblings, children) of people with the condition, suggesting there may be a genetic explanation. The genetic component may be a predisposing factor rather than a direct cause.

Depression is also linked to the disturbance of brain chemistry, specifically involving chemicals called neurotransmitters, which assist in transmitting messages between nerve cells in the brain across a small gap called a synapse.

Certain neurotransmitters are known to regulate mood. When they are not available in sufficient quantities, depression can result. Serotonin is a monoamine neurotransmitter that is believed to play an important role in the regulation of mood, with low levels associated with both depression and anxiety. Noradrenaline and dopamine have also been shown to be involved. The brain's response to stressful events may alter the balance of neurotransmitters and result in depression. Sometimes, a person may experience depression without any particular sad or stressful event that they can point to. People who have a genetic predisposition to depression may be more prone to the imbalance of neurotransmitter activity that is part of depression. Depression can also be linked to substance abuse that affects brain chemistry, for example alcohol abuse is linked to depression.

Hormones may also be involved in depression, with high levels of cortisol linked to over-activity of the hypothalamus. In pre-menstrual, post-natal and menopausal depression, an oestrogen-progesterone imbalance has been suggested.

Eysenck argued personality has a biological basis. He proposed that there were two major dimensions of personality, namely the extroversion – introversion dimension and the neuroticism – stability dimension. He argued most people's personalities would fall into one of four types, a stable extrovert, a neurotic extrovert, a stable introvert or a neurotic introvert as shown on the diagram on page 18.



Eysenck's personality theory

Eysenck later added psychoticism, which most people score very low on. Psychotic personalities are solitary, insensitive, uncaring, opposed to social customs and lacking in conscience.

In terms of the biological basis of extroversion, Eysenck proposed a link to the lower parts of the brain, where there are structures, which control the levels of arousal of higher brain

centres, for example sleeping and waking. These can 'boost' or 'dampen down' incoming messages. Extroverts have inherited a strong nervous system, which would inhibit (dampen down) incoming messages; therefore they become bored quickly by one set of stimuli and look for variation and novelty, usually by socialising. Introverts have a weak nervous system, which will amplify (boost) incoming information and so are less likely to be bored by one set of stimuli. They are able to maintain cortical activity with less stimulation and so are happy with solitary pursuits.

The biological basis of neuroticism is to do with how the nervous system responds to stress. Neurotic personalities have a nervous system that responds rapidly and strongly to stressful events and so are more likely to react emotionally. Stable personalities have slower, less strong reactions of the nervous system when responding to stress.

The biological basis of psychoticism was less clearly defined by Eysenck but he believed it was linked to an imbalance in the hormone androgen.

Eysenck would therefore regard depression as an inherited personality characteristic of a neurotic introvert.

From this perspective, treatments for depression include anti-depressants, specifically MOAIs, Tricyclics and SSRIs, and ECT.

Aggression

In short, aggressive behaviour is behaviour that causes physical or emotional harm to others. Examples of aggressive behaviours include hitting, pushing and verbally attacking others.

From the psychoanalytic perspective, like all problem behaviours aggression results from trauma buried in the unconscious mind and is linked to negative experiences in childhood. This perspective views aggression as instinctive or innate. Present in all humans, it is part of the death wish, the instinctive drive towards self destruction, so aggressive individuals may be perceived to be driven more by the death wish than the libido. Like depression, aggression can also occur due to fixation during the oral stage, as Freud argued that too little stimulation of the mouth would lead to an aggressive, pessimistic, depressive adult personality. An aggressive person may have missed out on the process of identification with the same sex parent during the phallic stage of development, as this is necessary to develop appropriate gender role behaviour and the superego, which gives the individual a sense of right and wrong, including the conscience; as a result of failing to achieve identification in this way, an individual may not realise his aggressive behaviour is wrong.

Aggression may also be seen as evidence of a defence mechanism, such as displacement whereby individuals unconsciously take out their anger on people who are not really responsible for it because it seems inappropriate to be aggressive to the real source of the anger, for example towards a parent.

From this perspective psychoanalysis is used for adults and play therapy for children to achieve catharsis and reduce aggressive behaviour.

From the humanistic perspective, the explanation for aggressive behaviour is exactly the same as the explanation as the explanation for depression, with aggressive behaviour reflecting the frustration of being out of synch with one's own self.

Activity

Read again how Roger's humanistic theory explains depression. Now write an explanation of aggressive behaviour from this perspective, incorporating the following key phrases:

- failing to self-actualise
- conditional and unconditional positive regard
- conditions of worth
- conditional self-regard
- the real self and the ideal self
- incongruity
- defence mechanisms.

From this perspective client-centred therapy and encounter groups are used to help individuals to self-actualise and therefore to stop being aggressive.

From the behaviourist perspective, aggression is a learned response to environmental stimuli, with the key learning process being conditioning.

According to Skinner's theory of operant conditioning, **reinforcement** is the process by which any behaviour including aggressive behaviour is learned or strengthened. Where aggressive behaviour has positive consequences for the individual it is repeated – the positive consequences may be in the form of a reward or **positive reinforcement** ,or example getting others to do what you want, or the opportunity to avoid something unpleasant or **negative reinforcement**, for example being aggressive towards others so they will not attack you. Aggressive behaviour may also have been learned because it has not been effectively punished.

From this perspective, aggressive behaviours can be reduced through the process of behaviour modification, which involves:

- Observing and quantifying the behaviours to be reduced i.e. counting acts of aggression
- Ignoring aggressive acts or punishing them by using 'time out' for example. where a child is removed from the situation by being made to spend some time alone
- Positively reinforcing non-aggressive behaviour for example. by giving attention or through the use of star charts and rewards
- Observing and measuring behaviour again to check for a reduction in acts of aggression.

From the cognitive perspective, irrational thoughts and beliefs cause aggression in the same way they cause depression. For Beck, examples of the cognitive triad of negative thoughts in someone who is aggressive might include:

- I have to be aggressive to protect myself (about the self)
- People are always out to get you (about the world)
- Nothing will change, people will always pick on me (about the future).

For Ellis the aggression results from catastrophising self statements like 'I'll never be in control of my life unless I take on other people'. In terms of the '**ABC model**' the **activating event (A)** might be a disagreement, leading to a **belief (B)**, which may be rational (for example, people have the right to have different opinions) or irrational (for

example, I'm always being challenged and picked on). The belief leads to **consequences (C)**, which can be **adaptive** (appropriate) for rational beliefs (for example, I'll try to understand this alternative point of view point) or **maladaptive** (inappropriate) for irrational beliefs (for example, becoming aggressive). People who are aggressive have developed maladaptive beliefs and behaviours.

From this perspective, Beck's cognitive restructuring and Ellis's RET and REBT aim to change the irrational or inappropriate thoughts that are causing the aggression. For example in a cognitive restructuring session, Beck might ask the client questions, such as:

- What is the evidence supporting the belief that people pick on him?
- What is another way of looking at the same situation ,for example listening to other people or putting forward a different view without getting angry
- What will happen if, indeed, the current conclusion/opinion is correct, for example if people do pick on him how could he deal with it in another way?

Ellis would challenge a client to prove unrealistic statements like ' the only way to get what you want is to fight your corner' and a therapy session might involve role playing different situations such as discussing something you disagree with someone about without becoming angry and aggressive. A task set by the therapist between sessions might involve talking over something you disagree with a family member on without becoming angry or shouting.

From the social perspective, Bandura's Social Learning Theory claims that aggressive behaviour is learned through observation by **imitating** and **modelling** the behaviour of role models and also through **identification** with aggressive **role models**, as well as by reinforcement as emphasised by Skinner. **Identification** is a progression from simply imitating aggression to '**internalising**' the behaviour so that aggression becomes part of the individual's personality. Aggressive role models teach children different ways of being aggressive and the learned aggression is generalised as aggressive acts are perpetrated in a whole range of other situations. Role models who are warm and loving, who have power, influence and competence and who are similar, for example in terms of sex or age, are particularly influential in modelling aggression.

Activity

Working in pairs, think of a situation in which a child is likely to learn to be aggressive. Use the key words highlighted in the previous paragraph to explain why the child will be aggressive.

From this perspective, modelling could be used to address aggressive behaviour. A client could be shown examples of people being rewarded for behaving in a cooperative way, or alternatively being punished for being aggressive. For example, an aggressive child could see a film of someone being given sweets for being co-operative and of an aggressive child being scolded. The models can be live and actually present or observed in a film. Social skills training could also be used to reduce aggressive responses and help individuals to learn new ways of dealing with others.

From the biological perspective, low levels of serotonin in the brain have been linked to a reduced ability to control aggressive impulses. Extreme aggression may also be linked to dysfunctions in certain parts of the brain, for example the hypothalamus, which regulates emotions. Other research has shown that there is a link between pain and aggression. The research suggested that stimuli that cause pain often also trigger aggressive behaviour.

Hormones may also be involved, for example, highly aggressive people may have higher testosterone levels. Research has shown that males may be generally more aggressive than females due to the chromosomal make up of men, an X and Y chromosome rather than the double X chromosome. One study showed that a proportion of very violent male criminals had an extra Y chromosome. Aggression may also be a biologically inherited personality characteristic, for example Eysenck views aggression as a personality characteristic of a neurotic extrovert.

From this perspective, minor tranquilisers such as benzodiazepines are used to reduce aggression.

Activity

Read this article to learn more about the biological basis of aggression.

Stress

Stress can be described as the response that occurs when an individual feels overwhelmed and unable to cope with stressors in the environment. Holmes and Rahe developed a scale to measure the impact of stressful life events. You can read more about it here.

The signs and symptoms of stress are described here.

From the humanistic perspective, stress is explained in the same way as both depression and aggression. It is due to an individual failing to self-actualise due to satisfying the conditions of worth of other people and the resulting incongruity between the self and the ideal self. The therapies for stress are also client-centred therapy and encounter groups.

From the behaviourist perspective, stress is a learned response to environmental stimuli. In Pavlovian terms, the individual has learned to associate certain situations with the stress response, for example the stress response may be a learned behaviour to deadlines. If the individual goes on to avoid the stimulus, for example by taking time off when there is a deadline to meet, the association fails to be extinguished or unlearned. From this perspective, time management techniques are used to treat stress.

From the cognitive perspective, Beck and Ellis's theories can explain stress in terms of irrational thought processes, and their therapies can be used to treat stress.

Activity

Based on what you have already learned about Beck and Ellis's theories and their associated therapies, write an essay on how stress can be understood and treated from the cognitive perspective.

From the biological perspective, Stress can be seen as a physiological reaction to external stimuli or stressors in the environment, such as the life events described by Holmes and Rahe. The **fight or flight response** is the reaction of the body which allows it to produce a great deal of energy at very short notice, allowing the individual to escape or to attack when in a stressful situation, such as being under attack – this is a fundamental survival process that evolved in mammals. It involves changes to the body to get a blood supply to the muscles include the heart beating faster, blood pressure increasing. As a high blood sugar level is needed for energy, stored sugar is released into the bloodstream and sugars are digested very quickly while digestion of other kinds of foods is delayed – saliva changes to achieve this so the mouth feels dry. Oxygen is also needed so breathing becomes deep and rapid. Other changes that form the alarm reaction include blood changing, so clots form more quickly, pupils dilating and the pilomotor response, which causes 'goose pimples'.

Selye's **General Adaptation Syndrome** explains the long-term changes to the body resulting from continuous stress. If the body continues to produce high levels of adrenaline, resistance and exhaustion follow the alarm phase. The alarm reaction is the body's mechanism for dealing with danger. It is triggered by the perception of a stressor and the body is mobilised for action, as described above as the 'fight or flight response'. During the resistance stage the body struggles to deal with the stress and attempts to return to its previous state. The exhaustion stage occurs when the body cannot achieve a return to its previous state and fails to cope with the stressor. The body's physical resources then become depleted and this leads to collapse. This explains the effects of

long-term stress on the immune system, as the individual becomes less resistant to disease and illness.

Eysenck would regard the stress response as the biological basis of neuroticism. Neurotic personalities have a nervous system that responds rapidly and strongly to stressful events and so are more likely to react emotionally. Stable personalities have slower, less strong reactions of the nervous system when responding to stress.

From the biological perspective, stress can be treated using drug therapies, including beta-blockers, antidepressants and anxiolytics. Biofeedback, relaxation and meditation can also help to control the physiological experience of stress.

Eating Disorders

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Two common eating disorders are **anorexia nervosa (AN)** and **bulimia nervosa (BN)**. Behavioural signs of AN include extreme fasting, excessive exercising, telling lies about eating, hiding food and claiming to be too fat when obviously underweight. People who have this eating disorder tend to be very underweight, suffer from a range of associated health effects like amenorrhoea and may even die.

Behavioural signs of BN include regular bingeing on large quantities of food and then purging (making oneself sick) as well as trying to hide evidence of bingeing, such as buying large quantities of food in secret. There are associated health problems such as dental caries, but people with BN tend to be of normal weight and are not at risk of dying from this condition.

Activity

Read more about AN and BN on the NHS website and the website of the voluntary organisation Beat. Make some additional notes on the signs and symptoms of both AN and BN and draw up a list of similarities and differences between the two.

From the psychoanalytic perspective, Freud saw eating disorders as personality problems resulting from fixation in the oral stage of development. Eating disorders stem from problems in childhood, which are hidden in the unconscious. AN can, for example, be related to early trauma, such as sexual abuse. Such experiences are repressed into the unconscious and express themselves in adolescence as AN, which may be an unconscious attempt by those who have been sexually abused to destroy their bodies, which they are disgusted by. AN is also considered to represent regression to childhood as it causes a childlike body shape and periods to stop in females, enabling the individual to avoid an adult sexual role. Other defence mechanisms may also help to explain eating disorders, for example eating is regarded as a substitute for sexual expression, and so eating disorders are regarded as a way of repressing sexual impulses.

Hilde Bruch further developed the psychoanalytic perspective on eating disorders, also linking AN to sexual immaturity, claiming young women fantasise about oral impregnation and confuse fatness with pregnancy and therefore starve themselves to

avoid 'pregnancy'. She also argued eating disorders are an attempt by adolescents to establish and control their own identities, particularly if they have domineering parents, allowing them to achieve self-control and independence.

From this perspective, psychoanalysis is the therapy to help clients uncover the unconscious emotional conflicts responsible for AN and BN.

From the behaviourist perspective, classical conditioning explains eating disorders as a learned association between food (stimulus) and avoidance due to anxiety about weight gain (response); therefore not eating becomes a 'habit'. In terms of operant conditioning, at the outset slimming is positively reinforced, for example, by praise for looking good from friends and family. As a result, the behaviours that lead to weight loss are learned and AN develops. For BN, bingeing is reinforced because it provides a sense of indulgence, but it also causes anxiety which purging reduces, so both bingeing and purging are reinforced. Reinforcement also takes the form of attention from parents, who are worried about the family member. Not eating can also be interpreted as a way of punishing parents.

From this perspective behaviour modification techniques based on operant conditioning have been used to treat eating disorders. This starts with measuring and quantifying the problem behaviours, for example observing eating behaviour and quantifying intake of food. Inappropriate behaviours are punished, for example pocket money or a shopping trip may be withdrawn if meals are not eaten or a residential setting may cancel a weekend home visit.

At the same time, appropriate behaviour is positively reinforced, for example by giving points for eating at mealtimes; by accumulating points clients can earn treats like time at home if they are in a residential setting. Eating behaviours are carefully monitored to check for improvement. This type of programme can be followed through both at a residential setting and at home, as consistency is essential.

From the cognitive perspective, research shows individuals who have eating disorders perceive their own size and weight inappropriately, for example they describe themselves as much fatter than they really are and will draw pictures of themselves as fat even when they are very underweight. These negative cognitions about themselves influence behaviours such as refusing to eat, not going out with friends, telling lies about eating, bingeing and purging. Since eating disorders are caused by maladjusted thinking, in order to understand an individual with AN or BN, it is necessary to understand his or her thought processes.

Activity

Using what you have already learned about Beck's theory and Ellis's theory, outline how each of them might explain and treat eating disorders.

(a) In terms of explaining eating disorders, for Beck's theory, you should include examples of the cognitive triad of negative thoughts that someone with an eating disorder might have. For Ellis's theory, you should outline how the ABC model might explain the development of an individual's eating disorder.
(b) Explain how each of these theorists would treat an individual with an eating disorder.

From the social perspective, eating disorders can be regarded as being influenced by role models. For example, it has been argued that 'size 0' models may be influential, for example in this news article from the BBC. This perspective focuses on the role of the social context in the development of eating disorders so, like the psychoanalytic perspective, family relationships are sometimes seen as influential.

From this perspective, family therapy as described previously is used to treat eating disorders.

Phobias

A phobia is a strong, irrational fear of something that poses little or no actual danger. There are many specific phobias. **Agoraphobia is a fear of public places, and claustrophobia is a fear of closed-in places**. People who become anxious and extremely self-conscious in everyday social situations have a social phobia. Other common phobias involve heights, tunnels, water, flying, animals and blood.

Activity

Research phobias and make notes on how a phobic individual would respond in the presence of the stimulus he or she fears. A good starting point is the NHS website.

From the psychoanalytic perspective, phobias are associated with unconscious sexual fears as opposed to conscious thought processes and may also be explained by traumatic childhood experiences. Phobias operate through defence mechanisms, particularly repression and displacement; the original source of fear is repressed into the unconscious and fear is displaced onto another object or situation. Freud's case study of a phobia is Little Hans who developed a fear of horses, which Freud related to an unconscious fear of his father. Freud's interpretation of Hans's phobia is complex and in line with his theory of the Oedipus Complex. You can read more about Freud's interpretation of Little Hans's phobia here. From the psychoanalytic perspective, the fear appears to be irrational because there is no conscious explanation for it.

From this perspective, phobias can be treated with psychoanalysis or play therapy.

From the behaviourist perspective, any phobia is a learned response to the feared stimulus. Classical conditioning of physiological reflexes suggests a phobia is a learned association between a stimulus (the feared object) and the response (fear). Watson and Raynor's Little Albert experiment illustrates this. They conditioned the child to be afraid of a white rat (the conditioned stimulus or CS) by pairing this stimulus with a loud bang (the unconditioned stimulus or UCS), which will produce a reflexive startle response (unconditioned response or UCR). After a while Albert showed a fear response to the rat (a conditioned response or CR) when the loud noise was not present. This fear was generalised to other furry stimuli for example, other animals and even a fur coat. You can watch a short video of the Little Albert experiment here. The focus in this perspective is on the learned behaviour rather than what the client is thinking or feeling. With a phobia, the fear is not extinguished because the stimulus is avoided. From the perspective of operant conditioning it could be argued this avoidance is reinforced by reduced anxiety.

From this perspective, behaviour therapies are used to extinguish phobic responses. These include systematic desensitisation, implosion therapy and flooding, as previously described.

From the cognitive perspective, irrational thoughts and beliefs cause phobias. For phobias, Beck's cognitive triad of negative, automatic thoughts might be:

- I'm too afraid to go out (about the self)
- The feared object is everywhere (about the world)
- I'll never be able to live a normal life (about the future)

Examples of Ellis's catastrophising self-statements might be 'I will die if I have to face that – I'll never be able to cope, my life is impossible'. An example of an activating event

(A) might be a wasp sting leading to an irrational belief (B) such as 'this is a major danger in my life', with the consequences (C) being a maladaptive and irrational belief i.e. the phobia.

From this perspective, Beck's cognitive structuring and Ellis's RET and REBT can alter the cognitive mistakes and distortions that cause the phobic reactions.

From the social perspective, Bandura's Social Learning Theory (SLT) claims that phobic behaviour is learned by imitating and modelling the behaviour of role models and consequently through identification with them, the fear becomes internalised.
From this perspective, modeling therapy is used to treat phobias.

The influence of socio-economic factors

The focus so far has been on psychological explanations of behaviour, but it is important to note that socio-economic factors can also influence the behaviours of individuals. Examples of socio-economic factors are gender, housing and environment, poverty, social class, family, the media, employment and unemployment, ethnicity and education.

Depression

Gender – women are almost twice as likely to become depressed as men. The higher risk may be due partly to hormonal changes brought on by puberty, menstruation, menopause, and pregnancy. Although their risk for depression is lower, men are more likely to go undiagnosed and less likely to seek help. Suicide is an especially serious risk for men with depression, who are four times more likely than women to kill themselves.

Housing and environment – people who live in poor or overcrowded housing conditions or in unpleasant environments, for example inner city estates with high levels of crime are at a higher risk than average of suffering from depression. This is highlighted by the voluntary organisation Mind in their guide to housing and mental health. Rates of depression are extremely high in those who experience social exclusion because of their housing and environment, such as homeless people living in hostels, temporary accommodation or on the streets; this is linked to the stress caused by poverty and also to the lack of social and family support.

Poverty – poor living conditions and financial problems increase the likelihood of suffering from depression: this links to other factors like housing, social class, ethnicity and employment or unemployment.

Social class – depression is more prevalent in socially disadvantaged groups where there is a higher lifetime prevalence of major mental health problems and relatively poor access to mental health care. Stressful life events are more common in the lower social classes and this contributes to the raised prevalence of depression. You can view statistics linking poverty and social class to depression here.

Family – there is some evidence, as outlined in the biological perspective that depression runs in families. It may also be related to levels of tension in family life or family breakdown.

Media – whilst the media does not in itself cause depression, depressed individuals can use media such as news stories to reinforce their negative views of the world. They may also allow media images, for example of perfect families in beautiful houses in advertisements to make them feel inadequate.

Employment or unemployment – the highest rates of depression are amongst the unemployed, however, many individuals who suffer from depression cite work related stress as a contributory factor. People who have interesting and challenging jobs they enjoy are much less likely to suffer from depression than those in jobs characterised by routine and repetitiveness or uncomfortable working conditions – there is a clear link here to the fact that middle class people are generally less likely to experience depression.

Ethnicity – some ethnic groups, for example African Caribbean and Irish people, are over-represented in terms of admission to psychiatric hospitals with severe depression. It is thought this is linked to other social and environmental factors, such as unemployment, living alone and poverty.

Education – higher levels of education tend to be linked to social class, so those with higher levels of education are less likely than those who have lower levels of education to be depressed. Well educated people and their families also have an increased capacity for getting help with depression, due perhaps to the resources they have for research, accessing services and dealing with professionals.

Aggression

It can also be argued that aggression is influenced by a range of socio-economic factors. For example, in terms of **housing and environment**, an individual may come from an area where there are few opportunities and where belonging to a gang and engaging in aggressive behaviour is seen as the norm. As a result of **poverty**, an individual may be angry and frustrated because he feels socially excluded, for example an individual may believe and feel frustrated that people from his area don't get offered jobs or that he can never attain the good things in life, and so aggression is an outlet for this frustration. In terms of **gender and class**, some researchers believe that aggressive behaviour is part of the sub-culture of young working class males; it can be a norm amongst their peers and may be rewarded and admired. From a biological perspective it is argued that males may be more aggressive due to high levels of the male hormone testosterone. An individual may be aggressive because others pick on him because of his **ethnicity** – the individual responds by engaging in violence and aggression towards those who attack or discriminate against him.

An individual who has had a poor experience in the **education system** may be angry and aggressive and he may hit back at authority with aggressive behaviour. An individual's **family** circumstances may be difficult, which may make the individual feel unloved and his reaction may be one of aggression; aggression may be a learned behaviour in the context of a violent family. Some theorists argue that aggression may result from exposure to violent **media** images, with repeated exposure desensitising individuals to the effects of violent behaviour on victims.

Activity

(a) In small groups, discuss your own views on whether media like television, films and video games can influence people to be aggressive.
(b) Read this article from the American Psychological Association. Does this change your views in any way?
(c) Watch the video Teenage Gangs of South London and make notes on the socio-economic factors that contribute to violence.

Stress

Activity

Conduct your own research on how the socio-economic factors listed above (under depression) might contribute to stress. The following are useful sources to start with, but you should find some of your own as well.

The Health and Safety Executive
Mind (some very useful links to follow on this website)
This report on poverty and social exclusion.

Make notes on how the socio-economic factors investigated could influence stress.

Eating disorders

Gender – eating disorders are more common in females, with some sources suggesting only 1 to 5% of people with AN and 5 to 10% of people with BN are male. You can read more about gender differences in eating disorders here. Beat claims, however, that NHS's Adult Psychiatric Morbidity Survey in 2007 showed that up to 25% of those showing signs of an eating in the UK disorder were male.

Social class – AN is more prevalent in middle classes/children of professionals. It has been argued that this may be linked to the pressure to succeed in **education** that middle class children experience, and that AN may be a way of diverting the parents' attention on to something else. Social class does not seem to impact on the BN.

Family – as previously suggested, AN may be an attempt to maintain a position as a child in the family or may stem from family pressure to succeed. It has also been argued that eating disorders may be designed to prevent dissension in the family for example, an attempt by an adolescent to divert attention onto herself to prevent the breakdown of her parents' marriage. There is some evidence that eating disorders can run in families, with first-degree biological relatives (parents, siblings, and children) of sufferers having an increased risk; a family history of mood or personality disorders is also associated with an increased risk of developing an eating disorder.

Media – eating disorders may be linked to images of attractiveness on television or in teenage magazines. You can read more about the influence of the media here.

Employment – jobs where there is an emphasis on appearance, particularly modelling is associated with high numbers developing eating disorders. Read Georgina Wilkin's article in the Telegraph about developing anorexia as a result of her modelling career.

Ethnicity – there seems to be some evidence that UK minority ethnic individuals are less likely to be referred for treatment for eating disorders than their white British counterparts, though this could possibly be due to missed or delayed diagnosis.

Activity

Watch the video documentary The Deadly Life of an Anorexic. Reflecting on what you have already learned about AN, make notes and contribute to a group discussion on what you saw in the video with regard to:

- factors that influence eating disorders
- theories that explain eating disorders
- therapies for eating disorders.

Phobias

Phobias are not generally influenced by socio-economic factors. Gender, housing and environment, poverty, social class, employment or unemployment, ethnicity and level of education seem to make no difference in whether an individual is likely to develop a phobia. From a social learning perspective **family** members may influence phobic behaviour and it could be argued that fear may be learned from the **media**, for example by films although there is no clear scientific evidence to support this.