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

(2)

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

(6)

(Total 8 marks)

2 What is meant by a *phobia*?

(Total 2 marks)

3

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)

4 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

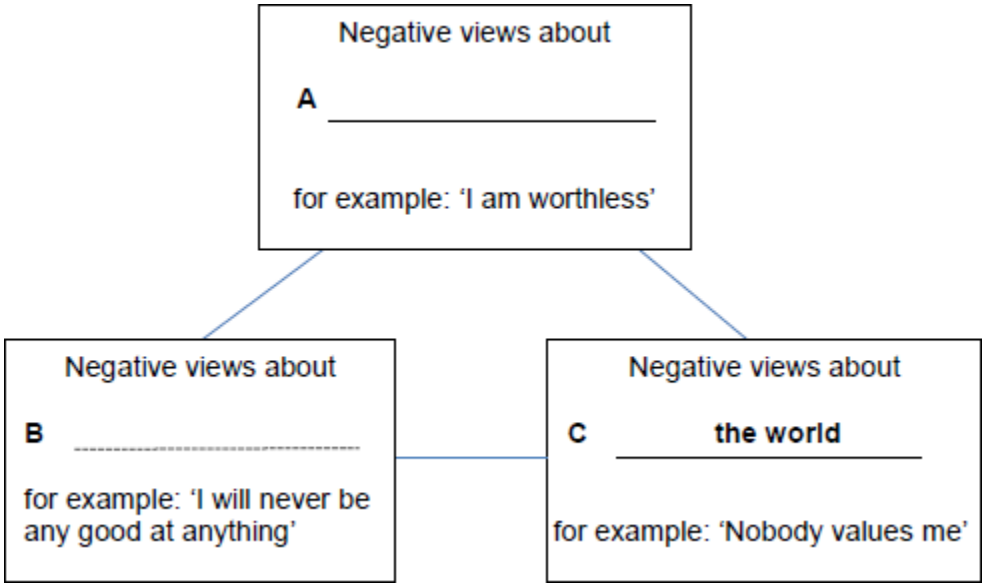
(Total 4 marks)

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

(Total 2 marks)

6 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)

7 Outline and evaluate the cognitive approach to explaining psychopathology.

(Total 8 marks)

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

(Total 16 marks)

9 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)

1 (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 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.

2 **[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.

3 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.

(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).

4

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.

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.

5

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 = 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.

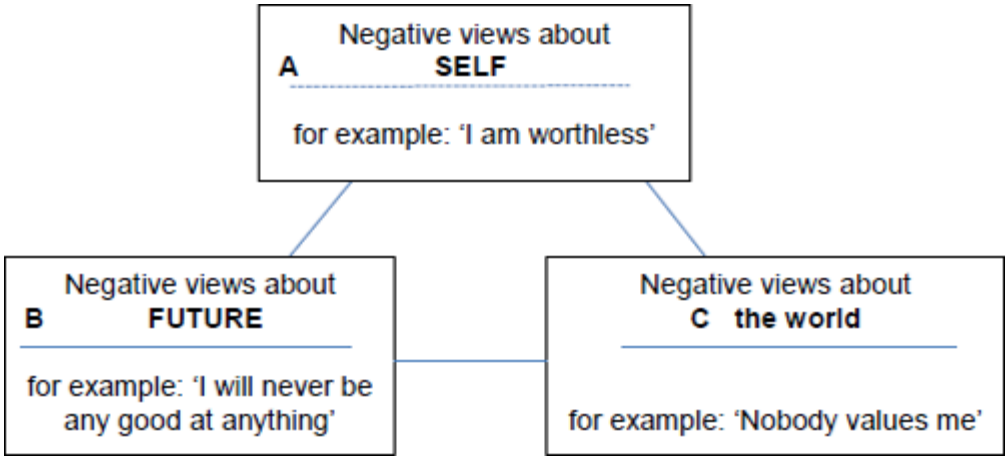
1 mark for a basic statement and a further mark for elaboration.

6

[AO1 = 2]

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

Terms must be in the correct position for credit.



7

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.

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.

8

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.

9

[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'.