The overall purpose of an introduction is to present the information that is available in the literature and to help the reader thoroughly understand the question that is being addressed in the study or studies. The most important thing to remember as you write an introduction is that you are making a case for your research question. By the end of the introduction the reader should understand a number of things. The first one is why the research area is important. Discussing the use of the concepts in psychology, and relating them to practical applications are good ways to achieve this goal.

A second goal is to give the reader the background they need to understand your predictions. To do this you need to talk about the relevant concepts and theories that are used in the literature. Depending on the area, you may need to discuss only one approach to the problem, or you may need to discuss 2 or 3 conflicting theories. If there is only a single approach that makes relevant predictions about your variables, you will need to explain that theory and offer evidence that supports it.

When there are multiple approaches that conflict over the variables you are interested in, you will need to use the existing studies to support the reasonableness of each position or to explain why one position is more reasonable than the others. You will also need to explain each position in enough detail that the reader can see how each theory makes its predictions. One approach you can take is to compare and contrast the theories, pointing out similarities and differences between them, and then focus on the data supporting the areas where the theories have differences. Sometimes multiple theories predict that the same variable will be important in determining outcomes. In this case the job of explaining the theories is simpler, since you can concentrate on the data supporting the importance of that variable from each perspective, without discussing other aspects where the theories take different stands.

In the early parts of your introduction you will be taking a broader focus on your topic in order to generally introduce your reader to the ideas. In this part you will probably be summarizing the results of previous studies or just the conclusions reached by those studies. Later in your introduction you will be focusing more specifically on the issues relevant to your study. At this point you will want to go beyond summarizing the conclusions of other studies. Instead it is appropriate include more detail about the studies and evaluate them. In what ways do they address the question you are interested in? What limitations are there on the conclusions? In this part, you may be pointing out weaknesses in the previous studies, that you will be correcting in your study. Another possibility is to simply point out a previously ignored aspect of the phenomenon that you will address. The goal here is to indicate to the reader how your study contributes to the literature and advances knowledge in the area.

After pointing out the information that is missing from the literature, most introductions give a brief overview of the study that is being presented in the current paper. This is the place to indicate how your study will find new information or answer a question in a better way than previous work has. This is not the place for extensive methodological detail but you need to talk about the variables you will use and justify your manipulations and measures. This section will also include a statement of your hypothesis.
Assignment for Lab # 1 & 2:

In this exercise you will be constructing the outline of an introduction to a research study. You will first read some information about the background, hypothesis and a description of the study. You will also be given a list of ideas from the introduction of the study. Your task is to organize these ideas in to an introduction that would be appropriate for the study. The introduction should begin with more general information and then build a case for the importance of the question asked in the study, justifying the hypothesis that was tested. In the week 1 lab, you will work through the example given below. Next week you will create your own organization for one of the other studies (beginning on page 5).

The following pages provide you with a choice of subject matter to work with in this exercise. It will be easiest if you choose the subject that you are most familiar with. You will work in pairs on this activity. Before you begin organizing the ideas, make sure you understand the hypothesis being tested and roughly what was done in the study. Then, begin by reading the information and sort it into groups of facts about related topics. Organize an outline for the article introduction using the given information and additional information needed to make understandable connections between the given ideas. Indicate how you will link the ideas together to make a coherent argument for this research project.


Children of depressed mothers often seem to have adverse developmental outcomes like higher rates of depression, anxiety and disruptive behavior.

Hypotheses: 1) The severity of maternal depression will be related to children’s behavior problems and cognitive outcomes. 2) The chronicity (duration of episodes) will be related to children’s behavior problems and cognitive outcomes. 3) These 2 variables are expected to interact in predicting child behavior problems and cognitive outcomes. 4) Maternal depression will have a greater impact at some points in the child’s development than at other times.

Study: Approximately 5000 mothers reported on their depressive symptoms at each of 4 time periods: during pregnancy, 3-4 days after the child’s birth, when the child was 6 months old, and when the child was 5 years old. The depression measures allowed the mothers to indicate the severity of the symptoms, and the duration of the symptoms. Those mothers who reported depression at only one of the time periods were compared (depression only during pregnancy, only at birth, only at 6 months and only at 5 years) to test the hypothesis about the effects of timing of depression. The researchers obtained ratings of the number of problem behaviors the children demonstrated and the children’s scores on the Peabody Picture Vocabulary test at age 5.

Ideas to use in your introduction:

1. Exposure to a depressed mother might have a greater effect at particular periods in the child’s development, for instance in the first 6 months of life when the child is forming an attachment.
2. Depressions can also vary in their time course with symptoms persisting across a long time in some cases, or for shorter durations in other cases.

3. Depression symptoms can vary from mild to very severe and the severity of the depression is related to how severely it impairs the person’s functioning.

4. Severity and chronicity of depression are correlated and can only be separated in very large samples assessed repeatedly over time.

5. Mothers who’s depression persisted through the 6 months after the child’s birth had fewer positive interactions with their infants than did non-depressed mothers. Mothers who were depressed 2 months after birth but who’s symptoms had remitted by 6 months, did not interact differently with their children (Campbell, Cohn, & Meyers, 1995).

6. Current mother depression is related to infant attachment (Campbell, Cohn, Meyers, Ross, & Flanagan, 1993; also other research studies).

7. Children, whose mothers have had more depressive episodes, were more likely to have more severe diagnoses (Hammen, 1991).

8. Many cross-sectional studies with clinical samples of depressed parents have shown higher levels of depression and disruptive behavior in their children (see review in Hammen, 1999).

9. In most of the existing studies on maternal depression and child outcomes, the severity, chronicity, and timing of the depression have not been distinguished.

10. A small prospective study showed that maternal depression at 14 months after birth was more predictive of child behavior disturbance than was maternal depression at either 27 or 42 months after birth (Ghodsian, Zajicek, & Wolkind, 1984).

11. A study showed that only recurrent, early-onset major depression in the parents was associated with major depression in the offspring (Warner, Wufson, & Weissamn, 1995).

12. Interaction with their children in the laboratory did not differentiate depressed from non-depressed mothers, but mothers with severe, chronic depression had children with more insecure attachments (Frankel & Harmon, 1996).

13. Many cross-sectional studies with community samples of mothers reporting depression symptoms, have shown higher levels of maladaptive reactions in children of a range of ages (see review in Glefand & Teti, 1990).

14. A study using retrospective reports of depression showed that depression only in the postpartum period was related to anxiety symptoms in children, and that depression only at the time of the study was related to hyperactivity symptoms (Alpern & Lyons-Ruth, 1993).
Begin by sorting the ideas into groups. In this case the hypotheses focus on effects of severity, chronicity and timing of depression so these would make good groups.

General maternal depression: 8, 9, 13
Severity of depression: 3, 4, 12

Chronicity of depression: 2, 4, 5, 7, 11, 12
Timing of depression: 1, 6, 10, 14

Starting with the general ideas and moving to more specific ideas with a direct relationship to the study that was conducted.

I. Maternal depression has an effect on outcomes for the child

A. (8) Many cross-sectional studies with clinical samples of depressed parents have shown higher levels of depression and disruptive behavior in their children (see review in Hammen, 1999).

B. (13) Many cross-sectional studies with community samples of mothers reporting depression symptoms, have shown higher levels of maladaptive reactions in children of a range of ages (see review in Glefand & Teti, 1990).

C. So there is good evidence linking parental depression and negative outcomes for children, however, (9) in most of the existing studies on maternal depression and child outcomes, the severity, chronicity, and timing of the depression have not been distinguished. These factors may influence which children of depressed parents will have difficulties.

II. Some studies have made distinctions

A. Evidence on chronicity
   1. (2) Depressions can vary in their time course with symptoms persisting across a long time in some cases, or for shorter durations in other cases.
   2. Chronicity effect in infancy on interactions with child and attachment (5 and 12): Mothers who’s depression persisted through the 6 months after the child’s birth had fewer positive interactions with their infants than did non-depressed mothers. Mothers who were depressed 2 months after birth but who’s symptoms had remitted by 6 months, did not interact differently with their children (Campbell, Cohn, & Meyers, 1995).
      Similarly, Frankel & Harmon (1996) found that mothers with severe, chronic depression had children with more insecure attachments. However, they did not find mother-infant interaction differences between depressed and non-depressed mothers in a laboratory task.
   3. Also effects on child psychopathology at later ages (7 & 11): Children, whose mothers have had more depressive episodes, were more likely to have more severe diagnoses (Hammen, 1991).
      A study showed that only recurrent, early-onset major depression in the parents was associated with major depression in the offspring (Warner, Wufson, & Weissamn, 1995).
B. Evidence on severity effects
   1. Reasonable that severity might matter because it effects interpersonal functioning (3) Depression symptoms can vary from mild to very severe and the severity of the depression is related to how severely it impairs the person’s functioning.
   2. No function differences observed but severity & chronicity did effect attachment (12) Interaction with their children in the laboratory did not differentiate depressed from non-depressed mothers, but mothers with severe, chronic depression had children with more insecure attachments (Frankel & Harmon, 1996).
   3. Do have evidence that severity and/or chronicity matter but not clear whether they have different effects. Severity and chronicity will be hard to separate. Separating them requires a big study (4). This is one of the reasons for the current study. It will be big enough to try to separate these 2 influences.

C. Timing of a single episode of depression might also matter
   1. Logical argument why timing might matter (1): Exposure to a depressed mother might have a greater effect at particular periods in the child’s development, for instance in the first 6 months of life when the child is forming an attachment.
   2. Maternal depression in late infancy does influence attachment (6) Current mother depression is related to infant attachment (Campbell, Cohn, Meyers, Ross, & Flanagan, 1993; also other research studies). In these studies the depression existed at the time that attachment was assessed, so at least temporarily maternal depression does influence attachment.
   3. There is some evidence for specific timing effects, where maternal depression has a worse effect on the child at one time in development than at another.
      a. One is a small prospective study (10) A small prospective study showed that maternal depression at 14 months after birth was more predictive of child behavior disturbance than was maternal depression at either 27 or 42 months after birth (Ghodsian, Zajicek, & Wolkind, 1984).
      b. Another is a retrospective study. The accuracy of retrospective reports of depression (when and how depressed were you 3-10 years ago?) are typically not very accurate. (14) A study using retrospective reports of depression showed that depression only in the postpartum period was related to anxiety symptoms in children, and that depression only at the time of the study was related to hyperactivity symptoms (Alpern & Lyons-Ruth, 1993).
      c. The evidence on specific timing effects is suggestive but not clear. This also requires a large, longitudinal study, where the outcomes associated with maternal depression at different times in development can be compared.

D. The final section of the introduction would briefly describe the current study, how it overcomes the limitations of prior work (attempts to separate aspects, larger study, current depression reports at different time periods—not retrospective, 5 years is longer term than most), and what new information will be provided.
Mechanisms of hypnotic pain relief

**Background:** Effective pain relief has been demonstrated with hypnotic suggestions that the relevant body part will not feel pain. This is called hypnotic analgesia. It is typically tested using cold water or a mechanism that presses on a finger. The participant is asked to endure this minor pain while giving ratings of how much it hurts. The participants are told they may stop the pain process at any time but are encouraged not to. There are individual differences in how susceptible people are to hypnosis. This dimension of individual differences in hypnotic suggestibility. People high on this dimension are easy to hypnotize while those low on this dimension are hard or impossible to hypnotize.

**Hypothesis:** It is possible to induce hypnotic analgesia using a hypnotic induction that does not include the suggestion of images.

**Study:** Highly hypnotically suggestible participants had their pain tolerance tested using a finger pressure apparatus in three conditions: baseline, hypnotic induction with counterpain images, and imageless hypnotic induction.

**Ideas to use in your introduction:**

More hypnotically suggestible people have a talent for fantasy and vivid imagery which they can become very involved in. (Hilgard & Hilgard, 1975)

Surprising results were found when subjects were given an image that was contradicted by the suggested state. For example, given the image of a bending arm after hypnotic suggestion made the arm rigid. Highly hypnotizable people were able to form vivid images of the action but did not actually bend their arm. This suggests that the involvement in the specific image does not play a causal role in creating the suggested actions. (Bartis & Zamansky, 1990; Zamansky & Clark, 1986)

Both dissociative and social psychology approaches to explaining hypnosis in general, and how hypnosis can block pain use the idea that the subject must become imaginatively involved in the ideas suggested by the hypnotist to achieve hypnotic effects (Spanos & McPeake, 1974)

No one has tested hypnotic pain inductions without counterpain imagery.

In hypnotic inductions, the target suggestions are reinforced with supportive imagery, for example, the suggestion that the person’s hand will become insensitive to pain, would be accompanied by images of the hand made of wood or stone, or enclosed in a heavy protective glove. These are called counterpain images.

It is possible that there could be 2 processes operating in hypnotic analgesia. One from counterpain imagery and a second from the suggested pain insensitive state. Each of these may be contributing to the analgesic effect. (Bowers, 1992)

Imaginative involvement is necessary in the social psychology model of hypnosis for the participant to experience actions as nonvolitional. The theory suggests that hypnotized individuals misattribute their hypnotic responses to the accompanying imagery, rather than to their own efforts to generate the suggested state of affairs. (Lynn, Rhue & Weekes, 1990)

Based on reports made after the pain trial, hypnotically suggestible people report that they were thinking about the counterpain images during the hypnotic procedure. (Hilgard & Hilgard, 1975)

Conditions that elicit automatic stereotyping

Background: In order to simplify the difficult task of predicting other people’s behavior we tend to form stereotypes of different groups of people. These stereotypes can contain positive or negative information. Once formed, stereotypes alter the way information about this group of people is perceived and remembered. It is important to discover what conditions are most likely to activate these stereotypes and what control can be exerted over them.

Hypothesis: Threats to one’s self-image should trigger the goal of restoring one’s self-image. When this is combined with the presence of a member of a stereotyped group, it may automatically activate and apply negative stereotypes of that group.

Study: Participants were exposed to a member of a racially stereotyped group. This exposure happened when the participant was either under a self-image threat or with no threat, and while the participant was engaged in a simultaneous task or with no task. The degree of stereotype activation was assessed in a word completion task, for the 4 possible combinations of 2 levels of threat (positive or negative feedback on a prior task) and 2 levels of cognitive load (simultaneous task or no task).

Ideas to use in your introduction:

The absence of counterstereotypic expectations (specific expectations that the person will not behave in a way that matches the stereotype) increases the chance of full activation of a stereotype. (Blair & Banaji, 1996)

Bargh’s (1997) Òauto-motiveÓ model proposes that motives or goals that are frequently paired with an environmental cue, can become automatically activated when the cue is encountered. Goals that are activated outside of awareness have the same effect as conscious goals do on the perceivers’ evaluations of a target.

Research shows that stereotypes may be activated spontaneously and without awareness when individuals perceive others who belong to a group with a well known stereotype, or when the group label is presented. (Bargh, 1997; Macrae, Bodenhausen & Milne, 1995)

Full stereotype activation may require that the perceiver have sufficient cognitive resources available. Subjects activated an Asian stereotype if they had resources available but did not when their resources needed to be devoted to a simultaneous cognitive task. (Gilbert & Hixon, 1991)

Perceivers may not be aware of the effects that activating a stereotype is having on their perceptions and judgements. (Bargh, 1994; Bargh, Chen & Burrows, 1996)

Devine (1989) proposed that motivated perceivers can suppress their application of stereotypes but cannot suppress the automatic activation of the stereotypes.

Fein & Spencer (1997) have shown that threat to their own self-images made participants more likely to evaluate a stereotyped target negatively, and that this negative evaluation raised the participants’ self esteem. Stereotypes may be a particularly effective means for people to restore a threatened self-image.

The strength and availability of the stereotype will influence the chance of full activation of a stereotype. (Wittenbrink, Judd & Park, 1997)

Interventions with children with conduct problems

**Background:** Two of the disorders often diagnosed in young children are oppositional defiant disorder, which centers around resisting compliance with authority figures, and conduct disorder, which involves general problem behavior in all social interactions.

**Hypothesis:** By combining both parent and child training interventions with young children with oppositional defiant disorder/conduct disorder, more of the risk factors increasing the likelihood of these conduct problems will be addressed. This type of intervention will result in better generalization of the improved conduct to other settings and greater overall improvements in children's behavior.

**Study:** Families with young children with oppositional defiant disorder or conduct disorder were randomly assigned to receive child training only, parent training only, both types of training, or placed on a waiting list as a control group. Outcomes were assessed with observations of parent-child interactions, as well as parent and teacher reports of adjustment.

**Ideas to use in your introduction:**

- Child training interventions with children diagnosed with oppositional defiant disorder and conduct disorder have not improved social or problem solving skills with younger or with more aggressive children (Coie, 1990)

- Early onset conduct problems are related to a variety of health & behavioral problems in adolescence, including peer rejection, drug abuse, depression, juvenile delinquency, and school dropout. (Loeber, 1991)

- Parents of children diagnosed with oppositional defiant disorder and conduct disorder often lack certain fundamental parenting skills. For young children 4-8 years, parent training can result in improvements in the children’s behavior and adjustment in at least 2/3 of treated children. (Patterson, 1982)

- Child training interventions with children diagnosed with oppositional defiant disorder and conduct disorder have improved social skills for older children (Kazdin, Esveldt-Dawson, French, & Unis, 1987)

- Current estimates suggest that 7% to 25% of children are affected with conduct problems.

- Children diagnosed with oppositional defiant disorder and conduct disorder have deficits in social skills, problem solving skills, and self control. These difficulties contribute to poor peer interactions, negative or hostile attributions about events, and conduct problems. (Rubin & Krasnor, 1986)

- Parent training interventions don't help all families with conduct problem children, even when many short term improvement measures are used. (Jacobsen, Follette, & Reavenstorff, 1984)

- Child training interventions with children diagnosed with oppositional defiant disorder and conduct disorder have not produced generalization of the new skills beyond the training setting for children of any age. (Prinz, Blechman, & Dumas, 1994)

- In long term follow-up studies, 30%-40% of parents who were trained to deal with their problem children, reported continued clinical problems in their children’s behavior (Webster-Stratton, Hollinsworth, & Kolpacoff, 1989). Teacher reports of 25%-50% continued problems reflect a similar lack of complete success (Webster-Stratton, 1990).

1. What are the variables used in the study?

2. How does the hypothesis suggest that the variables are related?

3. How are each of the variables manipulated or measured?

4. What is the new contribution to the literature that is made by the current study?

5. On the back of this page, create an outline using the provided ideas and any you would like to add. You are trying to build an argument for the study which was conducted. You should indicate how the ideas will be tied together. In your outline, use phrases or sentences to refer to the ideas in each section and subsection.