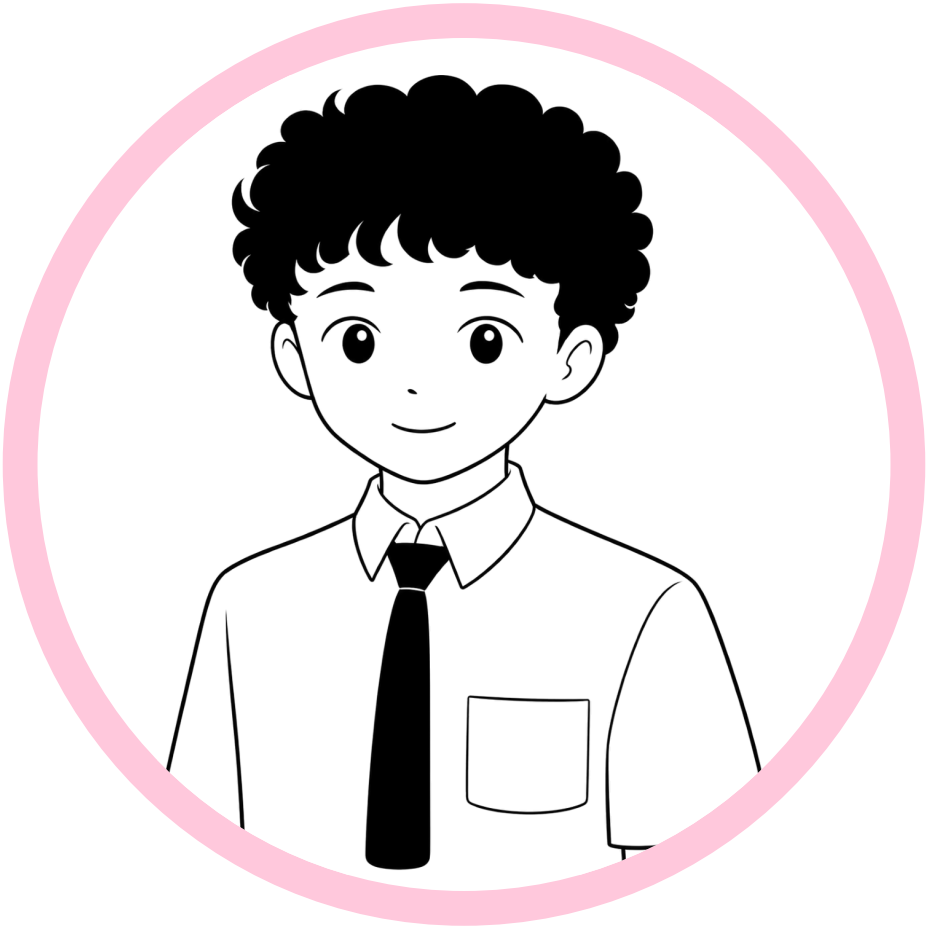
AQA A-LEVEL PSYCHOLOGY · 7182

PSYCHOLOGY



MARK SCHEME

3.3.6 ANOREXIA NERVOSA

SCORE	PERCENTAGE
/90	%

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Q1.

[AO1 = 6 AO3 = 10]

Level	Mark	Description
4	13-16	Knowledge of biological explanation(s) for anorexia nervosa is accurate with some detail. Discussion is thorough and effective. Minor detail and / or expansion of argument is sometimes lacking. The answer is clear, coherent and focused. Specialist terminology is used effectively.
3	9-12	Knowledge of biological explanation(s) for anorexia nervosa is evident but there are occasional inaccuracies / omissions. Discussion is mostly effective. The answer is mostly clear and organised but occasionally lacks focus. Specialist terminology is used appropriately.
2	5-8	Limited knowledge of biological explanation(s) for anorexia nervosa is present. Focus is mainly on description. Any discussion is of limited effectiveness. The answer lacks clarity, accuracy and organisation in places. Specialist terminology is used inappropriately on occasions.
1	1-4	Knowledge of biological explanation(s) for anorexia nervosa is very limited. Discussion 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.

Possible content:

- genetic explanation – disorder is heritable; genes / DNA passed down through generations; concordance in twins; identification of specific genes, e.g. EPHX2 / combination of genes
- genetic explanation – evolutionary - disorder has an adaptive function; Guisinger's 'flee famine' view; contemporary adaptive function of thinness, e.g. thin = attractive
- season of birth – spring babies' vulnerability
- neural explanations – activity of neurotransmitters serotonin, dopamine and noradrenaline; abnormal levels of serotonin and dopamine metabolites found in people with anorexia nervosa
- abnormalities in brain activity in areas associated with feeding behaviour, e.g. hypothalamus; insula area of the cortex
- knowledge of explanation embedded in evidence.

Possible discussion points:

- use of evidence to support / refute the explanation, e.g. use of twin evidence;

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metabolite studies
- implications of accepting the genetic explanation
- relevance of the flee famine hypothesis in modern Western society
- discussions of cause and effect, e.g. altered neurotransmitter function may be due to the disorder rather than the cause, but recovered patients show reductions in serotonin and dopamine function post-recovery
- problems of isolating the activity of specific brain structures
- discussions relating to broader issues of reductionism and determinism
- comparisons with other explanations, e.g. social / family etc.

Credit other relevant material.

[16]

Q2.

[AO1 = 4 AO2 = 4]

Level	Marks	Description
4	7 – 8	Knowledge of the family systems theory explanation for anorexia nervosa is accurate with some detail. Application is thorough and effective. Minor detail and/or expansion is sometimes lacking. The answer is clear, coherent and focused. Specialist terminology is used effectively.
3	5 – 6	Knowledge of the family systems theory explanation for anorexia nervosa is evident but there are occasional inaccuracies/omissions. Application is mostly effective. The answer is mostly clear and organised but occasionally lacks focus. Specialist terminology is used appropriately.
2	3 – 4	Limited knowledge of the family systems theory explanation for anorexia nervosa is present. Any application is of limited effectiveness. The answer lacks clarity, accuracy and organisation in places. Specialist terminology is used inappropriately on occasions.
1	1 – 2	Knowledge of the family systems theory explanation for anorexia nervosa is very limited. 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.

Possible content:
- Minuchin (1978) proposed characteristics of an ‘anorectic/psychosomatic family’ which lead to lack of autonomy and control, so child exercises only possible choice over what to eat
- enmeshment – families are over-involved, interdependent, no clear emotional boundaries, inhibited sense of individuality
- overprotectiveness – family members protect each other, reinforce family loyalty, parents see their role as a sacrifice
- rigidity of style – interactions are inflexible, denial of need to change
- conflict avoidance – family members suppress conflict, differences of

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opinion/problems are not discussed.

Possible application:

Credit explanation of links between theory and stem content.

- several references to enmeshment and lack of self-differentiation (Mia and mum worry about each other, shop together, wear same clothes)
- Mia's mum is over-protective, monitoring everything she does and her phone conversations ('always asking if I'm OK', 'wants to know everything', 'listens in when'
- Mia's mum is self-sacrificing to look out for Mia ('spends all her time...')
- Mia's relationship with her mother seems to be fixed as they have ('always been the same') suggesting rigidity of style
- no sense that Mia or anyone else wants anything to change or that family disagreements are in the open ('it has always been the same', 'we never argue...') suggesting conflict avoidance.

Credit other relevant material.

Q3.

[AO3 = 6]

Level	Marks	Description
3	5 – 6	Discussion of two limitations is clear and effective. The answer is coherent and well organised with effective use of specialist terminology.
2	3 – 4	Discussion of two limitations is evident although one or both lack detail. The answer is mostly organised with some appropriate use of specialist terminology. OR 3 marks for one limitation discussed at the top of Level 3.
1	1 – 2	At least one limitation is presented but discussion is limited/muddled. The answer lacks organisation and specialist terminology is either absent or inappropriately used. OR one limitation discussed at Level 2.
	0	No relevant content.

Possible limitations and discussion:

- ethical problems – seeing parents as responsible for their child's anorexia may cause greater stress and anxiety. Could be seen as destructive/damaging rather than productive
- problems in measuring enmeshments and possible lack of validity. Data is usually self-reported; patients and family members report own experiences of interaction. Reports may be distorted/biased by the need to explain/emotions etc
- inconsistent evidence – some studies show no differences in degree of enmeshment between eating disorder families and non-eating disorder families (Aragona 2001)
- over-controlling and overprotective family relationships and interactions may be the result of the child's disturbing behaviour rather than the cause – impossible to show a cause and effect relationship
- cannot explain changes in incidence of the disorder over time – incidence rates have increased over time but no evidence of corresponding changes in nature of family relationships
- alternatives may offer better explanation, eg evidence of a biological cause

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- family relationships and interactions may be a trigger but the initial cause is biological (genetic evidence).
- counterarguments of the limitation given.

Credit other relevant limitations.

Q4.

[AO1 = 6 AO3 = 10]

Level	Marks	Description
4	13 – 16	Knowledge of psychological explanations for anorexia nervosa is accurate and generally well detailed. Discussion 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 of psychological explanations for anorexia nervosa is evident. There are occasional inaccuracies. Discussion 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 of psychological explanation(s) for anorexia nervosa is present. Focus is mainly on description. Any discussion is only partly effective. The answer lacks clarity, accuracy and organisation in places. Specialist terminology is used inappropriately on occasions.
1	1 – 4	Knowledge of psychological explanation(s) for anorexia nervosa 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:

- family systems theory – concepts of autonomy vs enmeshment, over-protection, rigidity, conflict avoidance and control
- social learning theory – observation, imitation, identification, modeling, vicarious reinforcement, media influences, characteristics of preferred role models, cultural influences and norms
- cognitive theory – role of weight-based schema, perceptual distortions, cognitive biases, irrational beliefs
- personality correlates, eg low self-esteem.

Possible discussion points:

- use of research evidence to support / refute, eg evidence that families of sufferers are over controlling / over involved; evidence that sufferers are perfectionist, compliant and seek to exert control; evidence of irrational beliefs

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re body perception; biological evidence
- comparison with other explanations
- problem of demonstrating cause and effect
- multifactorial nature of anorexia nervosa.

Credit other relevant discussion points.

Only credit evaluation of the methodology used in studies when made relevant to discussion of the explanations.

Only credit reference to treatments where used to discuss explanations, eg if studies show family therapy is effective this supports the family systems explanation.

Q5.

[AO3 = 8]

Level	Marks	Description
4	7 – 8	Outline of one or more biological explanations for anorexia nervosa is accurate and generally well detailed. Evaluation is effective. The answer is clear, coherent and focused. Specialist terminology is used effectively. Minor detail and/or expansion of argument sometimes lacking.
3	5 – 6	Outline of one or more biological explanations for anorexia nervosa is evident. There are occasional inaccuracies. There is some effective evaluation. The answer is mostly clear and organised. Specialist terminology mostly used effectively.
2	3 – 4	Outline of one or more biological explanations for anorexia nervosa 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 – 2	Outline of one or more biological explanations for anorexia nervosa 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.

Possible content:
- Genetic factors, including Guisinger's 'adapted to flee famine' evolutionary hypothesis
- Abnormalities in neurotransmitters such as serotonin
- Abnormalities in the brain's feeding control centres – especially involving the hypothalamus
- Combination of abnormalities in neurotransmitters and feeding centres

Possible discussion points:
- Support from MZ and DZ twin studies for genetic factors in anorexia nervosa
- No genes actually identified

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- No direct evidence for the evolutionary famine hypothesis – and why would it not affect males?
- Support from recovered patients for reductions in serotonin function in anorexia nervosa (reduced levels of serotonin receptors)
- Findings hard to interpret as severe weight loss itself may produce changes in brain function
- No direct evidence of structural brain abnormalities eg in hypothalamus
- Evidence for alternative non-biological explanations – family dynamics, media – though focus must remain on biological explanations

Credit other relevant information.

Q6.

[AO1 = 3 AO3 = 5]

Level	Marks	Description
4	7 – 8	Knowledge of social learning theory as an explanation for anorexia is accurate and generally well detailed. Discussion is thorough and effective. Answer is clear, coherent and focused. Specialist terminology is used effectively. Minor detail sometimes lacking and/or expansion of argument sometimes lacking.
3	5 – 6	Knowledge of social learning theory as an explanation for anorexia is generally accurate. Discussion is mostly effective. The answer is mostly clear and organised. Specialist terminology is mostly used appropriately.
2	3 – 4	Knowledge of social learning theory as an explanation for anorexia is present. There are some inaccuracies. Discussion is sometimes effective. There is some appropriate use of specialist terminology.
1	1 – 2	Knowledge of social learning theory as an explanation for anorexia is limited and lacks detail. There is substantial inaccuracy/muddle. Discussion is limited, poorly focused or absent. Specialist terminology is either absent or inappropriately used.
	0	No relevant content.

Possible content:

- Features of SLT, including imitation, modelling, vicarious reinforcement; then direct reinforcement for weight loss from friends and family
- Media influences – magazines, TV, films, digital media, images of the idealised ‘thin’ woman
- Family influences – imitation of parents and peers
- Interaction with personality factors – eg low self-esteem, cognitive distortions of body size, perfectionism

Possible discussion points:

- Findings of research studies eg introduction of TV to isolated communities and subsequent increase in cases of anorexia nervosa
- Correlation between increases in anorexia and increased media focus on

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idealised thin women
- Problem of susceptibility, given that all young women are exposed to media influences
- Evidence for alternative explanations – family dynamics, biological factors – though focus must remain of SLT

Credit other relevant material.

Q7.

[AO1 = 2]

1 mark for brief outline of one irrational belief

1 further mark for accurate elaboration

Possible content:

- All or nothing thinking ('either I am attractive or ugly')
- Catastrophising ('if I eat this apple I will immediately get fat')
- Unfavourable comparisons with others, leading to negative self-labelling

Credit other relevant material. Note that personality characteristics such as perfectionism or low self-esteem are not relevant to this question.

Q8.

[AO3 = 2]

1 mark for brief explanation

Plus

1 further mark for accurate elaboration

Possible content:

- Supporting evidence that families where one or more members have an eating disorder have particular characteristics, such as over-involved, high achieving and controlling parents
- Family systems theory can explain particular symptoms, such as failing to eat and weight loss as attempts to exert some personal control and achieve autonomy
- Takes account of the fact that AN is a serious and complex disorder of self-perception, and considers the family and social context.

Q9.

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

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		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. One explanation only at Level 4
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. One explanation only at Level 3
	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

Eating disorders in the Specification are anorexia nervosa and obesity. For each disorder there is a range of potential explanations: e.g. for anorexia nervosa: cognitive, social learning and family systems, the genetic and neural - role of serotonin and the hypothalamus; for obesity: restraint theory, disinhibition and the boundary model, genetic and neural.

Credit also socio-cultural factors such as changes to the built environment, accessibility of high carbohydrate foods and lifestyle changes (these would be creditable together under the umbrella term of a psychological or socio-cultural explanation); body weight control systems; genome lag.
Note that evolutionary models of either disorder would be considered part of the biological approach. Note also, it is acceptable for two or more explanations to be accepted under an umbrella term such as ‘the behavioural approach’ or the ‘biological approach’.
If more than one psychological or biological explanation is covered, all should be marked and the best one credited.

AO3

Content will depend upon which disorder is chosen and which explanations are discussed. In some areas (e.g. social learning theory and anorexia nervosa; metabolic rate in obesity) there is research evidence that would provide very

effective evaluation; this includes cross-cultural and twin studies. In other areas, besides research evidence, commentary could cover some extremely critical points; why only some young girls seem susceptible to media images, conditions such as obesity probably involving more than one single explanation; the interplay between psychological and biological factors in all disorders.

Effective methodological evaluation could include the problems of demonstrating that e.g. increasing car use and sedentary pastimes have a cause-effect relationship with obesity; or that low self-esteem and body image disturbance have cause-effect relationships with bulimia nervosa; or that physiological and neural changes in anorexia nervosa are causes and not consequences of weight loss. Note that methodological evaluation of studies that is not related explicitly to explanations cannot earn credit.

Alternative explanations may earn marks if used as sustained and effective evaluation of the target explanations.

Other relevant evaluative comment could include gender and cultural differences, reductionism, nature / nurture, applications of findings and socially-sensitive research.

Q10.

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

Depending upon the disorder identified, there is a variety of explanations that can be used for this question. Anorexia nervosa can involve biological factors (genetics), family dynamics and psychodynamic approaches, body dissatisfaction, media influences and evolutionary hypotheses. Bulimia nervosa similarly may involve biological factors, family dynamics / psychodynamic approaches, body dissatisfaction, and media influence. Relevant explanations for obesity include mood regulation, availability of high carbohydrate and fatty foods, reduced exercise / increased car travel, sedentary pastimes and biological factors.
Candidates need to focus on one explanation only, and for marks in the top band provide accurate and coherent detail of the explanation. If more than one explanation is presented, both should be marked and the better one credited. There can be an overlap between disorders and explanations, particularly for anorexia nervosa and bulimia nervosa. Examiners should be lenient where such overlaps occur.

If candidates explicitly present several explanations / factors in relation to explanations for eating disorders under a single umbrella term eg biological psychodynamic, socio-cultural explanations, then they may be credited as a single explanation. Note, however that a

simple list of relevant factors without reference to explanations will not move out of Rudimentary.

Evaluation and commentary on the explanation are not required in this question part. Studies used to illustrate explanations can be credited in so far as they add to the explanation eg twin studies of anorexia and bulimia nervosa and genetic explanations, and can receive AO1 credit if used in this way.

No credit for identifying a disorder, but if no disorder is clearly identified a maximum mark of 3 can be awarded, however detailed the explanation.

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.

Q11.

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:

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- 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

Examples of eating disorders given in the Specification are anorexia nervosa, bulimia nervosa and obesity. Each of these has a range of psychological explanations, such as social / cultural influences (eg social learning theory and other conditioning explanations) and psychodynamic approaches (eg Bruch, Minuchin).

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Explanations of obesity are likely to focus on a range of cultural and environmental factors. These should be considered as one psychological explanation.

Answers should be assessed on their accuracy and coherence, and focus on a *single* disorder. Where a single disorder cannot be identified, such generic answers eg on the role of social learning on eating disorders in general, can earn a maximum of 3 marks. Studies can be credited to the extent to which they illustrate the explanation.

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.

Q1.

This question elicited some detailed responses, although the knowledge was not always accurate. As with question 25, students often tried to include too much and would have been better to limit the range of material, giving themselves time to provide detailed knowledge and more thorough discussion. A number of the weakest answers attempted a response based solely on ghrelin and leptin. It was evident from some answers that students would have preferred a question on psychological explanations.

Q2.

Students tended to respond well to this question up to a point and the stem afforded ample opportunity for application. Most could offer useful description of family systems theory and were able to pick out relevant material from the stem for application to Mia. It was less common to see full coverage of the family systems theory explanation for anorexia nervosa, in other words, students often failed to describe how the behaviours (enmeshment, control, etc) might lead to the development of anorexia nervosa. Only students who fully explored this in their answers achieved higher level marks. Weaker responses consisted of repetition of the stem or basic paraphrasing of the stem in common sense terms, and thus showed no evidence of psychological knowledge or understanding.

Q3.

Blaming the family and the issue of cause and effect were probably the most effective limitations, although these were often quite brief. Comparisons with other explanations, mainly biological, were not always very effective, as they tended to stray into discussion of the alternative. A number of answers focused on therapy rather than on the explanation. As with the parallel question on schizophrenia, many students asserted inappropriately that the family dysfunction explanation is ‘reductionist’.

Q9.

This was another popular question. For marks in the higher bands there needed to be a reasonable balance between the two explanations, but this was not an issue for most students. Anorexia nervosa (AN) was the most popular choice of disorder. Psychological explanations included psychoanalytic and behavioural approaches, and there was a welcome increase in the depth and detail of the psychoanalytical approach. However, in contrast, answers outlining social learning theory and the influence of parents, peers and media tended to lack detail of the SLT processes involved. Biological explanations included the possible role of the hypothalamus, neurotransmitters, evolutionary theory and genetic factors.

Evaluation of explanations focused on research studies, and, especially for psychoanalytic explanations, the effectiveness of therapies and familial characteristics. There was often confusion over the interpretation of twin studies and the relevance of work with non-human animals, eg hypothalamic mechanisms and feeding behaviour, was sometimes not explicit.

General commentary included the complexity of AN and the need for a variety of approaches. Other IDA included gender and cultural differences and reductionism, with marks awarded according to the level of understanding and relevance demonstrated.

There were few answers on bulimia nervosa, but some impressive accounts of obesity. Psychological explanations included socio-cultural factors (eg accessibility of high carbohydrate foods, lifestyle changes) and mood regulation. Biological explanations included hypothalamic mechanisms and evolutionary approaches (the ‘thrifty’ gene).

Where more than one explanation was explicitly presented under an umbrella term, eg behavioural approaches including operant and classical conditioning, social learning; neurotransmitters such as serotonin and dopamine, all were credited.

Q10.

This short answer question was well answered. The most popular disorders identified were anorexia nervosa and obesity. For anorexia nervosa explanations varied from the psychoanalytical through media influences to the biological / genetic. The genetic explanation was often limited, with descriptions of only twin studies given and no reference to possible mechanisms, or to what is actually inherited. In general the role of neurotransmitters was covered more successfully. For obesity the focus was either on socio-cultural factors or physiological mechanisms of feeding behaviour.

Weaker answers often described symptoms or provided evaluative material that was not relevant in this question. A further common weakness was for answers using media influence to focus on largely anecdotal material with no reference to, for example social learning theory. For anorexia nervosa, the key stage of why media influence leads to pathological slimming was usually ignored.

Q11.

Anorexia nervosa was the most popular disorder considered and the media / social learning approach was the most popular explanation. The question was answered moderately well though many answers lacked sufficient detail of the psychological processes involved to move into the top bands. Technical terms such as observational learning, modelling, vicarious reinforcement etc should all form part of an outline of the role of SLT in any behaviour. Psychodynamic explanations were usually more impressive, with the roles of enmeshment and over control accurately outlined. Obesity and bulimia nervosa were less popular, but the socio-cultural explanation of obesity was used effectively by some candidates. A significant minority of answers were either too long or too short for the marks available, and in some cases presented AO2 / AO3 material that did not earn marks.

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