ALevel Psychology Paper 1

Psychopathology Past Questions and Mark Scheme

Name:

Class:

Time:

Marks:

Comments:

1 What is meant by 'statistical infrequency' as a definition of abnormality?

_____

_____

_____

_____

(Total 2 marks)

2 Which **two** of the following are examples of Jahoda's criteria for 'ideal mental health'? Shade **two** boxes only. For each answer completely fill in the circle alongside the appropriate answer.

A Dependence on others ⬭

B Environmental mastery ⬭

C Lack of inhibition ⬭

D Maladaptiveness ⬭

E Resistance to stress ⬭

(Total 2 marks)

3 Read the item and then answer the question that follows.

The following article appeared in a magazine:

Hoarding disorder – A 'new' mental illness

Most of us are able to throw away the things we don't need on a daily basis. Approximately 1 in 1000 people, however, suffer from hoarding disorder, defined as 'a difficulty parting with items and possessions, which leads to severe anxiety and extreme clutter that affects living or work spaces'.

Apart from 'deviation from ideal mental health', outline **three** definitions of abnormality. Refer to the article above in your answer.

(Total 6 marks)

4 (a) Outline **one** definition of abnormality.

(2)

(b) Outline and evaluate **one other** definition of abnormality.

(6)
(Total 8 marks)

5 The following statements are all linked to different definitions of abnormality.

Select the **two** statements that describe the deviation from ideal mental health definition of abnormality.

Tick **two** boxes.

- Behaviour that is different from the way most people in society act ☐
- Not achieving self-actualisation ☐
- Not following the standards set by society ☐
- Causing distress or discomfort to others ☐
- Behaviour that interferes with everyday life ☐
- Not being able to resist stress ☐

(Total 2 marks)

6 Explain **one** limitation of the failure to function adequately definition of abnormality.

_____

_____

_____

_____

Extra space _____

_____

(Total 2 marks)

7 It has been suggested that the meeting of certain criteria indicates whether or not a person has ideal mental health. Helen has been told that she has ideal mental health: for example, she adapts well to her environment.

Give **two** other criteria for ideal mental health that you would expect Helen's behaviour to show.

_____

_____

_____

_____

(Total 2 marks)

8 Outline **two** limitations of the deviation from ideal mental health definition of abnormality.

_____

_____

_____

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_____

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_____

Extra space _____

_____

_____

_____

(Total 4 marks)

9

(a) One definition of abnormality is deviation from social norms. Identify and explain **one other** definition of abnormality.

(3)

(b) Evaluate the definition of abnormality that you identified in your answer to (a).

Extra space

(4)
(Total 7 marks)

10 Diane is a 30-year-old business woman and if she does not get her own way she sometimes has a temper tantrum. Recently, she attended her grandmother's funeral and laughed during the prayers. When she talks to people she often stands very close to them, making them feel uncomfortable.

(a) Identify **one** definition of abnormality that could describe Diane's behaviour. Explain your choice.

Definition _____

_____

Explanation of your choice _____

_____

_____

_____

_____

_____

(3)

(b) Explain **one** limitation of this way of defining abnormal behaviour.

_____

_____

_____

_____

_____

_____

(3)
(Total 6 marks)

11 Identify **one** definition of abnormality and explain **one** limitation associated with this definition.

(Total 3 marks)

12 Abnormality can be defined as 'the failure to function adequately'.

Outline and evaluate this definition of abnormality.

Extra space _____

(Total 6 marks)

13

(a) Outline **two** definitions of abnormality.

Definition One _____

Definition Two _____

(6)

(b) Choose **one** of these definitions and describe a limitation associated with it.

_____

_____

_____

_____

(2)
(Total 8 marks)

14 Before leaving the house each morning, Angus has to go round checking that all the lights are switched off. He has to do this several times before he leaves and it makes him late for work.

(a) Give **one** definition of abnormality.

_____

_____

(1)

(b) Use this definition to explain why Angus' behaviour might be viewed as abnormal.

_____

_____

_____

_____

(2)
(Total 3 marks)

15 "Abnormality is very difficult to define. It can be hard to decide where normal behaviour ends and abnormal behaviour begins."

Discuss **two or more** definitions of abnormality.

(Total 12 marks)

16 One way of defining abnormality is to see whether or not someone meets the criteria for mental health. Ivan has high self-esteem and a strong sense of identity.

(a) Describe **two** other criteria that you would expect Ivan to display if he were psychologically healthy.

Criteria 1 _____

_____

_____

_____

Criteria 2 _____

_____

_____

_____

(4)

(b) Outline **one** weakness of defining abnormality in terms of mental health.

_____

_____

_____

_____

(2)

(Total 6 marks)

17 Outline the characteristics of depression.

(Total 4 marks)

18 Outline the characteristics of obsessive compulsive disorder.

(Total 4 marks)

19 What is meant by a *phobia*?

(Total 2 marks)

20 A researcher wanted to investigate the effectiveness of therapy as a treatment for obsessive-compulsive disorder in children. Before the therapy started, the mothers of 10 children with obsessive-compulsive disorder each rated the anxiety of their child. They used a rating scale of 1–10, where 1 meant not at all anxious and 10 meant extremely anxious. Each child then attended a programme of therapy. At the end of the programme, each mother rated her child again, using the same anxiety scale. The scores for each child before and after therapy were used to calculate a median anxiety rating.

The data are shown in the table below.

Median ratings of children's anxiety before and after therapy

	Before therapy	**After therapy**
Median rating of anxiety	8.5	4.0

(a) Identify **two** symptoms of obsessive-compulsive disorder.

(2)

(b) Name and outline the experimental design used in this study.

(2)

(c) Explain **one** advantage of this experimental design.

(2)

(Total 6 marks)

21 Outline characteristics of **either** phobic disorders **or** obsessive compulsive disorder.

(Total 4 marks)

22 Outline characteristics of depression.

(Total 4 marks)

23 Outline **and** evaluate the behavioural approach to treating phobias.

(Total 12 marks)

24 Read the item and then answer the question that follows.

> Kirsty is in her twenties and has had a phobia of balloons since one burst near her face when she was a little girl. Loud noises such as 'banging' and 'popping' cause Kirsty extreme anxiety, and she avoids situations such as birthday parties and weddings, where there might be balloons.

Suggest how the behavioural approach might be used to explain Kirsty's phobia of balloons.

(Total 4 marks)

25 Read the item and then answer the question that follows.

> Tommy is six years old and has a phobia about birds. His mother is worried because he now refuses to go outside. She says, 'Tommy used to love playing in the garden and going to the park to play football with his friends, but he is spending more and more time watching TV and on the computer'.

(a) A psychologist has suggested treating Tommy's fear of birds using systematic desensitisation. Explain how this procedure could be used to help Tommy overcome his phobia.

(4)

(b) Explain why systematic desensitisation might be more ethical than using flooding to treat Tommy's phobia.

_____

_____

_____

_____

(2)
(Total 6 marks)

26 'Behaviourists believe that all behaviour, both normal and abnormal, is learned through processes such as classical conditioning, operant conditioning and social learning.'

Discuss the behavioural approach to explaining phobias.

(Total 16 marks)

27 'Behaviourists believe that all behaviour, both normal and abnormal, is learned through processes such as classical conditioning, operant conditioning and social learning.'

Discuss the behavioural approach to explaining phobias.

(Total 12 marks)

28 Mia has a phobia of eating in public. She is about to go to university where she knows that she will have to eat her meals in a large dining hall surrounded by other students.

Describe how a therapist might use systematic de-sensitisation to help Mia overcome her phobia of eating in social situations.

Extra space

(Total 4 marks)

29 (a) Outline a behavioural explanation of phobias.

(2)

(b) Briefly discuss **one** limitation of the behavioural explanation of phobias that you have outlined in your answer to part (a).

(3)
(Total 5 marks)

30 Sammy has a phobia of birds. This started when he was three years old. A seagull frightened him when it swooped down and stole his sandwich as he was eating it.

Sammy is now eight years old. He is scared when walking to school and is so afraid of birds that he will not play outside.

(a) Use your knowledge of the behavioural explanation of phobias to outline how Sammy's phobia might have developed.

(2)

(b) Describe and evaluate systematic desensitisation as a treatment for phobias. Refer to Sammy in your answer.

(16)
(Total 18 marks)

31

Sammy has a phobia of birds. This started when he was three years old. A seagull frightened him when it swooped down and stole his sandwich as he was eating it.

Sammy is now eight years old. He is scared when walking to school and is so afraid of birds that he will not play outside.

(a) Use your knowledge of the behavioural explanation of phobias to outline how Sammy's phobia might have developed.

(2)

(b) Describe and evaluate systematic desensitisation as a treatment for phobias. Refer to Sammy in your answer.

(12)
(Total 14 marks)

32

Outline what is involved in systematic de-sensitisation.

_____

_____

_____

_____

_____

_____

(Total 3 marks)

33

Describe systematic de-sensitisation as a method of treating abnormality.

_____

_____

_____

_____

_____

_____

(Total 3 marks)

34 Explain **one** weakness of systematic de-sensitisation.

(Total 2 marks)

35 Hamish has a phobia of heights. This phobia has now become so bad that he has difficulty in going to his office on the third floor, and he cannot even sit on the top deck of a bus any more. He has decided to try systematic de–sensitisation to help him with his problem.

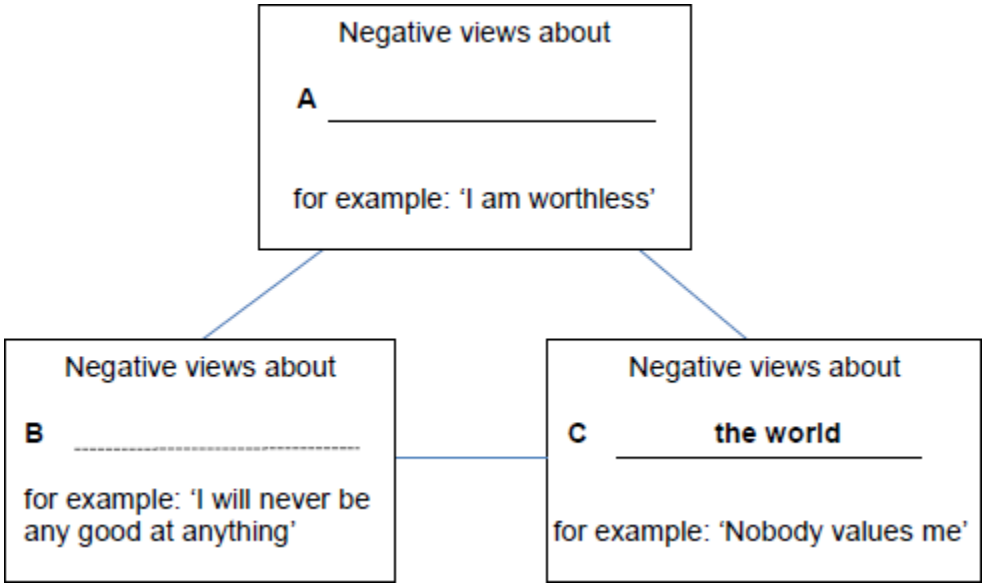
Explain how the therapist might use systematic de-sensitisation to help Hamish to overcome his phobia.

Extra space

(Total 6 marks)

36 Complete the diagram below, by filling in **A** and **B**, to show Beck's negative triad as it is used to explain depression.

Beck's negative triad



(Total 2 marks)

37 Briefly outline **one** strength of the cognitive explanation of depression.

_____

_____

_____

_____

(Total 2 marks)

38 Outline cognitive behaviour therapy as a treatment for depression.

(Total 4 marks)

39 Outline and evaluate the cognitive approach to explaining psychopathology.

(Total 8 marks)

40 Briefly describe **one** study in which treatment for unipolar depression **or** bipolar depression was investigated.

(Total 3 marks)

41 Outline and evaluate **at least one** cognitive approach to explaining depression.

(Total 12 marks)

42 Outline **at least two** ways in which a cognitive psychologist might explain depression in a person who has recently become unemployed.

(Total 4 marks)

43 Read the item and then answer the questions that follow.

> Researchers analysed the behaviour of over 4000 pairs of twins. The results showed that the degree to which obsessive-compulsive disorder (OCD) is inherited is between 45% and 65%.

(a) Distinguish between obsessions and compulsions.

(2)

(b) With reference to the study described above, what do the results seem to show about possible influences on the development of OCD?

(4)
(Total 6 marks)

44

Gavin describes his daily life.

'I sometimes get gripped with the thought that my family is in danger. In particular, I worry about them being trapped in a house fire. I now find that I can only calm myself if I check that every plug socket is switched off so an electrical fire couldn't start. I used to switch each socket on and off, but now I have to press each switch six times. It takes me ages to leave the house'.

Outline **two** characteristics of obsessive-compulsive disorder. Refer to Gavin in your answer.

(Total 4 marks)

45 Read the item and then answer the question that follows.

> Steven describes how he feels when he is in a public place.
>
> 'I always have to look out for people who might be ill. If I come into contact with people who look ill, I think I might catch it and die. If someone starts to cough or sneeze then I have to get away and clean myself quickly.'

Outline **one cognitive** characteristic of OCD and **one behavioural** characteristic of OCD that can be identified from the description provided by Steven.

(Total 2 marks)

46 Outline and evaluate **one** biological explanation for obsessive compulsive disorder (OCD).

(Total 16 marks)

47 Outline and evaluate **one** biological explanation for obsessive compulsive disorder (OCD).

(Total 12 marks)

48 Discuss biological explanations of obsessive compulsive disorder (OCD). Refer to evidence in your answer.

(Total 16 marks)

49 Two different drug therapies were tested on a group of patients. All the patients suffered with the same anxiety disorder. Half the patients were given **Therapy A** and the other half were given **Therapy B**. Improvement was assessed on a scale from 0-25, where 0 = no improvement.

The table below shows the improvement made between the start and the end of the treatment.

Average and range of improvement scores

	Average	**Range**
Therapy A	6.5	2 – 19
Therapy B	6	4 – 9

Explain what these findings suggest about the different therapies?

Extra space

(Total 4 marks)

Mark schemes

1

AO1 = 2

2 marks for a clear and accurate explanation of the term ‘statistical infrequency’ as a definition of abnormality.

1 mark for a weak, muddled or very limited explanation.

Content: A person’s trait, thinking or behaviour would be considered to be an indication of abnormality if it was found to be numerically (statistically) rare / uncommon / anomalous.

2

[AO1 = 2]

B and E.

3

[AO1 = 3 and AO2 = 3]

1 mark for each correct outline, plus **1 mark** for linking each outline appropriately to the stem.

Definitions must be outlined rather than simply stated / identified for credit.

AO1 Outline:

- statistical infrequency / deviation from statistical norms – abnormal behaviour is that which is rare / uncommon / anomalous
- deviation from social norms – abnormal behaviour is that which goes against / contravenes unwritten rules / expectations (in a given society / culture)
- failure to function adequately – abnormal behaviour is that which causes personal distress / anguish **OR** inability to cope with everyday life / maladaptiveness.

AO2 Application to stem:

- statistical infrequency – ‘approximately 1 in 1000 people…’
- deviation from social norms – ‘most of us are able to throw away the things we don't need on a daily basis…’
- failure to function adequately – ‘difficulty parting with items and possessions…leads to severe anxiety’ **OR** ‘affects living or work spaces’.

4

(a) **AO1 = 2**

Possible definitions:

- Statistical infrequency/deviation from statistical norms – abnormal behaviour is that which is rare/uncommon/anomalous.
- Deviation from social norms – abnormal behaviour is that which goes against/contravenes unwritten rules/expectations in a given society/culture.
- Failure to function adequately – abnormal behaviour is that which causes person distress/anguish or an inability to cope with everyday life/maladaptiveness.
- Deviation from ideal mental health – abnormality is that which fails to meet prescribed criteria for psychological normality/wellbeing: e.g. accurate perception of reality, resistance to stress, etc.

(b) **AO1 = 2 and AO3 = 4**

Level	Marks	Description
3	5 – 6	Knowledge of definition of abnormality is clear and accurate. Evaluation is relevant and well explained. The answer is clear and coherent. Specialist terminology is used effectively.
2	3 – 4	Knowledge of definition of abnormality is present though there may be some inaccuracy/lack of clarity. There is some relevant evaluation but there may be some omissions/lack of detail. There are some inaccuracies. There is some appropriate use of specialist terminology.
1	1 – 2	Knowledge of definition(s) of abnormality is briefly stated with no elaboration. There is a brief attempt to evaluate or this may be absent. The answer is brief, or has many inaccuracies and is poorly organised. Specialist terminology is either absent or inappropriately used.
	0	No relevant content.

AO1 – possible content:

- Statistical infrequency/deviation from statistical norms – abnormal behaviour is that which is rare/uncommon/anomalous.
- Deviation from social norms – abnormal behaviour is that which goes against/contravenes unwritten rules/expectations in a given society/culture.
- Failure to function adequately – abnormal behaviour is that which causes person distress/anguish or an inability to cope with everyday life/maladaptiveness.
- Deviation from ideal mental health – abnormality is that which fails to meet prescribed criteria for psychological normality/wellbeing: e.g. accurate perception of reality, resistance to stress, etc.

Note that definition chosen must be **different** from that outlined in the question.

AO3 – Possible evaluation points:

- Statistical infrequency/deviation from statistical norms – fails to account for behaviour that is statistically rare but desirable such as having a very high IQ; some disorders are not statistically rare; issue of who decides where the cut-off point is.
- Deviation from social norms – eccentric behaviours are not necessarily abnormal; social norms vary with time and with culture.
- Failure to function adequately – many mental disorders do not cause personal distress; many behaviours, e.g. smoking are maladaptive but not a sign of psychological abnormality.
- Deviation from ideal mental health – the criteria are too demanding – most people would be judged abnormal based on this definition; many of the criteria reflect Western cultural norms of psychological 'normality'.

Accept other relevant evaluation points.

5

AO1 = 2

The correct boxes are the 2nd one and the 6th one.

6

AO2 = 2

FFA: Limitation:

- Not a true definition, but a way of deciding how bad their problems are
- There are often exceptions to the rule, where maladaptive behaviour is not abnormal but due to a specific circumstance
- Cultural relativism

One mark for a brief identification of the limitation and a further mark for elaboration. For example, cultural relativism is one limitation; what may be seen as functioning adequately in one culture may not be adequate in another (1 mark). This is likely to result in different diagnoses in different cultures (2nd mark).

7

AO2 = 2

Jahoda suggested the following criteria necessary for ideal mental health:

- Resistance to stress
- Growth, development or self-actualisation
- High self-esteem and a strong sense of identity
- Autonomy
- Perception of reality.

Examiners should be aware that these terms are subjective / descriptive and that students may name the concepts in slightly different ways.

8

Please note that the AOs for the new AQA Specification (Sept 2015 onwards) have changed. Under the new Specification the following system of AOs applies:

- AO1 knowledge and understanding
- AO2 application (of psychological knowledge)
- AO3 evaluation, analysis, interpretation.

AO2 = 4

- Difficulty of meeting all criteria, very few people would be able to do so and this suggests that very few people are psychologically healthy.
- The criteria are subjective and not operationalised, so being defined as abnormal is not objective.
- These ideas are culture-bound, based on a Western idea of ideal mental health: cultural relativism.

One mark for identification of each weakness and a further mark for elaboration.

9

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- AO3 evaluation, analysis, interpretation.

Although the essential content for this mark scheme remains the same, mark schemes for the new AQA Specification (Sept 2015 onwards) take a different format as follows:

- A single set of numbered levels (formerly bands) to cover all skills
- Content appears as a bulleted list
- No IDA expectation in A Level essays, however, credit for references to issues, debates and approaches where relevant.

(a) **AO1 = 3**

Candidates may choose any definition: deviation from ideal mental health and failure to function adequately are named on the specification. However, other definitions such as statistical infrequency are also creditworthy.

1 mark for identifying the definition and a further 2 marks for elaboration.

(b) **AO2 = 4**

The evaluation must be relevant to the definition given in (a).

Failure to Function Adequately:

- Context is very important when deciding whether someone is functioning adequately; what may seem irrational in one context can be seen as rational in another. Thislimits the definition.
- Cultural relativism is an issue, what is considered adequate in one culture is notnecessarily adequate in another. This also makes it difficult for this to be a universal definition.

Deviation from Ideal Mental Health:

- The characteristics are very strict and it is unlikely that many people would be able to meet them all, thus being defined as abnormal.
- The definition was based on Jahoda's views of psychological health and therefore represents a very Western view.

Examiners should be aware of depth / breadth trade-off.

Credit any other relevant point of evaluation.

AO2 Evaluation of one definition of abnormality
4 marks Effective evaluation Evaluation demonstrates sound analysis and effective use of a range material to evaluate one definition of abnormality.
3 marks Reasonable evaluation Evaluation demonstrates reasonable analysis and use of material to evaluate one definition of abnormality.
2 marks Basic evaluation Evaluation demonstrates basic analysis and superficial evaluation of one definition of abnormality.
1 mark Rudimentary evaluation Evaluation demonstrates rudimentary, muddled analysis of one definition of abnormality.
0 Marks No creditworthy material

10

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(a) **AO2 = 3**

Several definitions could be applicable: deviation from social norms; failure to function adequately and deviation from ideal mental health. Candidates need to engage with the question in order to explain their choice. However, they can make a case for any of the definitions. For example, deviation from social norms (1 mark): It is not the norm for someone who is 30 to have a temper tantrum, even though it is normal for a 3 year old, so she is breaking an age-related social norm (2 marks for explanation).

1 mark for identification of a definition of abnormality and further two marks for the explanation why it has been chosen.

(b) **AO2 = 3**

The limitation must refer to the definition offered in part (a). For example, a limitation of the deviation from social norms definition is that social norms can vary from culture to culture. This means that what is considered normal in one culture may be considered abnormal in another. 1 mark for identification of a limitation and a further 2 marks for elaboration.

11

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- AO1 knowledge and understanding
- AO2 application (of psychological knowledge)
- AO3 evaluation, analysis, interpretation.

AO1 = 1

AO2 = 2

The definitions on the specification are:

- Deviation from social norms
- Failure to function adequately
- Deviation ideal mental health.

However, other definitions are also credit-worthy (eg statistical infrequency).

AO1 = 1 mark for correct identification of a definition of abnormality.

The limitation must be appropriate to the definition given. For example, one limitation of the deviation of social norms definition is that norms can vary over time. This means that behaviour that would have been defined as abnormal in one era is no longer defined as abnormal in another. With failure to function adequately, there is a cultural limitation in that the definition does not take account that 'adequate' behaviour varies from one culture to another.

The main limitation with ideal mental health is that the criteria are so demanding that very few people will be able to meet all the criteria.

AO2 = 1 mark for identifying the limitation and a further mark for elaboration.

12

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- AO2 application (of psychological knowledge)
- AO3 evaluation, analysis, interpretation.

AO1 = 3

AO2 = 3

Failure to function adequately (FFA) refers to abnormality that prevent the person from carrying out the range of behaviours that society would expect from them, such as getting out of bed each day, holding down a job etc. Rosenhan & Seligman suggested a range of criteria that are typical of FFA. These include observer discomfort, unpredictability and irrationality among others.

1 mark for a basic outline of FFA and a further two marks for elaboration.

Evaluation of FFA:

- Cultural relativism – what is considered adequate in one culture might not be so in another.
- FFA might not be linked to abnormality but to other factors. Failure to keep a job may be due to the economic situation not to psychopathology.
- FFA is context dependent; not eating can be seen as failing to function adequately but prisoners on hunger strikes making a protest can be seen in a different light.

13

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- AO2 application (of psychological knowledge)
- AO3 evaluation, analysis, interpretation.

(a) **AO1 = 3+3**

The definitions given on the specification are: deviation from social norms, failure to function adequately and deviation from ideal mental health and these are the most likely ones to be used. However, other definitions (such as statistical infrequency) are also acceptable. Note: models of abnormality are not acceptable.

1 mark for identification of the definition and a further two marks for elaboration. For example, deviation from ideal mental health (1 mark) is a list of criteria that state what is healthy (2nd mark) eg self actualisation (further mark).

(b) **AO1 = 2**

There are several limitations candidates could consider, but whichever they select it must apply to their chosen definition. For example:

- Deviation from social norms – limitations = changes with time; who decides on the norm, role of context, culturally specific.
- Failure to function adequately – limitations = who decides on what is adequate; distinction between maladaptive and abnormal.
- Deviation from ideal mental health – limitations = difficult to achieve many of the criteria; culturally specific.

1 mark for identification of limitation and a further mark for elaboration.

14

(a) **AO1 = 1**

There are three definitions on the specification; deviation from social norms, failure to function adequately and deviation from ideal mental health. However, any alternative definition such as statistical infrequency can also be credited.

(b) **AO2 = 2**

The definition of abnormality given in part (a) must be the one used to explain the behaviour. For example:

- (Deviation from social norms): this checking behaviour is not what most people do and therefore deviates from social norms. Many people check their lights once but not several times.
- (Failure to function adequately): this checking behaviour is making them late for work; consequently they are not functioning adequately (they might lose their job, or just not be able to do it very well).
- (Deviation from ideal mental health): these people are not psychologically healthy, the constant checking might cause them stress, and they show that they cannot deal with anxiety. Resistance to stress is one of Jahoda's criteria for ideal mental health.

15

Please note that the AOs for the new AQA Specification (Sept 2015 onwards) have changed. Under the new Specification the following system of AOs applies:

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- No IDA expectation in A Level essays, however, credit for references to issues, debates and approaches where relevant.

AO1 = 6

AO2 = 6

There are three definitions of abnormality named on the specification: deviation from social norms, failure to function adequately and deviation from ideal mental health. However, other definitions are also credit-worthy. Candidates could offer several definitions in less detail or two definitions but in more detail, breadth / depth trade off.

However, approaches or models are not credit-worthy.

The commentary could consider the strengths and / or limitations of each definition, eg the problems associated with cultural relativism or it could include a generic discussion of the problems of defining abnormality. One limitation of the deviation from social norms definition is that social norms change with time; this is illustrated by the changing views on homosexuality. With the deviation from ideal mental health, there is the problem of cross-cultural variations. A further problem is that the ideals are so demanding that almost everyone would be considered abnormal to some degree. The ‘failure to function adequately’ definition has the advantage of a more objective measuring scale (eg the GAF). However, it can be criticised as not differentiating sufficiently between abnormal behaviour and unconventional or eccentric behaviour.

AO1 Knowledge and understanding	AO2 Application of knowledge and understanding
6 marks Accurate and reasonably detailed Accurate and reasonably detailed description that demonstrates sound knowledge and understanding of at least two definitions of abnormality. There is appropriate selection of material to address the question.	**6 marks Effective evaluation** Effective use of material to address the question and provide informed commentary. Effective evaluation of research. Broad range of issues and/or evidence in reasonable depth, or a narrower range in greater depth. Clear expression of ideas, good range of specialist terms, few errors of grammar, punctuation and spelling.
5 – 4 marks Less detailed but generally accurate Less detailed but generally accurate description that demonstrates relevant knowledge and understanding. There is some evidence of selection of material to address the question. Partial performance: if only one definition is given, accurate and reasonably detailed, max 4 marks.	**5 – 4 marks Reasonable evaluation** Material is not always used effectively but produces a reasonable commentary. Reasonable evaluation of research. A range of issues and/or evidence in limited depth, or a narrower range in greater depth. Reasonable expression of ideas, a range of specialist terms, some errors of grammar, punctuation and spelling. Partial performance: max 4 marks.
3 – 2 marks Basic Basic description that demonstrates some relevant knowledge and understanding but lacks detail and may be muddled. There is little evidence of selection of material to address the question.	**3 – 2 marks Basic evaluation** The use of material provides only a basic commentary. Basic evaluation of research. Superficial consideration of a restricted range of issues and/or evidence. Expression of ideas lacks clarity, some specialist terms used, errors of grammar, punctuation and spelling detract from clarity.
1 mark Very brief/flawed or inappropriate Very brief or flawed description demonstrating very little knowledge. Selection and presentation of information is largely or wholly inappropriate.	**1 mark Rudimentary evaluation** The use of material provides only a rudimentary commentary. Evaluation of research is just discernible or absent. Expression of ideas poor, few specialist terms used, errors of grammar, punctuation and spelling often obscure the meaning.
0 marks No creditworthy material.	**0 marks** No creditworthy material.

16

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- AO2 application (of psychological knowledge)
- AO3 evaluation, analysis, interpretation.

(a) **AO2 = 4**

Possible criteria might include:

- Self-actualisation of one's potential
- Resistance to stress
- Personal autonomy
- Accurate perception of reality
- Adapting to the environment.

Other appropriate criteria can also be credited.
For each criterion: 1 mark for identification and a further mark for elaboration.

(b) **AO2 = 2**

One weakness is the difficulty of meeting all criteria, very few people would be able to do so, and this suggests then that few people are psychologically healthy.
Another weakness is that these ideas are culture-bound, based on a Western ideal of mental health.
1 mark for weakness of the limitation and a further mark for elaboration.

17

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- AO2 application (of psychological knowledge)
- AO3 evaluation, analysis, interpretation.

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Note that candidates can legitimately cover unipolar and/or bipolar depression for this question.

AO1 = 4

AO1 credit is awarded for an outline of the characteristics of depression.
It is acceptable for candidates to cover major depressive disorder or bipolar disorder.
Depression is characterised by a range of symptoms and candidates could refer to emotional, cognitive (suicidal thoughts) physical (weight loss or gain) or behavioural symptoms (decrease in sexual activity). A diagnosis of MDD can be made when five symptoms are present for at least two weeks.

To achieve top band marks at least one of two 'core' symptoms should be present:

- depressed mood for most of the day
- diminished interest or pleasure in activities.

Epidemiology i.e. prevalence, gender differences, prognosis etc., are creditworthy.

AO1 Mark bands	**Knowledge and understanding**
4 marks Sound Knowledge and understanding are accurate and well detailed. Organisation and structure of the answer are coherent.	
3 marks Reasonable Knowledge and understanding are generally accurate and reasonably detailed. Organisation and structure of the answer are reasonably coherent.	
2 marks Basic Knowledge and understanding are basic / relatively superficial. Organisation and structure of the answer are basic.	
1 mark Rudimentary Knowledge and understanding are rudimentary and may be very brief, muddled and / or inaccurate. Lacks organisation and structure.	
0 marks No creditworthy material.	

18

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AO1 = 4

AO1 credit is awarded for an outline of the characteristics of OCD. The main diagnostic criteria include:

- the presence of obsessions (recurrent, persistent thoughts, impulses or images) and / or compulsions (repetitive behaviours that the person feels driven to perform) on most days for a period of two weeks or more

- obsessions & compulsions are repetitive and unpleasant and interfere with daily life.

For 4 marks, students should refer to both obsessions and compulsions. Examiners should be mindful of the time constraints when awarding credit.

AO1 Mark bands
4 marks Sound Knowledge and understanding are accurate and well detailed. Organisation and structure of the answer are coherent.
3 marks Reasonable Knowledge and understanding are generally accurate and reasonably detailed. Organisation and structure of the answer are reasonably coherent.
2 marks Basic Knowledge and understanding are basic / relatively superficial. Organisation and structure of the answer are basic.
1 mark Rudimentary Knowledge and understanding are rudimentary and may be very brief, muddled and / or inaccurate. Lacks organisation and structure.
0 marks No creditworthy material.

19 **[AO1 = 2]**

Up to 2 marks for a description of features of a phobia.
Likely points:
An extreme fear of an object / situation / activity (1)
An irrational fear (1)
Fear that is disproportionate (to the actual danger) (1)
A fear that leads to avoidance (1)
A fear that is disruptive to everyday life / maladaptive (1)
For two marks there must be some reference to fear.

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- AO3 evaluation, analysis, interpretation.

(a) **[AO1 = 2]**

Up to 2 marks for description of both obsessions – recurrent / persistent thoughts / ideas / images / impulses and compulsions – repetitive behaviours / ritual acts / behaviour that reduces anxiety.
Accept physiological symptoms of anxiety.

(b) **[AO3 = 2]**

1 mark for naming repeated measures design.
1 further mark for an elaboration of repeated measures design.
Possible answers:
Repeated measures design means that the same participants are used in both conditions of the study.
If the answer is related to the study described: This means that the children whose anxiety ratings are taken in the before therapy condition are the same children as those who provide the anxiety ratings for the after therapy condition.

(c) **[AO3 = 2]**

Up to 2 marks for an explanation of one advantage of using repeated measures design.
The advantage of repeated measures design (in this study) is that there will be no participant variables (1) so any differences in performance (the median anxiety ratings before and after therapy) are more likely to be due to the manipulated variables / variables under test (therapy programme) than other variables so the validity of the results is increased.
Answers based on the idea that fewer participants are required than in other designs are relevant.

Note:
If the answer to (b) is incorrect **full credit** can be awarded for (c) if the advantage given matches the experimental design identified in the answer to (b).

21

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AO1 = 4

The outline might include:

- physiological, behavioural, emotional and cognitive signs / symptoms
- incidence and prevalence
- course and prognosis.

Examiners should be mindful that this part of the question is only worth 5 marks and so candidates are not expected to cover all these points to access the top marks. However, top band answers should refer to some diagnostic criteria – in particular there must be some reference to the underlying anxiety that characterises these anxiety disorders. It is acceptable to refer to different types of phobia but these distinctions on their own are not credit-worthy – they must be accompanied by a description of the characteristics of each type.

AO1 Mark bands
4 marks Outline is accurate and coherent.
3 – 2 marks Outline is limited, generally accurate and reasonably coherent
1 mark Outline is weak and muddled or very limited
0 marks No creditworthy material

22

AO1 = 4

- physiological, behavioural, emotional and cognitive signs / symptoms
- incidence and prevalence
- course and prognosis
- criteria for diagnosis.

Examiners should be mindful that this part of the question is only worth 4 marks and so candidates are not expected to cover all these points to access the top marks. However, they do have to refer to diagnostic criteria, specifically some reference to the core symptom of low mood / sadness. It is acceptable to refer to types of depression such as endogenous or reactive but these distinctions on their own are not credit-worthy – they must be accompanied by a description of the characteristics of each type.

AO1 Mark bands
4 marks Outline is reasonably thorough, accurate and coherent.
3 – 2 marks Outline is limited, generally accurate and reasonably coherent.
1 mark Outline is weak and muddled or very limited.
0 marks No creditworthy material.

23 **[AO1 = 6 and AO3 = 6]**

Level	Marks	Description
4	10 – 12	Knowledge of the behavioural approach to treating phobias is accurate and generally well detailed. Evaluation is effective. The answer is clear, coherent and focused on treating phobias. Specialist terminology is used effectively. Minor detail and / or expansion of argument sometimes lacking.
3	7 – 9	Knowledge of the behavioural approach to treating phobias is evident. The answer is mostly well focused. There are occasional inaccuracies. There is some effective evaluation. The answer is mostly clear and organised. Specialist terminology mostly used effectively.
2	4 – 6	Knowledge of the behavioural approach to treating phobias is present. Focus is mainly on description. Any evaluation is of limited effectiveness. The answer lacks clarity, accuracy and organisation in places. Specialist terminology used inappropriately on occasions.
1	1 – 3	Knowledge of the behavioural approach to treating phobias is limited. Evaluation is limited, poorly focused or absent. The answer as a whole lacks clarity, has many inaccuracies and is poorly organised. Specialist terminology either absent or inappropriately used.
	0	No relevant content.

Outline – possible content:

- aims to replace a faulty association between CS and CR that has resulted in a phobic response
- gradually using systematic desensitisation – relaxation technique, anxiety hierarchy, exposure stages, imagined and or real / in vivo
- suddenly using flooding – no relaxation, visualisation, intensive exposure in vivo or in vitro
- virtual reality exposure therapy as an in vitro form of systematic desensitisation
- detail of studies illustrating aspects of behavioural therapies, eg Lang and Lazovik (1963).

Credit other relevant aspects of the behavioural approach to treating phobias.

Evaluation – possible content:

- issues related to suitability and effectiveness for different types of phobia
- success outside the clinical situation and long-term effectiveness
- ethical problems, eg with flooding
- side effects such as nausea for VRET
- comparison with alternative treatments
- use of evidence to support or refute effectiveness.

Credit other relevant evaluation points.

24 **[AO2 = 4]**

Level	Marks	Description
2	3 – 4	Knowledge of relevant aspects of the behavioural approach is clear and mostly accurate. The material is used appropriately to explain Kirsty's phobia of balloons. The answer is generally coherent with effective use of behaviourist terminology.
1	1 – 2	Knowledge of aspects of the behavioural approach is evident although not always explicitly related to the acquisition of phobias. Links to Kirsty's phobia are not always effective. The answer lacks accuracy and detail. Use of behaviourist terminology is either absent or inappropriate.
	0	No relevant content.

Credit features of classical and / or operant conditioning (the 'two process model') applied to Kirsty's phobia of balloons.

Possible content:

- Kirsty's phobia has developed through classical conditioning – she has formed an association between the neutral stimulus (balloon) and the response of fear
- the conditioned response is triggered every time she sees a balloon (or hears similar noises)
- her phobia has generalised to situations where balloons might be present, such as parties and weddings, and to similar noises, 'banging' and 'popping'
- her phobia is maintained through operant conditioning – the relief she feels when avoiding balloons becomes reinforcing.

Credit other relevant features of conditioning applied to Kirsty's phobia.

25 (a) **AO2 = 4**

1 mark each for applied description of the following aspects of systematic desensitisation: relaxation, hierarchy development, gradual exposure.

Plus 1 further mark for some elaboration of any of the three aspects.

Content:

- Tommy would be taught relaxation techniques he could use when he encounters birds as part of the therapy.
- Tommy would devise his hierarchy so it reflects his least to most feared bird situation (for example, small picture of a sparrow, then a small bird through a window…).
- Tommy would then be exposed to birds gradually, ensuring he is relaxed at each stage.

(b) **AO3 = 2**

2 marks for a clear and coherent explanation of the benefits of systematic desensitisation over flooding as a treatment for a phobia for a child.

1 mark for a very brief, weak or muddled explanation.

Possible points:

- SD is gradual so the anxiety produced in the treatment is limited whereas in flooding the most feared situation is presented immediately which would be too traumatic for a small child.
- Tommy may not fully understand that consent to flooding would mean immediate exposure to his most feared situation so his consent to systematic desensitisation increases his protection from harm.

26

Marks for this question: AO1 = 6, AO3 = 10

Level	Marks	Description
4	13 – 16	Knowledge is accurate and generally well detailed. Discussion / evaluation / application is thorough and effective. The answer is clear, coherent and focused. Specialist terminology is used effectively. Minor detail and / or expansion of argument sometimes lacking.
3	9 – 12	Knowledge is evident. There are occasional inaccuracies. Discussion / evaluation / application is apparent and mostly effective. The answer is mostly clear and organised. Specialist terminology is mostly used effectively. Lacks focus in places.
2	5 – 8	Some knowledge is present. Focus is mainly on description. Any discussion / evaluation / application is only partly effective. The answer lacks clarity, accuracy and organisation in places. Specialist terminology is used inappropriately on occasions.
1	1 – 4	Knowledge is limited. Discussion / evaluation / application is limited, poorly focused or absent. The answer as a whole lacks clarity, has many inaccuracies and is poorly organised. Specialist terminology either absent or inappropriately used.
	0	No relevant content.

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AO1

Remember not to credit information given in the quote

The emphasis of the behavioural approach is on the environment and how the behaviour is acquired, through classical conditioning, operant conditioning and social learning. For marks in the top two bands, the focus must be on explaining psychological abnormality, rather than on behaviour in general.

AO3

Discussion can include strengths; such as it has provided some convincing explanations for some disorders such as phobias and has also led to some very successful therapies (systematic desensitization). The weaknesses are that it ignores the role of biology and there is plenty of evidence to support a genetic transmission of some disorders. Studies (eg "Little Albert") can be *used* as commentary.

27

Marks for this question: AO1 = 6, AO3 = 6

Level	Marks	Description
4	10 – 12	Knowledge is accurate and generally well detailed. Discussion / evaluation / application is effective. The answer is clear, coherent. Specialist terminology is used effectively. Minor detail and / or expansion of argument sometimes lacking.
3	7 – 9	Knowledge is evident. There are occasional inaccuracies. There is some effective discussion / evaluation / application. The answer is mostly clear and organised. Specialist terminology is mostly used appropriately.
2	4 – 6	Knowledge is present. Focus is mainly on description. Focus is mainly on description. Any discussion / evaluation / application is of limited effectiveness. The answer lacks clarity, accuracy and organisation in places. Specialist terminology is used inappropriately on occasions.
1	1 – 3	Knowledge is limited. Discussion / evaluation / application is limited, poorly focused or absent. The answer as a whole lacks clarity, has many inaccuracies and is poorly organised. Specialist terminology is either absent or inappropriately used.
	0	No relevant content.

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AO1

Remember not to credit information given in the quote

The emphasis of the behavioural approach is on the environment and how the behaviour is acquired, through classical conditioning, operant conditioning and social learning. For marks in the top two bands, the focus must be on explaining psychological abnormality, rather than on behaviour in general.

AO3

Discussion can include strengths; such as it has provided some convincing explanations for some disorders such as phobias and has also led to some very successful therapies (systematic desensitization). The weaknesses are that it ignores the role of biology and there is plenty of evidence to support a genetic transmission of some disorders. Studies (eg "Little Albert") can be *used* as commentary.

28

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AO2 = 4

First the therapist would teach Mia how to relax, using a technique that would allow deep muscle relaxation. Then together the therapist and Mia would construct an anxiety hierarchy, starting with the least feared situation, such as looking at pictures of people sitting at tables in a café just talking and drinking coffee, working up to the most feared situation, such as Mia eating in a restaurant full of people. The therapist would start by showing Mia pictures and helping her to remain relaxed, then perhaps getting her to sit in a café, but without eating anything, and then continuing up the hierarchy until her phobia is gone.

For full marks there must be explicit engagement with the stem. Up to 2 marks for a reasonable description of systematic desensitisation without any engagement.

AO2 **Analysis of unfamiliar situation and application of knowledge of systematic desensitisation**
4 marks Effective analysis of unfamiliar situation Effective description that demonstrates sound knowledge of systematic desensitisation including both the anxiety hierarchy and relaxation techniques. There is explicit engagement, which relates to the stem.
3 marks Reasonable analysis of unfamiliar situation Reasonable explanation that demonstrates knowledge of the systematic desensitisation with some reference to the stem.
2 marks Basic analysis of unfamiliar situation Basic explanation of systematic desensitisation with some reference to stem **or** effective description without any engagement.
1 mark Rudimentary analysis of unfamiliar situation Rudimentary, muddled, explanation of systematic desensitisation demonstrating very limited knowledge.
0 marks No creditworthy material.

29

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(a) **[AO1 = 2]**

Award up to two marks for an outline of a behavioural explanation of phobias.
Likely content: the idea that phobias are learnt through classical conditioning; fear is acquired when a neutral stimulus becomes associated with a frightening event; description of the two-process theory; reference to avoidance learning; reference to generalisation.
Credit descriptions based on social learning theory.
Both of these marks may be awarded for an accurately labelled 'Pavlovian' diagram of how a phobia might develop.
Maximum 1 mark if outline does not refer to fear / phobias.

(b) **[AO1 = 1, AO2 = 2]**

AO1

One mark for identifying an appropriate limitation.
Likely answers: not all phobias are triggered by a traumatic experience; explanation cannot account for all phobias; fails to account for evidence that phobias may have a biological basis; difficulty explaining why some phobias are more common than others; the idea that the explanation can better account for specific phobias.

AO2

Up to 2 marks for discussion of the limitation which might include analysis / expansion; counter-argument; use of evidence; reference to alternative explanations.
Possible answer: Not all phobias are triggered by a traumatic experience (1), where the initial association (between the phobic object / situation and fear) is formed (1), which suggests that alternative explanations are needed (1).

Accept limitations based on the methodology of individual studies eg Little Albert, but for full marks, these should be made relevant to discussion of the explanation.

30 (a) **AO2**

Outline of an appropriately applied behavioural explanation Sammy's phobia.
This might include reference to: the learning by association of a UCS with a CS producing a CR – a fear is acquired when a previously neutral stimulus (bird) is associated with a frightening event (sudden theft of sandwich) and a fear response results; a description of the two-process theory; reference to avoidance learning; reference to generalisation to all birds.

(b) **Marks for this question: AO1 = 6, AO2 = 4, AO3 = 6**

Level	Marks	Description
4	13 – 16	Knowledge is accurate and generally well detailed. Discussion / evaluation / application is thorough and effective. The answer is clear, coherent and focused. Specialist terminology is used effectively. Minor detail and / or expansion of argument sometimes lacking.
3	9 – 12	Knowledge is evident. There are occasional inaccuracies. Discussion / evaluation / application is apparent and mostly effective. The answer is mostly clear and organised. Specialist terminology is mostly used effectively. Lacks focus in places.
2	5 – 8	Some knowledge is present. Focus is mainly on description. Any discussion / evaluation / application is only partly effective. The answer lacks clarity, accuracy and organisation in places. Specialist terminology is used inappropriately on occasions.
1	1 – 4	Knowledge is limited. Discussion / evaluation / application is limited, poorly focused or absent. The answer as a whole lacks clarity, has many inaccuracies and is poorly organised. Specialist terminology either absent or inappropriately used.
	0	No relevant content.

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AO1

Description of key elements of systematic desensitisation.

Likely points: hierarchy, graduated steps, training in relaxation techniques, gradual exposure to anxiety-provoking stimuli from the hierarchy. Credit reference to virtual reality exposure therapy: in VRET the systematic desensitisation takes place in a virtual world.

AO2 / AO3

Evaluation and application of systematic desensitisation. Discussion of the strengths / weaknesses of the therapy: usually effective, phobia is removed at completion of the programme; gradual exposure is considered to be less traumatic than other therapies eg flooding; discussion of merits of in vivo (real-life exposure) rather than in vitro (imagined exposure). Discussion of the limitations: difficulty in generalising improvement from the therapeutic situation to real life; expense of VRET equipment; therapy may not be suitable for other types of phobia. Credit comparison with alternative therapies.

Credit use of evidence to support / refute arguments./p>

Application of SD to the Sammy – how it would be used in his case of bird phobias.

31 (a) **AO2**

Outline of an appropriately applied behavioural explanation Sammy's phobia.
This might include reference to: the learning by association of a UCS with a CS producing a CR – a fear is acquired when a previously neutral stimulus (bird) is associated with a frightening event (sudden theft of sandwich) and a fear response results; a description of the two-process theory; reference to avoidance learning; reference to generalisation to all birds.

(b) **Marks for this question: AO1 = 6, AO2 = 2, AO3 = 4**

Level	Marks	Description
4	10 – 12	Knowledge is accurate and generally well detailed. Discussion / evaluation / application is effective. The answer is clear, coherent. Specialist terminology is used effectively. Minor detail and / or expansion of argument sometimes lacking.
3	7 – 9	Knowledge is evident. There are occasional inaccuracies. There is some effective discussion / evaluation / application. The answer is mostly clear and organised. Specialist terminology is mostly used appropriately.
2	4 – 6	Knowledge is present. Focus is mainly on description. Any discussion / evaluation / application is of limited effectiveness. The answer lacks clarity, accuracy and organisation in places. Specialist terminology is used inappropriately on occasions.
1	1 – 3	Knowledge is limited. Discussion / evaluation / application is limited, poorly focused or absent. The answer as a whole lacks clarity, has many inaccuracies and is poorly organised. Specialist terminology is either absent or inappropriately used.
	0	No relevant content.

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AO1

Description of key elements of systematic desensitisation.

Likely points: hierarchy, graduated steps, training in relaxation techniques, gradual exposure to anxiety-provoking stimuli from the hierarchy. Credit reference to virtual reality exposure therapy: in VRET the systematic desensitisation takes place in a virtual world.

AO2 / AO3

Evaluation and application of systematic desensitisation. Discussion of the strengths / weaknesses of the therapy: usually effective, phobia is removed at completion of the programme; gradual exposure is considered to be less traumatic than other therapies eg flooding; discussion of merits of in vivo (real-life exposure) rather than in vitro (imagined exposure). Discussion of the limitations: difficulty in generalising improvement from the therapeutic situation to real life; expense of VRET equipment; therapy may not be suitable for other types of phobia. Credit comparison with alternative therapies.

Credit use of evidence to support / refute arguments.

Application of SD to the Sammy – how it would be used in his case of bird phobias.

32

AO1 = 3

SD involves teaching the client deep muscle relaxation, client and therapist constructing an anxiety hierarchy, and then working through the hierarchy while remaining relaxed.

For each therapy, 1 mark for a basic answer and a further two marks for elaboration.

33

AO1 = 3

SD involves the client and therapist designing a list or hierarchy of frightening / stressful events or objects. The client is then taught deep muscle relaxation. Finally the therapist helps the client to work their way up the hierarchy while maintaining this deep relaxation.
At each stage, if the client becomes upset they can return to an earlier stage and regain their relaxed state.

1 mark for a basic statement and a further 2 marks for elaboration.

34

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AO2 = 2

One weakness of SD is that it relies on the client's ability to be able to imagine the fearful situation. Some people cannot create a vivid image and thus SD is not effective.
Another weakness is that while SD might be effective in the therapeutic situation, it may not work in the real world.

1 mark for a basic statement and a further mark for elaboration.

35

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AO2 = 6

Main techniques are: firstly, teach deep muscle or progressive relaxation. Then the therapist and client construct an anxiety hierarchy, starting with situations that cause a small amount of fear – in Hamish's case this might be standing on a small stepladder – then listing situations that cause more fear, with the most frightening situation being at the top of the hierarchy, such as standing on top of a mountain. Finally, they work through this list, with the client remaining relaxed at each stage. The two main features are relaxation and working through the anxiety hierarchy.

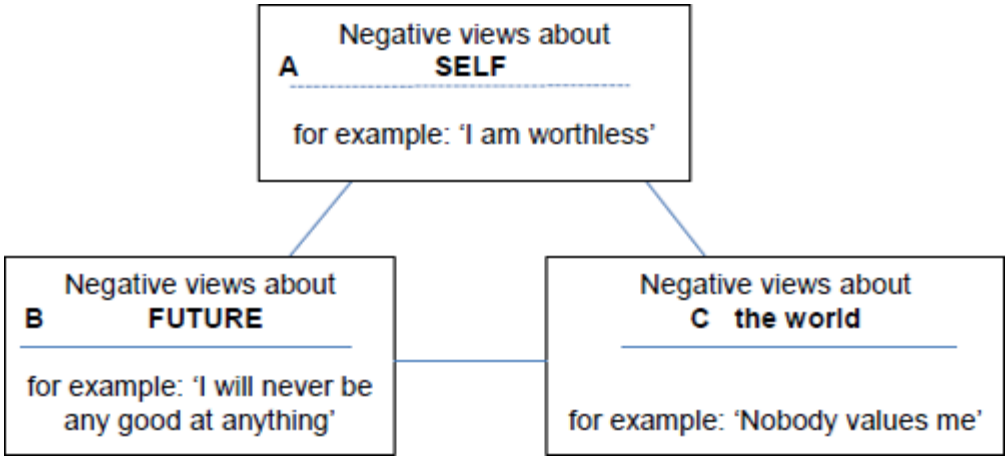
6 marks Effective explanation Effective explanation of the main stages of systematic de-sensitisation demonstrating sound knowledge of the therapy as applied to fear of heights.
5 – 4 marks Reasonable explanation Reasonable explanation of the main stages of systematic de-sensitisation applied to fear of heights.
3 – 2 marks Basic explanation Basic explanation of systematic de-sensitisation with some attempt to apply to fear of heights.
1 mark Very brief/flawed of inappropriate Rudimentary, muddled explanation of systematic de-sensitisation demonstrating very limited knowledge
0 marks No creditworthy material.

36

[AO1 = 2]

A – self **1 mark**
B – future **1 mark**

Terms must be in the correct position for credit.



37

Marks for this question: AO3 = 2

2 marks for a clear and coherent outline of one strength of the cognitive explanation of depression with some elaboration.

1 mark if the strength is briefly outlined / vague / muddled.

Possible content:

- based on sound experimental research
- have provided effective treatments for depression
- acknowledges role of thoughts in behaviour / disorders.

Credit other relevant strengths.

38

[AO1 = 4]

Level	Marks	Description
2	3 – 4	Outline of cognitive behaviour therapy is clear and mostly accurate. Aspects of the therapy are appropriately linked to the treatment of depression. The answer is generally coherent with effective use of specialist terminology.
1	1 – 2	Outline of cognitive behaviour therapy is evident although not always explicitly or effectively linked to treatment of depression. The answer lacks accuracy and detail. Use of specialist terminology is either absent or inappropriate.
	0	No relevant content.

AO1 Possible Content:

- general rationale of therapy – to challenge negative thought / negative triad
- identification of negative thoughts – 'thought catching'
- hypothesis testing; patient as 'scientist'
- data gathering through 'homework', eg diary keeping
- reinforcement of positive thoughts; cognitive restructuring
- rational confrontation as in Ellis's REBT.

Credit other relevant aspects of cognitive behaviour therapy.

39

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AO1 = 4

AO2 = 4

AO1: The cognitive approach believes that abnormality stems from faulty cognitions about others, our world and us. This faulty thinking may be through cognitive deficiencies (lack of planning) or cognitive distortions (processing information inaccurately). These cognitions cause distortions in the way we see things; Ellis suggested it is through irrational thinking, while Beck proposed the cognitive triad. An outline of the ABC model would be one way to outline the cognitive approach.

AO1 Knowledge of the cognitive approach to explaining psychopathology
4 marks Accurate and reasonably detailed Accurate and reasonably detailed answer that demonstrates sound knowledge and understanding of the cognitive approach to explaining psychopathology. There is appropriate selection of material to address the question.
3 marks Less detailed but generally accurate Less detailed but generally accurate answer that demonstrates relevant knowledge and understanding. There is some evidence of selection of material to address the question.
2 marks Basic Basic answer that demonstrates some relevant knowledge and understanding but lacks detail and may be muddled. There is little evidence of selection of material to address the question.
1 mark Very brief / flawed or inappropriate Very brief or flawed answer demonstrating very little knowledge. Selection and presentation of information is largely or wholly inappropriate.
0 marks No creditworthy material.

AO2: There are research studies to support this approach, e.g. Rachman. It has provided some convincing explanations for disorders such as depression and also some effective therapies such as CBT. However, it is not clear whether faulty cognitions are a cause of the psychopathology or a consequence of it. Contrasting this approach with others is one way to provide commentary. Students could also comment on the view that sometimes these negative cognitions are in fact a more accurate view of the world: depressive realism.

AO2 Evaluation of the cognitive approach to explaining psychopathology
4 marks Effective evaluation Effective use of material to address the question and provide informed commentary. Effective evaluation of research. There is appropriate selection of material to address the question.
3 marks Less detailed but generally accurate Material is not always used effectively but produces a reasonable commentary. Reasonable evaluation of research. There is some evidence of selection of material to address the question.
2 marks Basic The use of material provides only a basic commentary. Basic evaluation of research. There is little evidence of selection of material to address the question.
1 mark Very brief / flawed or inappropriate The use of material provides only a rudimentary commentary. Evaluation of research is just discernible or absent.
0 marks No creditworthy material.

40 **[AO1 = 3]**

Credit any details of relevant study including the aim, method, result or conclusion. Note for full marks there must be some information about what was done and what was found. Vague descriptions without detail eg which disorder / which medication / length of treatment / measurement of depression / symptoms maximum 1 mark.
Likely studies include: Elkin (1985) comparison of therapies for depression using four conditions; Robinson (1990) meta-analysis of different therapies for depression; Hollon (2006) comparison of cognitive and drug treatment for depression.

41 (a) **AO1 = 6 AO3 = 6**

Level	Marks	Description
4	10 – 12	Knowledge of a least one cognitive explanation for depression is accurate and generally well detailed. Discussion is mostly effective. The answer is clear, coherent and focused. Specialist terminology is used effectively. Minor detail and / or expansion sometimes lacking.
3	7 – 9	Knowledge of at least one cognitive explanation for depression is evident. Discussion is apparent and mostly effective. There are occasional inaccuracies. The answer is mostly clear and organised. Specialist terminology is mostly used appropriately. Lacks focus in places.
2	4 – 6	Knowledge of at least one cognitive explanation for depression is present. Focus is mainly on description. Any discussion is of limited effectiveness. The answer lacks clarity, accuracy and organisation in places. Specialist terminology used inappropriately on occasions.
1	1 – 3	Knowledge of at least one cognitive explanation for depression is limited. Discussion is limited, poorly focused or absent. The answer as a whole lacks clarity, has many inaccuracies and is poorly organised. Specialist terminology either absent or inappropriately used.
	0	No relevant content.

Possible content:

- Underlying assumption of the cognitive explanation – depression is the result of disturbance in ‘thinking’.
- Beck’s negative triad – childhood negative schemas develop providing a negative framework for viewing events pessimistically. In adulthood these become biases such as overgeneralisation; magnification; selective perception and absolutist thinking.
- The negative triad is where people think consistently negatively about the self, the world and the future.
- Ellis’s ABC model – developed to explain response to negative events – how people react differently to stress and adversity.
- The model provides the sequence of the process: A – the adversity or event to which there is a reaction; B – the belief or explanation about why the situation occurred; C – the consequence – the feelings and behaviour the belief now causes. In essence the external event is ‘blamed’ for the unhappiness being experienced.
- Both models explain depression as a consequence of faulty and negative thinking about events and suggest it can be managed by challenging this faulty thinking.
- Evidence to support either model such as Beck 1976.

Possible evaluation:

- The use of examples to illustrate the negative triad or the ABC model.
- The use of evidence to support cognitive explanation(s).
- The development of successful therapies based on cognitive explanations: CBT and / or REBT.
- Cognitive explanation(s) do not explain the links between anger and depression well.
- Cognitive explanations do not distinguish cause and effect factors.
- Cognitive explanations do not deal with the manic phases in bipolar I and II.
- Comparison with alternative explanations eg biological evidence suggests genetic, neurochemical and neuroanatomical influences are a biological predisposition.

Credit other relevant information.

42 **[AO2 = 4]**

Up to 4 marks to be awarded for application of two different concepts or ideas from the cognitive explanation for depression to the novel situation. Many different aspects of cognitive theory can be applied here. Credit should be given for any valid application. Candidates may focus on just two concepts or ideas in some detail or on several separate points in less detail. Possible content will probably come from Beck's theory:

- cognitive triad - person will have negative thoughts about self, world, future eg I'm useless, the world is horrid, I'll never get a job
- the person may overgeneralise 'no-one wants me'
- person may show selective perception of negatives eg focus on loss of job and ignore the many good things in life
- person may magnify significance / catastrophise eg loss of job will take on extraordinary significance and will be seen as major disaster
- person makes negative attributions – person will blame themselves for loss of job and negate the influence of external factors eg world economy
- person shows absolutist thinking 'if I can't have that job then it's a disaster, no other job will do'.

Up to 2 marks if the explanation is relevant to depression but relevance to unemployment may not have been made explicit.

Maximum 2 marks if only one concept or idea is offered

43

(a) **[AO1 = 2]**

2 marks for a clear and coherent answer emphasising internal vs external distinction: obsessions are internal components because they are thoughts, and compulsions are external components because they are behaviours.

1 mark for a muddled or vague answer in which the distinction is suggested but is unclear or incomplete.

OR

1 mark for straightforward definition of **each** component (obsessions are intrusive thoughts, compulsions are repetitive behaviours / acts).

(b) **[AO2 = 4]**

Level	Marks	Description
2	3 – 4	Research findings are clearly explained in terms of both genetic and alternative explanation(s) and are mostly accurate. The answer is generally coherent with effective use of terminology.
1	1 – 2	Research findings are explained with some link to genetic and / or alternative explanation(s). The answer lacks accuracy and detail. Use of terminology is either absent or inappropriate.
	0	No relevant content.

Content:

- results indicate development of OCD is at least partly genetic
- the findings suggest that heritability is high (between 45% and 65%)
- this means that there must also be other explanations (inherited influence is not 100%)
- so other factors (eg environment or other bio factors) may also partly account for OCD.

44 **AO1 = 2 AO2 = 2**

Level	Marks	Description
2	3 – 4	Outline of characteristics of OCD is clear. Application to the stem is clear. The answer is generally coherent with effective use of terminology.
1	1 – 2	There is limited / partial explanation of the characteristics of OCD and application to the stem. Explanation of OCD characteristics is clear but the application is missing or inaccurate OR application is clear but the explanation is missing or inaccurate. The answer lacks accuracy and detail. Use of terminology is either absent or inappropriate.
	0	No relevant content.

Possible content:

- A cognitive characteristic would be an irrational belief or persistent recurring thoughts – catastrophic thinking such as: 'my family is in danger and might get trapped in a house fire'.
- An emotional characteristic would be feeling anxiety or the reduction of anxiety such as: 'worry about them' or 'feeling calm after making sure a fire cannot start'.
- A behavioural characteristic would be performing a repetitive action such as: switching plug sockets six times.

Credit for two characteristics of OCD, if student offers three, credit the best two.

45 **[AO2 = 2]**

1 mark for outline of a cognitive characteristic of OCD from the stem: hypervigilance – 'looking out for people who are ill'; catastrophic thinking – 'I might catch it and die'.

Plus

1 mark for outline of a behavioural characteristic of OCD from the stem: repetitive cleaning – 'I have to clean myself'.

46

Marks for this question: AO1 = 6, AO3 = 10

Level	Marks	Description
4	13 – 16	Knowledge is accurate and generally well detailed. Discussion / evaluation / application is thorough and effective. The answer is clear, coherent and focused. Specialist terminology is used effectively. Minor detail and / or expansion of argument sometimes lacking.
3	9 – 12	Knowledge is evident. There are occasional inaccuracies. Discussion / evaluation / application is apparent and mostly effective. The answer is mostly clear and organised. Specialist terminology is mostly used effectively. Lacks focus in places.
2	5 – 8	Some knowledge is present. Focus is mainly on description. Any discussion / evaluation / application is only partly effective. The answer lacks clarity, accuracy and organisation in places. Specialist terminology is used inappropriately on occasions.
1	1 – 4	Knowledge is limited. Discussion / evaluation / application is limited, poorly focused or absent. The answer as a whole lacks clarity, has many inaccuracies and is poorly organised. Specialist terminology either absent or inappropriately used.
	0	No relevant content.

Please note that although the content for this mark scheme remains the same, on most mark schemes for the new AQA Specification (Sept 2015 onwards) content appears as a bulleted list

AO1

The main biological explanations for OCD are as follows:

- genetics – there is some evidence of a tendency to inherit OCD, with a gene (Sapap3) recently identified
- neuroanatomy – dysfunctions of the orbital frontal cortex (OFC) over-activity in basal ganglia and caudate-nucleus thalamus have been proposed

Also accept:

- biochemistry – serotonin deficiency has been implicated
- evolutionary – adaptive advantages of hoarding, grooming, etc.

AO3

Evaluation will depend on the explanation offered, but is likely to include supporting / refuting evidence.

- genetics – relatives of sufferers are around 9 times more likely to be diagnosed (Arbor 2006), with a CR of between 65% and 80% MZ twins (Rasmussen 1986, Carey and Gottesman), sample sizes in twin studies, difficulty separating genetic and environmental influences
- Difficulty establishing cause and effect
- Possibility of multiple factors
- neuroanatomy – some support for claims, eg Rauch et al 1994, PET scans show over activity in basal ganglia, co-morbidity with Tourette's which is also linked to basal ganglia (Rapoport 1990).
- biochemistry – SSRI's are only effective for about 50% of sufferers

47

Marks for this question: AO1 = 6, AO3 = 6

Level	Marks	Description
4	10 – 12	Knowledge is accurate and generally well detailed. Discussion / evaluation / application is effective. The answer is clear, coherent. Specialist terminology is used effectively. Minor detail and / or expansion of argument sometimes lacking.
3	7 – 9	Knowledge is evident. There are occasional inaccuracies. There is some effective discussion / evaluation / application. The answer is mostly clear and organised. Specialist terminology is mostly used appropriately.
2	4 – 6	Knowledge is present. Focus is mainly on description. Focus is mainly on description. Any discussion / evaluation / application is of limited effectiveness. The answer lacks clarity, accuracy and organisation in places. Specialist terminology is used inappropriately on occasions.
1	1 – 3	Knowledge is limited. Discussion / evaluation / application is limited, poorly focused or absent. The answer as a whole lacks clarity, has many inaccuracies and is poorly organised. Specialist terminology is either absent or inappropriately used.
	0	No relevant content.

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48

Marks for this question: AO1 = 6, AO3 = 10

Level	Marks	Description
4	13 – 16	Knowledge is accurate and generally well detailed. Evidence is clear. Discussion / evaluation / application is thorough and effective. The answer is clear, coherent and focused. Specialist terminology is used effectively. Minor detail and / or expansion of argument sometimes lacking.
3	9 – 12	Knowledge is evident. There are occasional inaccuracies. Evidence is presented. Discussion / evaluation / application is apparent and mostly effective. The answer is mostly clear and organised. Specialist terminology is mostly used effectively. Lacks focus in places.
2	5 – 8	Some knowledge is present. Focus is mainly on description. Any discussion / evaluation / application is only partly effective. The answer lacks clarity, accuracy and organisation in places. Specialist terminology is used inappropriately on occasions.
1	1 – 4	Knowledge is limited. Discussion / evaluation / application is limited, poorly focused or absent. The answer as a whole lacks clarity, has many inaccuracies and is poorly organised. Specialist terminology either absent or inappropriately used.
	0	No relevant content.

Please note that although the content for this mark scheme remains the same, on most mark schemes for the new AQA Specification (Sept 2015 onwards) content appears as a bulleted list.

AO1

Marks for description of biological explanations of OCD. Credit can be awarded for any or all of the following explanations:
Genetic explanation - some people are predisposed to develop the disorder as a result of inherited familial influence.
Biochemical explanation – low levels of serotonin associated with anxiety; high levels of dopamine linked to compulsive behaviour / stereotypical movements.
Physiological explanation - basal ganglia in the brain responsible for psychomotor functions, hypersensitivity of the basal ganglia may result in repetitive movements; linked to abnormality / excessive activity in the orbital frontal cortex.
Limited credit for simply naming / listing explanations.
Likely studies: McKeown and Murray (1987), Bellodi et al. (2001), Pauls et al. (1995), Rapoport and Wise (1988), Aylward et al. (1996).

AO3

Marks for discussion of biological explanations of OCD. Likely points include: the effectiveness of biological / drug therapies and how this supports the (biochemical) explanation eg anti-depressants that increase serotonin levels reduce OCD symptoms in many patients; problem that not all sufferers respond to drug treatment; issue of causation; treatment fallacy; contradictory evidence in brain scan studies; alternative explanations for findings from family / twin studies such as shared environments; brain structural accounts tend to explain repetitive behaviour but not obsessional thoughts. Credit discussion of broader issues such as reductionism, determinism and reasoned comparison with alternative explanations e.g. cognitive. Only credit evaluation of the methodology used in studies when made relevant to discussion of the explanation.
Credit use of evidence.

49

Please note that the AOs for the new AQA Specification (Sept 2015 onwards) have changed. Under the new Specification the following system of AOs applies:

- AO1 knowledge and understanding
- AO2 application (of psychological knowledge)
- AO3 evaluation, analysis, interpretation.

Although the essential content for this mark scheme remains the same, mark schemes for the new AQA Specification (Sept 2015 onwards) take a different format as follows:

- A single set of numbered levels (formerly bands) to cover all skills
- Content appears as a bulleted list
- No IDA expectation in A Level essays, however, credit for references to issues, debates and approaches where relevant.

AO3 = 4

- The two averages are very similar, suggesting that both therapies are as good as each other.
- The range of each group is very different. This suggests that for some people Therapy A was very beneficial, but for others it had little benefit. For Therapy B, there was a much smaller range, suggesting that it has a similar effect on improvement for all the patients.

4 marks Effective interpretation of data Effective interpretation that demonstrates sound knowledge of what the data shows, with reference to both the average and the range.
3 marks Reasonable interpretation of data Reasonable interpretation of what the data shows; or effective interpretation of either the average or the range.
2 marks Basic interpretation of data Basic interpretation of what the data shows.
1 mark Rudimentary interpretation of data Rudimentary, muddled interpretation of the data, demonstrating very limited knowledge. Or reference to, for example, larger range/higher average/similar range.
0 marks No creditworthy material.

Examiner reports

5

This question required students to select two statements that described the deviation from ideal mental health definition of abnormality and most found this a straightforward question. Unfortunately, there were some students who failed to read the question and ticked more than two boxes, resulting in no credit at all.

6

This question referred to a different definition and those students who did not read the question often failed to gain any credit (unless their limitation could have applied to failure to function adequately). Better answers referred to the issue of context, or that sometimes failure might be due to factors such as the economy rather than a psychological disorder. Although cultural relativism is a limitation, many students struggled to use this effectively.

7

Examiners took a fairly lenient view in terms of how these criteria were expressed. However, since “adapts well to her environment” had already been given, answers that referred to environmental mastery were not credited. Some students confused this definition with failure to function adequately and offered observer discomfort as a criterion.

The limitations given must apply to deviation form ideal mental health and not merely be a generic comment on, for example, cultural relativism. In this instance, a better answer would focus on how Jahoda’s criteria were very Western and some cultures do not value autonomy.

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9

The main difficulty for many students appeared to be identifying one definition and then explaining the same one. Students often identified failure to function adequately, but then went on to explain deviation from ideal mental health, or vice versa. Some answers were so poorly expressed that it was impossible to decide which definition it applied to; for example “deviation from behaviour” or “failure to behave”.

The answers to (b) were sometimes very generic and could apply to any definition, to gain credit they needed to show how the evaluation applied to their chosen definition. However, some students made very good use of relevant examples (rather than superficial ones that did not relate to psychopathology) to illustrate their evaluation.

10

(a) This question required candidates to demonstrate their ability to apply knowledge. Most candidates chose deviation from social norms and successfully used the stimulus material to justify their choice. Candidates who chose either failure to function adequately or deviation from ideal mental health, found it a little more difficult to apply it to the scenario, but made some creditworthy attempts.

(b) The most common limitation offered was that the definition suffers from cultural relativism, but for the full marks, candidates needed to explain why this is a limitation, rather than explaining what it is.

11

A very well answered question and one that was obviously popular with the candidates. Many wrote extensively on their chosen definition. This however, wasted time and candidates need to understand that identification of a definition does not mean explain in great detail; especially when so few marks are available. The limitation was usually in terms of era dependency, context or cultural relativism.

12

There were some excellent outlines of this definition, with good use of Rosenhan and Seligman's features as well as the GAF. Unfortunately some students failed to note that this question also required evaluation and so failed to access half the marks. The most common mistake here was to confuse this definition with deviation from ideal mental health.

13

Both parts of this question were generally answered well. However, some of the examples candidates used to illustrate their answers often lacked any connection to psychopathology. Similarly the use of 'naked tribes in Africa' as an example shows very limited understanding.

14

Most candidates could give one definition of abnormality, however, they were less able to apply it to the scenario. Weaker candidates seemed confused as to the distinction between the definitions when it came to applying them.

15

Students seemed very well prepared for this question and there were some extremely detailed and well-written essays. The main problem for many candidates was that they provided only a brief statement identifying the definition, which resulted in low AO1 marks. The other pitfall was for those candidates who confused definitions with models and gained no credit. A recommendation for candidates is that they try and illustrate their definitions with examples from psychopathology. Many of the examples used were sometimes little better than commonsense examples; using more psychologically relevant examples would add depth to an answer.

16

Candidates frequently confused the different definitions of abnormality, so offered failure to function adequately as one criteria and deviation from social norms as the other. However, those candidates who did understand that the definition for psychological health has several criteria, such as autonomy and self-actualisation, were able to gain full marks. Clearly some centres had prepared candidates well and they knew about Jahoda's criteria in great detail.

17

This option was attempted by around 25% of students.

This question required students to outline the characteristic of depression. Some students presented a wealth of material, often far in excess of the 4 marks available. Most students focused on unipolar depression but a small number chose to cover bi-polar disorder in addition providing an impressive amount of detail on both.

18

In this question, students were required to outline the characteristics of OCD. Most students tackled this question well, making appropriate reference to both obsessions and compulsions and providing details of frequency.

19

This was generally very well answered; although some students described symptoms of a phobia, most were able to access both marks.

20

(a) Two symptoms of obsessive-compulsive disorder were accurately described by many – typically, and predictably, the 'obsessions' and the 'compulsions'; though physiological symptoms of anxiety were also deemed creditworthy. Some students gave symptoms that did not adequately distinguish OCD from other disorders, such as 'irrational thinking'.

(b) Many students could identify the correct experimental design used in the study but fewer could provide an appropriate outline. A considerable number, however, thought the design was 'independent groups' or even 'matched pairs'. Finally, 'quasi-experiment' was an often seen answer.

(c) The advantage of 'repeated measures' was often stated rather than explained, for instance, 'no participant variables' was frequently offered without elaboration. Better, fuller answers tended to be those based on the time and cost-saving benefits of using the same participants twice in comparison to alternative designs. It was possible to gain two marks if the answer in part (c) could be matched to that in part (b), therefore, many students scored full marks in this question for an advantage of independent groups having named it above.

21

Candidates were well prepared for this question and there were some excellent, accurate answers. Most candidates were able to include the obvious characteristic of anxiety and how it is an essential part of these disorders.

22

Candidates seemed well prepared for this question and there were some excellent, accurate answers. Some candidates missed out the most obvious characteristic of "sad mood" or failed to give any indication of the severity of symptoms.

26

The quote was given to guide students, but they gain no marks by repeating it in their essay. Writing out the quote simply wastes time. It was hoped that by giving some guidance, students would not write about another approach.

The problem for too many students was that while they could write at length about classical conditioning (using Pavlov), operant conditioning (using Skinner) and social learning (using Bandura), they simply failed to make any link with abnormality at all. Such answers remained in the basic mark band. Ironically, those who used Watson and Rayner's study with Little Albert often failed to note that he developed a phobia. Many students were unable to use their knowledge of conditioning, to demonstrate how this could explain abnormality. Better answers explained how phobias or anorexia could be explained using learning processes.

The commentary could have considered the successful therapies that this approach has developed (although detailed descriptions of SD was not an effective use of material). Weaknesses could consider the fact that this approach ignores the role of biology. However, criticising the studies without considering the implication for the approach is not creditworthy. Many examiners noted that this was a very disappointing question to mark. Students had learned a considerable amount about the behavioural approach, often in extremely accurate detail, but made no attempt to use their knowledge to answer a question on abnormality. It was almost as if they had failed to read the question carefully, in spite of the fact that this was the section on Psychopathology (abnormality).

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28

Most students had good knowledge of what is involved in systematic de-sensitisation and were able to identify the main elements: being taught relaxation, construction of hierarchy, working through the hierarchy while remaining relaxed. The main problem was the lack of engagement with the scenario. Simply mentioning Mia's name was not evidence of engaging with the scenario. Students needed to provide some specific examples of the different stages on a hierarchy intended to overcome a phobia of eating in public in order to gain full marks.

29

(a) There was some confusion over the features of classical conditioning and the description was not always clearly linked to a 'phobia', for example, through an illustration. Better answers often elaborated both elements of the two-process model of phobias, although this was not essential for two marks.

(b) Better answers were those that structured their response around the notion that not all phobics can recall an 'association event' that produced the phobia in the first place. Well elaborated answers based on this theme often used the Di Nardo study to good effect. These were few and far between, however. As ever, students do seem to find the three-mark format challenging, when applied to the explanation of a single limitation (or indeed 'strength', as in previous series).

30

(a) Attempts to explain Sammy's phobia varied and this question tended to discriminate well. Most attempted to explain the scenario using classical conditioning but many gave muddled accounts using appropriate terminology (CS, UCR, etc.) but in the wrong places. A mark was often awarded for a vague reference to association linked to the events described in the stem. Some students demonstrated a sophisticated understanding of behaviourist principles, referring to both classical conditioning and avoidance learning in their answers and would have scored several more marks had they been available.

(b) Essays in this section were not quite as strong as they have been in recent series. Many students did not seem to have the depth of knowledge of systematic desensitisation required to gain all the AO1 marks that were available. Instead, 'sketchy' descriptions were often advanced and key concepts, such as 'anxiety hierarchy', were mentioned but not elaborated.
Most students could assemble two or three relevant evaluation points, but other attempts at analysis such as those centred around 'cost', 'time', 'effort', etc were rarely reasoned or based on comparison. For instance, systematic desensitisation was often claimed to be 'unethical', 'expensive' and 'time-consuming' without any acknowledgement of treatments that would be more ethical, cheaper or faster.

Not all essays fell into this category however, and there were students who clearly knew this area very well, producing detailed, reasoned analyses of the treatment in the context of possible alternatives.

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Not all essays fell into this category however, and there were students who clearly knew this area very well, producing detailed, reasoned analyses of the treatment in the context of possible alternatives.

32 Candidates demonstrated better knowledge, and were able to include reference to the anxiety hierarchy, deep muscle relaxation and the gradual working up through the hierarchy.

33 The advice to candidates is, just answer the question, there is no need to waste time in writing out the question. Far too many answers started with "systematic desensitisation is one method of treating abnormality" and often went on to explain that it was best suited to treating phobias. This is not was the question required and such answers often ran out of space before they started to describe what is involved. However, those candidates who read the question carefully often provided accurate and detailed answers.

34 There seems to be some misconceptions about this therapy, especially with respect to ethical concerns. Some candidates argued that it is unethical making people face their worst fear, however the whole point of counter-conditioning is that the client is completely relaxed at the time. This type of behavioural therapy is considered one of the most ethical therapies.

35 While the majority of candidates were able to describe systematic desensitisation, they often omitted the relaxation aspect of the therapy and they were poor at applying the therapy to Hamish and his particular phobia. Relatively few candidates gave sufficient detail of the hierarchy, as it would apply to Hamish.
This again suggests that the area candidates find most difficult is the application of knowledge.

39

At the top end of the marks, were some extremely well-informed students who made excellent use of both Beck's and Ellis's models. Such answers produced clearly written accounts of these cognitive approaches with explicit links to psychopathology. The AO2 was usually not quite so good and it was a shame that so few used research studies to evaluate the approach. Some students did gain credit for using cognitive based therapies to evaluate the approach. Much AO2 was generic and could have been applied to any approach and there was evidence of a confused understanding of reductionism (something that continues into A2). This concept does not refer to one approach ignoring other approaches; it refers to the principle of taking a complex concept and reducing it down to its simplest parts. The two major pitfalls that could have been avoided if the students had read the question were: firstly ignoring the term cognitive and writing about any approach; and secondly providing examples to illustrate the approach that were not drawn from psychopathology.

40

Answers to this question were often very poor indeed, being either largely generic descriptions of a type of treatment or extremely vague descriptions of a plausible study, for example, comparing an unspecified drug with placebo for an unspecified time. A further large proportion of students left this question blank altogether.

42

There were some very detailed answers to this question, with many full-mark responses. In some of the less well-organised answers to this question it was difficult to see exactly which two ways were being outlined; students offered multiple cognitive concepts with applications that could not be unambiguously linked to any of the concepts or sometimes no application at all. Students offering Seligman did not always remember to focus on the cognitive aspect.

46

This option was attempted by around 5% of students.

This question required an outline and evaluation of one biological explanation for OCD. The most popular responses focused on the Orbital Frontal Cortex (OFC) (worry circuit), or the role played by biochemistry in OCD. Successful students provided impressive detail which was often in excess of the 4 AO1 marks available. Some students were able to make use of recent research that has identified specific genes as well as basal ganglia activity demonstrating that some teachers have an impressive knowledge of this engaging topic.

47

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48

Most answers discussed two or three explanations. In some, key details, such as the ‘levels of serotonin’ linked to OCD, were inaccurate. Some answers began to write about Selective Seratonin Reuptake Inhibitors (SSRI) as a treatment for OCD and the support for the ‘serotonin’ explanation, but got ‘side-tracked’ into describing different treatments rather than focusing back on the biological explanation. Discussions of the basal ganglia were often well done, but there was occasional confusion between the ‘hyperactivity’ associated with this brain region, and the cognitive notion of ‘hypervigilance’.

49

It was encouraging to see that this cohort of candidates was able to go beyond simply describing the findings. They were able to make suggestions about what they showed. For example, that both therapies showed some improvement, as there were no scores of zero; that in fact neither showed much improvement as the average was only 6.

However, it was also clear from the responses that a minority of candidates had no real understanding of what range tells us about data.