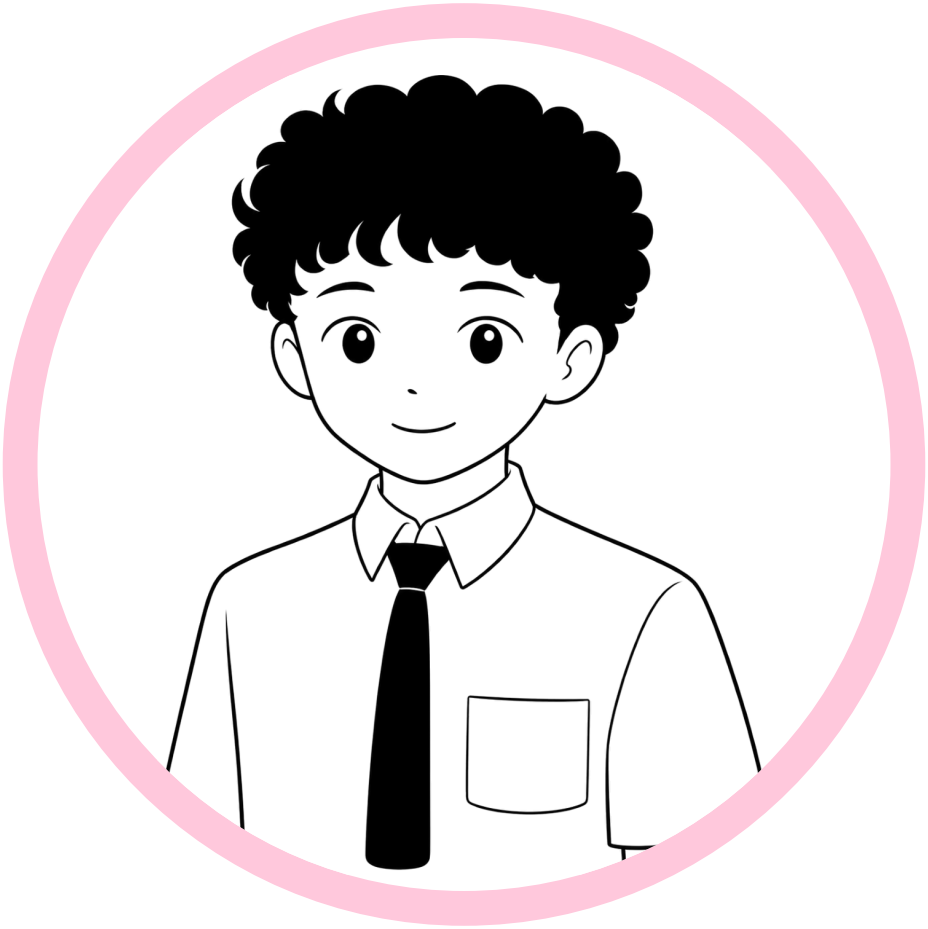
PEARSON EDEXCEL A-LEVEL PSYCHOLOGY · 9PS0

PSYCHOLOGY



MARK SCHEME

TOPIC 5: CLINICAL PSYCHOLOGY

SCORE	PERCENTAGE
/336	%

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Mark Scheme

Q1.

Question Number	Indicative content	Mark
	AO1 (4 marks), AO3 (4 marks) **AO1** • Reliability refers to consistency. • If something is done more than once, one would expect the same results. • If the same results are found, then they are reliable. • This applies to the diagnosis of mental health issues, as if one person goes to two different clinicians and gets a different diagnosis, then there is no reliability. • Also, if a clinician gives one diagnosis for one person presenting with a set of symptoms and features, and then another person with the same presenting issues with the same clinician gets a different diagnosis, this shows unreliability and lack of validity in the diagnosis too. • The subjective nature of diagnosis could lead to different diagnoses. **AO3** **Unreliable** • There are two diagnostic systems used worldwide: ICD and DSM. There are distinct differences in these as the diagnosis depends on which system is used, therefore reducing the reliability of diagnosis. • There has been found to be only a 68% agreement (Andrews et al, 1999) between the ICD and DSM. • Rosenhan (1973) provided evidence that diagnoses were flawed, as staff were unable to tell mentally disordered patients apart from those who were mentally healthy. • Spitzer and Fleiss (1974) claimed that reliability was not high for any mental disorder and that reliability for psychosis and schizophrenia was just 'fair' rather than 'good'.	**(8)**

Question Number	Indicative content	Mark
cont.	**Reliable** • Reliability of diagnosis varies for different disorders: good for depression, worse for post-traumatic stress. So there is some reliability. • The use of diagnostic manuals, names/nomenclature and systems means more communication between clinicians, which is likely to increase reliability (Spitzer and Fleiss, 1974). • The DSM and ICD undergo continuous review. Updates ensure that it is possible to make more accurate diagnoses based on up-to-date evidence. Though DSM V has not been well received. • Wilson (1993) suggests that DSM III was developed precisely to tackle the unreliability of the previous manuals. • Many structured interviews have been developed which also increases reliability as clinicians use the same interviews/questions (e.g. Sheehan et al., 1998). • The reliability of diagnosis can be significantly improved when clinicians liaise with other clinicians when making diagnosis, as this increases inter-rater reliability. **Look for other reasonable responses.**	

Level	Mark	Descriptor
AO1 (4 marks), AO3 (4 marks) **Candidates must demonstrate an equal emphasis between knowledge and understanding vs assessment/conclusion in their answer.**		
Level 0	0	No rewardable material.
Level 1	1–2 marks	Demonstrates isolated elements of knowledge and understanding. (AO1) Generic assertions may be presented. Limited attempt to address the question. (AO3)
Level 2	3–4 marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Candidates will produce statements with some development in the form of mostly accurate and relevant factual material, leading to a generic or superficial assessment being presented. (AO3)
Level 3	5–6 marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning. Leading to an assessment being presented which considers a range of factors. Candidates will demonstrate understanding of competing arguments/factors but unlikely to grasp their significance. The assessment leads to a judgement but this may be imbalanced. (AO3)
Level 4	7–8 marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical assessment, containing logical chains of reasoning throughout. Demonstrates an awareness of the significance of competing arguments/factors leading to a balanced judgement being presented. (AO3)

Q2.

Question Number	Answer	Mark
(a)	**AO2 (2 marks)** Up to two marks for a description of volunteer sampling in relation to the scenario. For example: • Motsi could post an advertisement online in both the UK and Japan asking for people to take part in her study on treatments of mental health disorders (1). She could then use the first 25 people from each country who responded to her advertisement and see what type of treatment they used (1). **Answers must relate to the scenario.** **Look for other reasonable marking points.** **Generic answers score 0 marks.**	**(2)**

Question Number	Answer	Mark
(b)	**AO2 (1 mark), AO3 (1 mark)** One mark for identification of why a random sample may be better than volunteer sampole for Motsi's investigation (AO2). One mark for justification of why a random sample may be better than volunteer (AO3) For example: • A random sample means that everyone in Japan and the UK who has a mental health disorder has an equal chance of being a participant (1), so Motsi's sample should be more representative because a volunteer sample may consist of people who are more motivated to access treatments and therefore not typical (1). **Answers must relate to the scenario.** **Look for other reasonable marking points.** **Generic answers score 0 marks.**	**(2)**

Question Number	Answer	Mark
(c)	**AO2 (1 mark), AO3 (1 mark)** One mark for identification of one weakness in relation to the scenario (AO2). One mark for justification of one weakness (AO3). For example: • Motsi may ask each participant with a mental health disorder different questions depending on their answers about any treatment they have received (1), which may make it difficult for Motsi to analyse and compare her data to come to a conclusion about treatment choice in Japan and the UK (1). **Answers must relate to the scenario.** **Look for other reasonable marking points.** **Generic answers score 0 marks.**	**(2)**

Q3.

Question Number	Answer	Mark
(a)	**AO2 (1 mark)** One mark for an appropriate suggestion of an open question in relation to the scenario. For example: • How has your relationship with your family member been affected by their mental health disorder? (1). **Answers must relate to the scenario.** **Look for other reasonable marking points.**	**(1)**

Question Number	Answer	Mark
(b)	**AO2 (2 marks)** One mark for each accurate statement in relation to the scenario. For example: • Andromache was looking for a difference in relationships in patients and their families who were waiting for a diagnosis or who had a diagnosis (1). • She used nominal data as she measured whether family relationships had improved or deteriorated (1). **Answers must relate to the scenario.** **Look for other reasonable marking points.**	**(2)**

Question Number	Answer	Mark
(c)	**AO2 (1 mark), AO3 (1 mark)** One mark for identifying the correct critical value (AO2) One mark for accurate judgement of difference (AO3) For example: • There is a significant difference in quality of family relationships whilst waiting for a diagnosis compared to having a diagnosis (1) as the observed value (5.84) for a one-tailed test when *df*=1 is greater than the critical value (5.02) (1). **Answers must relate to the scenario.** **Look for other reasonable marking points.**	**(2)**

Question Number	Answer	Mark
(d)	**AO2 (2 marks), AO3 (2 marks)** One mark for identification of each strength/weakness in relation to scenario (AO2) One mark for justification of each strength/weakness (AO3) For example: Strength • It allows Andi to reduce the large amount of data she has received about family relationships after diagnosis of a mental disorder into manageable themes (1), which allows her to summarise the key findings so they are easily understandable by support groups who help families with mental health diagnoses (1). Weakness • Andi would decide on the themes about family relationships prior to conducting the analysis so could be biased (1), therefore she may miss out some themes that the patients or their family think are important so her interpretation of the data may lack validity (1). **Answers must relate to the scenario.** **Generic answers score 0 marks.** **Look for other reasonable marking points.**	**(4)**

Q4.

Question Number	Indicative Content	Mark
	AO1 (4 marks), AO3 (4 marks) **Read the candidate response and apply the appropriate level.** **AO1** • Aimed to see if diagnosis of mental disorders was valid/reliable • All pseudopatients were admitted with either a diagnosis of schizophrenia or manic depression (now bipolar) • Rosenhan said the pseudopatients acted normally once admitted e.g. making conversations with fellow patients. • Once admitted the pseudopatients did not claim to hear voices anymore **AO3** • As they did not know they were part of a study the staff did not give consent to take part in the study. • The validity of the results is higher as a variety of real hospitals were selected for the observations. • As the pseudo patients were admitted, the staff had no reason to think they were faking it, as healthy people do not say they hear voices that are not there. • Staff could be distressed, and may question their work which would negatively impact on real patients. **Look for other reasonable marking points.**	**(8)**

Level	Mark	Descriptor
Candidates must demonstrate an equal emphasis between knowledge and understanding vs evaluation/conclusion in their answer.		
	0	No rewardable material.
Level 1	1-2 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) A conclusion may be presented, but will be generic and the supporting evidence will be limited. Limited attempt to address the question. (AO3)
Level 2	3-4 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Candidates will produce statements with some development in the form of mostly accurate and relevant factual material, leading to a superficial conclusion being made. (AO3)
Level 3	5-6 Marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning, leading to a conclusion being presented. Candidates will demonstrate a grasp of competing arguments but evaluation may be imbalanced. (AO3)
Level 4	7-8 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical evaluation, containing logical chains of reasoning throughout. Demonstrates an awareness of competing arguments, presenting a balanced conclusion. (AO3)

Q5.

Question Number	Indicative Content	Mark
	AO1 (8 marks), AO2 (4 marks), AO3 (8 marks)	**(20)**
	AO1 • It is thought that too many dopamine receptor sites in the brain lead to too much dopamine being used and this causes schizophrenia. • Schizophrenics have a higher number of D2 receptor sites, and these are more likely to pick up dopamine that other dopamine receptors sites meaning the dopamine is more likely to have an effect as more of it is received. • Too much dopamine in the mesolimbic system is thought to cause the positive symptoms of schizophrenia, such as delusions. • Too much dopamine in the mesocortical system is thought to cause the negative symptoms of schizophrenia such as poverty of speech. • Another neurotransmitter that may be involved is glutamate, with a decrease in glutamate causing symptoms such as psychosis. • Glutamate is thought to control the amount of dopamine released by the brain, and normally seems to lower levels of dopamine. • A reduction in glutamate can lead to an increase in the amount of dopamine released. • An increase in serotonin activity can also lead to the positive and negative symptoms of schizophrenia.	
	AO2 • If Michael had an increase of dopamine in his mesolimbic system it could explain why he hears voices telling him what to do. • Michael's symptoms of not going out with his friends any more can be due to an excess of dopamine in his mesocortical system. • Michaels' use of PCP may have limited the effect of glutamate, as it is an antagonist, therefore causing Michael to develop schizophrenia. • It may be that Michael has too much serotonin in his brain and this could be the reason why he has both positive and negative symptoms. **AO3** • Carlsson et al. (2000) found that dopamine, glutamate and serotonin are all implicated in the development of schizophrenia showing that neurotransmitters can explain the development of schizophrenia. • It could be that genes cause the changes in glutamate that is thought to cause schizophrenia, so the neurotransmitter explanation is not a full explanation. • Anti-psychotic drugs work by blocking dopamine receptors and are effective in reducing the symptoms of schizophrenia,	

	suggesting that excess dopamine does explain the development of schizophrenia. • Anti-psychotic drugs block dopamine receptors very quickly but it takes a few days for the symptoms of schizophrenia to be reduced so there may be other factors involved in developing schizophrenia, not just neurotransmitters so does not full explain the development of schizophrenia. • Lindstroem et al. (1999) found that schizophrenics used L-DOPA faster than the control group, suggesting they were producing more dopamine at a quicker rate, and the excess dopamine can explain how schizophrenia is caused. • Depatie & Lal (2001) found that giving people drugs that increase their production of dopamine does not create the symptoms of schizophrenia as would be expected if excess dopamine caused it, so it is not the only explanation of the causes of schizophrenia. • The neurotransmitter explanation of schizophrenia can be said to be incomplete as it ignores other possible causes of schizophrenia such as early childhood experiences or cognitive processes, and it is not the only explanation. • Researchers at Liverpool University in 2012 found that childhood trauma makes you three times more likely to develop schizophrenia, suggesting that there is a strong relationship between the environment and the development of schizophrenia and it is not just due to neurotransmitters. **Look for other reasonable marking points.**	

Level	Mark	Descriptor
AO1 (8 marks), AO2 (4 marks), AO3 (8 marks) Candidates must demonstrate an equal emphasis between knowledge and understanding vs judgement/conclusion in their answer. Application to the scenario is capped at maximum 4 marks.		
	0	No rewardable material.
Level 1	1–4 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) Provides little or no reference to relevant evidence from the context (scientific ideas, processes, techniques and procedures). (AO2) A judgement/decision may be presented, but will be generic and the supporting evidence will be limited. Limited attempt to address the question. (AO3)
Level 2	5–8 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Line(s) of argument occasionally supported through the application of relevant evidence from the context (scientific ideas, processes, techniques and procedures). (AO2) Candidates will produce statements with some development in the form of mostly accurate and relevant factual material leading to a judgement/decision being presented. Candidates will demonstrate a grasp of competing arguments but response may be imbalanced. (AO3)
Level 3	9–12 Marks	Demonstrates accurate knowledge and understanding. (AO1) Line(s) of argument supported by applying relevant evidence from the context (scientific ideas, processes, techniques and procedures). Might demonstrate the ability to integrate and synthesise relevant knowledge. (AO2) Displays a mostly developed and logical argument, containing mostly coherent chains of reasoning. Demonstrates an awareness of competing arguments, presenting a judgement/decision which may be imbalanced. (AO3)

Level 4	13–16 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Line(s) of argument supported throughout by sustained application of relevant evidence from the context (scientific ideas, processes, techniques or procedures). Demonstrates throughout the skills of integrating and synthesising relevant knowledge with consistent linkages to psychological concepts and/or ideas. (AO2) Displays a well-developed and logical argument, containing logical chains of reasoning throughout. Demonstrates an awareness of competing arguments and presents a balanced response, leading to a balanced judgement/decision. (AO3)
Level 5	17–20 Marks	Demonstrates accurate and comprehensive knowledge and understanding. (AO1) Line(s) of argument supported throughout by sustained application of relevant evidence from the context (scientific ideas, processes, techniques or procedures). Demonstrates consistently the skills of integrating and synthesising relevant knowledge with thorough, accurate linkages to psychological concepts and/or ideas. (AO2) Displays a well-developed and logical argument, containing logical chains of reasoning throughout. Demonstrates a full awareness of competing arguments and presents a fully balanced response, leading to an effective nuanced and balanced judgement/decision. (AO3)

Q6.

Question Number	Answer	Mark
	AO1 (3 marks) One mark for a description of each feature of schizophrenia. For example: • Episodes of psychosis tend to appear between the ages of late adolescence and the mid-thirties, with males having it at a slightly earlier age than females (1). • People who have psychosis before late adolescence often have a worse prognosis that those who develop it later on, with it being more severe and lasting longer (1). • About 50% of people with schizophrenia have times where they have the symptoms and times where they do not have the symptoms (1). **Look for other reasonable marking points.**	**(3)**

Q7.

Question Number	Indicative content	Mark
	AO1 (8 marks), AO3 (12 marks) **e.g. cognitive explanation** **AO1** • According to the cognitive explanation symptoms such as hallucinations are caused by sensory overload. • Schizophrenics do not filter out irrelevant information from the senses, creating cognitive overload. • Hallucinations can also be caused by thinking our inner voice is an external voice telling us what to do. • A poor link between memory and perception can lead to disorganised thinking as people will not know what to expect from a situation. • The cognitive explanation also says that whilst dopamine may cause symptoms such as delusions, the person with schizophrenia tries to make sense of them. • When a person tries to make sense of delusions they may then get other symptoms of schizophrenia such as disorganised thinking. • A person may feel paranoia if they ask other people to confirm a hallucination, and the other people cannot confirm it. • Delusions may be caused by an inability to process social situations appropriately, so leading to feelings of persecution.	**(20)**

	AO3 • It could be that the sensory overload is due to having schizophrenia, not a cause of it, so reducing the credibility of the explanation. • It has been found, using PET scans (e.g. Butler et al., 2012), that there is less activity in the frontal lobes of those with schizophrenia, showing they are less likely to monitor information from the senses so disagreeing with the cognitive explanation. • McGuire et al. (1996) found that the temporal lobe is less active during hallucinations, so people with schizophrenia are less able to monitor their inner voice as the cognitive explanation states. • Carlsson et al. (2002) found that neurotransmitters such as glutamate cause symptoms such as hallucinations, so the cognitive explanation is not a full explanation of schizophrenia. • Dickson et al. (2018) found that adolescents at risk of developing schizophrenia had deficits in a variety of cognitive functions so suggesting they may be a cause of schizophrenia. • The cognitive explanation focuses on both nature, in the form of neurotransmitters and nurture, so it is a more complete explanation than the biological explanation.	

	• The cognitive explanation ignores the impact of social class on the development of schizophrenia so may not fully explain the disorder. • Sitskoorn et al. (2004) found that relatives of schizophrenics had similar cognitive deficits, but they did not develop schizophrenia, meaning that other factors must also be involved. • The cognitive explanation has led to cognitive behavioural therapy for schizophrenics, which has some effectiveness suggesting the cause of schizophrenia is cognitive. • Cognitive behavioural therapy is less effective for symptoms such as lack of emotional expression, suggesting these symptoms may have another cause rather than cognitive.	

Level	Mark	Descriptor
AO1 (8 marks), AO3 (12 marks) Candidates must demonstrate a greater emphasis on assessment/conclusion vs knowledge and understanding in their answer. Knowledge & understanding is capped at maximum 8 marks.		
	0	No rewardable material.
Level 1	1–4 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) Generic assertions may be presented. Limited attempt to address the question. (AO3)
Level 2	5–8 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Candidates will produce statements with some development in the form of mostly accurate and relevant factual material, leading to a generic or superficial assessment being presented. (AO3)
Level 3	9–12 Marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning, leading to an assessment being presented which considers a range of factors. Candidates will demonstrate understanding of competing arguments/factors but unlikely to grasp their significance. The assessment leads to a judgement but this will be imbalanced. (AO3)
Level 4	13–16 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a logical assessment, containing logical chains of reasoning throughout which consider a range of factors. Demonstrates an understanding of competing arguments/factors but does not fully consider the significance of each which in turn leads to an imbalanced judgement being presented. (AO3)
Level 5	17–20 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical assessment, containing logical chains of reasoning throughout. Demonstrates a full understanding and awareness of the significance of competing arguments/factors leading to a balanced judgement being presented. (AO3)

Q8.

Question Number	Answer	Mark
(a)	**AO1 (2 marks)** One mark for each point related to a symptom of schizophrenia, which in combination provides a logical description up to two marks. Responses likely to focus on: • Delusions of grandeur/grandiose delusions whereby the person believes themselves to be someone famous, wealthy and/or powerful. The delusions tend to have a religious/supernatural/science fiction theme. • Hallucinations/auditory where the person hears voices talking to them. The hallucinations are powerful and the person sees them as separate to themselves/there is wakefulness unlike being in a dream state. • Hallucinations/visual where the person experiences events that are not actually happening. Like auditory hallucinations they are vivid/very real/separate from the individual. • Poverty of speech/alogia which is when responses use as few words as possible. There is not the usual response given in speech/additional content in speech is not prompted by someone who is not present. • Social withdrawal involves withdrawing from family and friends and refusing company. The individual may lose interest in life and stay at home/they may not start conversations with people. • Flattening effect which means showing a lack of expression in face and voice. There is a limited range of emotions shown, even in situations where you would expect someone to show sadness/happiness. For example: Many people experiencing schizophrenia have delusions/grandiose delusions about who they are (1) often believing they are famous, wealthy or powerful (1). Features such as frequency or type of schizophrenia do not gain credit. **Look for other reasonable marking points.**	**(2)**

Question Number	Answer	Mark
(b)	**AO1 (3 marks)** One mark for each point related to a diagnosis of schizophrenia in terms of validity, which in combination provides a logical description, up to 3 marks. • A valid diagnosis is one where the symptoms match the label so if someone suffering from hallucinations and thought insertion are diagnosed as schizophrenia then this is valid (1). However, it is difficult for clinicians to accurately determine if an individual is experiencing hallucinations (1). Symptoms of schizophrenia such as social withdrawal may also be associated with other disorders such as depression so may prevent a valid diagnosis (1). **Answers must relate to schizophrenia** **Generic answers score 0 marks.** **Look for other reasonable marking points.**	**(3)**

Q9.

Question Number	Indicative content	Mark
	AO1 (8 marks), AO3 (12 marks) **AO1** • Neurotransmitter functioning is seen as a cause of schizophrenia, such as the dopamine hypothesis and the idea that serotonin is also involved - possibly an imbalance between the two. • Genes are also discussed as a cause of schizophrenia, which can run in families, as shown by twin studies. • Another cause of schizophrenia is a social one: pressures of living can cause symptoms, and a stressful life event and emotional reaction can cause a psychotic episode. • The bio psychosocial model is an idea that combines biological, social and psychological factors as causes of schizophrenia. • Schizophrenia might be caused by some difference in the brain (such as in the ventricles), which is also a biological cause, although not all of those with schizophrenia have the same damage. This is just one of the ideas about causes. • Drug misuse seems to relate to the onset of schizophrenia, but that might not be a cause as such so much as a trigger for one of the other (or more than one, it might be a combination) causes. • Depression/OCD/anorexia nervosa have biological causes such as genetic causes or neurotransmitters. • They also have psychological elements such as the effect of lack of social support on depression/media on anorexia nervosa. • Mental health disorders can be said to have biological, psychological and social causes. This is the bio psychosocial model. • Biological explanations for depression/OCD/anorexia nervosa include the monoamine hypothesis for depression, which is about deficiency in neurotransmitters/circuit that relays information from the orbitofrontal cortex to the thalamus, or issues related to serotonin in OCD/and for anorexia nervosa perhaps hormonal factors or factors around malnutrition.	**(20)**

Question Number	Indicative content	Mark
cont.	• Psychological explanations for depression/OCD/anorexia nervosa are, for depression, issues around social factors such as work issues or social support. For OCD, issues exist around stress and life events /and issues such as a tendency towards depression or OCD, or to perfectionism for anorexia nervosa. **Depression** • Although there is a well-established biochemical theory of brain chemical imbalance for depression, cognitive explanations are also strongly favoured. **OCD** • There is a strong theory of conditioning being involved in OCD. **Anorexia nervosa** • SLT is strongly involved in the development of eating disorders, as are cognitive causes, but there is also a suggestion of a genetic element. **AO3** **Biological evidence in favour of biological causes of schizophrenia, for example dopamine.** • Paranoia in drug users where dopamine levels are kept too high supports the role of dopamine. • Also, effectiveness of drugs that reduce the availability of dopamine supports its role as implicated in the disorder. • The positive correlation between schizophrenia and dopamine is consistent and, according to Seeman (2006), without exception. **Evaluation of biological evidence** • Excess dopamine can be measured only after onset, which means that the high levels of dopamine may be an effect rather than a cause. • Although antipsychotic drugs reduce dopamine availability in a very short time, the effect on symptoms takes several weeks to appear, suggesting other factors are involved.	

Question Number	Indicative content	Mark
cont.	**Evidence of non-biological causes of schizophrenia, for example social causation.** • Research by for example, Dohrenwend et al (1992), showed the incidence of schizophrenia in low-income groups is significantly greater than in higher-income groups. • One possibility is that low-income families are exposed to more risk factors such as infection levels and stress. • Evidence of the level of schizophrenia in immigrant groups provides evidence as they are often in a low-income situation in the host country, compared to the same groups in their home countries where schizophrenia is lower. **Evaluation of non-biological evidence** • Since Dohrenwend et al.'s research, subsequent studies have questioned a causal link, despite the correlation between income and incidence of schizophrenia. • However, there is still uncertainty whether such features are diagnostic, as individuals who do not have schizophrenia are not screened. **Other disorders** • Compare the evidence for or against a biological explanation of these other disorders compared to that of schizophrenia. • OCD is treated effectively by psychological therapies such as CBT. • Anorexia shows that family therapy is effective also cognitive therapies. • Depression treatment uses several effective drugs, but cognitive therapy also has an effective track history. • Conclusions can be that in the other mental disorders it can be argued that there is more evidence for causes other than biological ones than for schizophrenia, though the opposite conclusion can be drawn if evidence is used to support it. **Look for other reasonable marking points, including alternative appropriate psychological evidence.**	

Level	Mark	Descriptor
AO1 (8 marks), AO3 (12 marks) **Candidates must demonstrate a greater emphasis on evaluation/conclusion vs knowledge and understanding in their answer. Knowledge & understanding is capped at maximum 8 marks.**		
Level 0	0	No rewardable material.
Level 1	1–4 marks	Demonstrates isolated elements of knowledge and understanding. (AO1) A conclusion may be presented, but will be generic and the supporting evidence will be limited. Limited attempt to address the question. (AO3)
Level 2	5–8 marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Candidates will produce statements with some development in the form of mostly accurate and relevant factual material, leading to a superficial conclusion being made. (AO3)
Level 3	9–12 marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning. Leading to a conclusion being presented. Candidates will demonstrate a grasp of competing arguments but evaluation may be imbalanced. (AO3)
Level 4	13–16 marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical evaluation, containing logical chains of reasoning throughout. Demonstrates an awareness of competing arguments, presenting a balanced conclusion. (AO3)
Level 5	17–20 marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical evaluation, containing logical chains of reasoning throughout. Demonstrates an awareness of competing arguments and presents a balanced response, leading to an effective nuanced and balanced conclusion. (AO3)

Q10.

Question Number	Indicative Content	Mark
(a)	**AO2 (4 marks)** Up to 4 marks for the description of the symptoms of schizophrenia. For example • Tanya may experience hallucinations, which may be where she hears something that is not there (1) such as if she hears voices telling her she is useless (1). She may be delusional, where she believes something that is not true (1). Tanya may have poor motivation which may affect her ability to keep a job (1). **Answers must relate to the scenario.** **Generic answers score 0 marks.** **Look for other reasonable marking points.**	**(4)**

Question Number	Indicative Content	Mark
(b)	**AO3 (4 marks)** 1 mark per explicit comparison. The answer must include at least one similarity **and** one difference otherwise max 3 marks. For example: Neurotransmitters/biological and cognitive explanation. • Both the biological and cognitive explanations state that increased dopamine can cause positive symptoms such as hallucinations (1). However, the cognitive explanation says that it is when trying to make sense of these hallucinations that other symptoms such as distrust of others occur, whilst the biological approach does not look beyond biological causes of all the symptoms (1). Frith says that schizophrenia is caused by the inability to recognise internal thoughts as coming from ourselves whereas the biological approach says schizophrenia is due to increased dopamine (1). Both explanations have provided treatments for schizophrenia, the biological approach anti-psychotic drugs, and the cognitive approach through CBT (1). **Look for other reasonable marking points.**	**(4)**

Q11.

Question Number	Answer	Mark
(a)	**AO1 (4 marks)** Up to four marks for a description of Rosenhan's (1973) results. For example: • Rosenhan found that 11 out of the 12 hospitals admitted the pseudopatients with a diagnosis of schizophrenia (1). The average time a pseudo patient stayed in hospital was 19 days, it ranged from 7 to 52 days (1). In three cases the pseudo patients writing behaviour was seen as part of their pathological behaviour by nurses (1). In his second experiment he found that 41 patients were said to be pseudo patients by at least one member of staff (1). **Look for other reasonable marking points.**	**(4)**

Question Number	Answer	Mark
(b)	**AO1 (1 mark), AO3 (1 mark)** One mark for identification of a strength (AO1). One mark for justification of the strength (AO3). For example: • Rosenhan used quantitative, objective data in the form of number of days spent in the hospital (1), this means that other researchers could conduct a similar study and compare the results to see if they are similar to test the reliability of Rosenhan's results on newer versions of DSM (1). **Look for other reasonable marking points.**	**(2)**

Question Number	Answer	Mark
(c)	**AO1 (1 mark), AO3 (1 mark)** One mark for identification of an improvement (AO1). One mark for justification of the improvement (AO3). For example: • Rosenhan could have used a range of hospitals across all of America rather than just the east and west coast (1) which would have shown that the results were representative of all states within America and how they treat patients in mental institutions (1). **Look for other reasonable marking points.**	**(2)**

Q12.

Question Number	Indicative content	Mark
	AO1 (4 marks), AO3 (4 marks) **AO1** • Longitudinal research investigates the same participants with mental health over a long period of time, often months or years. • A longitudinal design can collect data in various ways, such as observations of those with mental health as well as interviewing them over time. • The same tools for data collection will be used throughout various points in the study e.g. Vallentine et al. (2010) took three measures of ward placement. • Longitudinal research can collect quantitative data such as measurements on the Beck depression inventory or qualitative data over a period of time. **AO3** • As they take place over a long period of time the development of the mental health issue can be tracked which can give more valid data than cross sectional studies. • As the same participants are studied over a period of time participant variables such as the effect of their home life on their mental health are controlled for, increasing reliability. • As the participants and researchers would be in regular contact, the researchers may become too emotionally involved with the participants which may lead bias towards how a mental disorder is progressing. • Participants with severe mental illness may drop out of the study if it is over a long period of time so the sample may become biased towards a specific severity of mental ill health. **Look for other reasonable marking points.**	**(8)**

Level	Mark	Descriptor
AO1 (4 marks), AO3 (4 marks) Candidates must demonstrate an equal emphasis between knowledge and understanding vs evaluation/conclusion in their answer.		
	0	No rewardable material.
Level 1	1-2 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) A conclusion may be presented, but will be generic and the supporting evidence will be limited. Limited attempt to address the question. (AO3)
Level 2	3-4 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Candidates will produce statements with some development in the form of mostly accurate and relevant factual material, leading to a superficial conclusion being made. (AO3)
Level 3	5-6 Marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning leading to a conclusion being presented. Candidates will demonstrate a grasp of competing arguments but evaluation may be imbalanced. (AO3)
Level 4	7-8 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical evaluation, containing logical chains of reasoning throughout. Demonstrates an awareness of competing arguments, presenting a balanced conclusion. (AO3)

Q13.

Question Number	Answer	Mark
	AO1 (4 marks), AO2 (4 marks) **AO1** • Case studies use a variety of research methods to gather a lot of detailed data. • Case studies focus on one individual or a small group of people, usually due to unique circumstances. • Case studies can use secondary and primary data, or can compare the individual throughout the length of the case study. • Case studies use triangulation to compare the results from the various methods used to check the results of each method for consistency. **AO2** • George could use interviews to gather information about his patient's thought processes and experiment to compare his ability at different problem solving tasks. • George would focus his research on his patient and not include other people at this time, as the case is unusual. • George can compare his observations of the patient's behaviour with the observations in his notes from the previous doctor to build up a picture of the patient over time. • George could compare the interview comments from the patient about their thought processes with the patient's performance on problem solving tasks to see if they support each other. **Look for other reasonable marking points.**	**(8)**

Level	Mark	Descriptor
AO1 (4 marks), AO2 (4 marks) **Candidates must demonstrate an equal emphasis between knowledge and understanding vs application in their answer.**		
	0	No rewardable material
Level 1	1–2 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) Provides little or no reference to relevant evidence from the context (scientific ideas, processes, techniques and procedures). (AO2)
Level 2	3–4 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Discussion is partially developed, but is imbalanced or superficial occasionally supported through the application of relevant evidence from the context (scientific ideas, processes, techniques and procedures). (AO2)
Level 3	5–6 Marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning. Candidates will demonstrate a grasp of competing arguments but discussion may be imbalanced or contain superficial material supported by applying relevant evidence from the context (scientific ideas, processes, techniques and procedures (AO2)
Level 4	7–8 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical balanced discussion, containing logical chains of reasoning. Demonstrates a thorough awareness of competing arguments supported throughout by sustained application of relevant evidence from the context (scientific ideas, processes, techniques or procedures). (AO2)

Q14.

Question Number	Indicative Content	Mark
	AO1 (8 marks), AO3 (12 marks) **E.g. Anorexia Nervosa.** **AO1** • Cognitive behavioural therapy can be used to treat anorexia nervosa and focuses on the thoughts and behaviours associated with the disorder. • It is usually carried out on a one to one basis with the therapist and the client over around 20 sessions or more if needed. • At the beginning of the treatment the client will be told the facts about their disorder, such as the effects on their body. • They will be told what the treatment entails so that they understand the process and feel part of the treatment. • The therapist will spend some sessions focussing on the reasons why the client has anorexia, looking at factors such as their body image. • The therapist will look at any rules the client has about food, and the thought processes involved in these rules. • Towards the end of the cognitive behavioural therapy the sessions may look at the client's thought processes to try and avoid the client relapsing in the future. • The client and therapist may also create a plan, that both agree on, to help stop the client from going back to their old eating habits.	**(20)**
	AO3 • If the client is not willing to engage in the therapy from the beginning and is not motivated to change their eating habits, then the therapy will not be effective. • Pike et al. (2003) found that cognitive behavioural therapy was more effective than counselling for those who had anorexia nervosa, with a lower relapse rate. • Brown et al. (2013) found that the early therapeutic alliance between the therapist and the client did not affect completing cognitive behavioural therapy for anorexia nervosa, but that the therapeutic alliance at the middle of the treatment did. • Cognitive behavioural therapy does look at factors that affect anorexia nervosa so may be more effective than drug treatment which just aims to control the symptoms. • Zipfel et al. (2013) found that enhanced cognitive behavioural therapy was no more effective in weight gain compared to a focal psychodynamic therapy, so either treatment is effective. • Cognitive behavioural therapy can give the clients the ability to monitor and challenge their thought processes, so it can be used by the client in the long term, if they have any future issues. • It can be time consuming for the client, as they have to attend sessions at least once a week, as well as do homework outside the sessions.	

- Cognitive behavioural therapy can be used on outpatients, so the person with anorexia nervosa can carry out their daily lives, such as carry on working, which may be more convenient for them.
- Cognitive behavioural therapy focuses on current maladaptive thought processes so it does not look at other reasons for the development of anorexia nervosa, such as issues from childhood.
- Cognitive behavioural therapy can be quicker than other therapies such as psychoanalysis, which is important as the client may become very ill from the side effects of anorexia nervosa if it is not treated quickly.
- CBT can be carried out in group sessions, so it may be cheaper than other therapies which require one to one intervention.
- CBT requires the patient to be committed to the therapy, which may not be the case for people with anorexia as they may not think they need therapy.

E.g. Obsessive-compulsive disorder.

AO1

- In cognitive behavioural therapy the therapist will first look at the obsessive thoughts and compulsive behaviours of the client to understand what drives their behaviour.
- The therapist aims to challenge these thoughts by asking the client what makes the thoughts cause anxiety.
- The obsessive thoughts will also be tested to see if they are actually true, in the hope that this will reduce the anxiety caused by the thoughts.
- The clients may be asked to think about what would happen if they did not do a certain behaviour, such as checking, and these would be discussed to see what the most likely outcome would be.
- If the client avoids doing certain things due to their compulsion, such as eat in restaurants the therapist may use behavioural experiments to show what does actually happen in these situations.
- Clients may be asked to do certain tasks that trigger their anxiety outside of the sessions with the aim of them reducing their anxiety the more they carry out the tasks.
- Clients may also be given more adaptive thoughts to practise when carrying out tasks that make them anxious, such as 'I will not get ill if I only wash my hands once'.
- The client measures their anxiety levels throughout the sessions and also the homework, and to take notice of reductions to anxiety in different situations.

AO3

- March et al. (2004) found that cognitive behavioural therapy on its own, or combined with a drug treatment, was more effective in treating OCD in children and adolescents than a drug treatment on its own.
- March et al. (2004) found that the best treatment for OCD was a combination of CBT and sertraline, suggesting that CBT on its own is not as effective.

- Cognitive behavioural therapy for OCD does not have any physical side effects, unlike drug therapy so can be seen as better for the client.
- It may not be effective for everybody, such as those who have more complicated mental health issues, as they may not be able to engage with the treatment and so may not change their behaviour.
- Sadri et al. (2017) found that CBT did reduce perfectionism and other symptoms for OCD in children, however this difference was not significant.
- Cognitive behavioural therapy focuses on thought processes, so it does not look at other reasons for the development of OCD, such as classical conditioning.
- CBT can be more cost effective than other therapies such as psychoanalysis, as it can be done in group sessions and takes less time.
- Abramowitz et al. (2005) found that cognitive behavioural therapy was just as effective in the treatment of OCD as exposure therapies.
- It can be time consuming for the client, as they have to attend sessions at least once a week, as well as do homework outside the sessions.
- Cognitive behavioural therapy is available free of charge on the NHS in the United Kingdom so may be more accessible to clients than other treatments which they may have to pay for.
- Cognitive behavioural therapy can give the clients the ability to monitor and challenge their thought processes, so it can be used by the client in the long term, if they find their compulsive behaviour is returning.
- If accessed through the NHS sessions may be limited in number, and so CBT may not be effective in treating OCD.

E.g. Unipolar depression.

AO1

- Cognitive behavioural therapy for clients with depression often lasts for 6 to 12 sessions on the NHS, with the clients receiving one or two sessions a week.
- It aims to challenge the client's maladaptive thoughts that have led to the depression.
- At the beginning of the treatment clients may be told how their thought patterns lead to their depression and behaviours.
- The therapist listens to the client's core beliefs about themselves to understand what the client is thinking and the processes involved.
- Clients may be taught how to notice when they are thinking maladaptive thoughts that lead to their depression.
- The therapist will help the client work through some more adaptive thoughts for given situations, which should reduce their depression.
- The client may be taught how to focus on how shouting at a child does not make them a bad parent, just a parent who may be tired at that point in time.
- Clients may be given homework to do outside the sessions, such as carry out a task, which will hopefully also challenge their negative thoughts.

	AO3 • Williams et al. (2013) found that CBM-I combined with iCBT significantly reduced the symptoms of unipolar depression on all the measures they used. • People with unipolar depression may not have the energy or motivation to engage with cognitive behavioural therapy, so it may not be useful without anti-depressants to start with. • Ebert et al. (2015) in a review of 7 studies found that computer based CBT was effective for treating depression in children and adolescents • Shallcross et al. (2015) found that a mindfulness based cognitive behavioural treatment was no more effective at preventing relapse in clients with depression than an active control condition. • Cognitive behavioural therapy does not have physical side effects, unlike the use of anti-depressants, so can be considered more ethical. • Cognitive behavioural therapy focuses on current maladaptive thought processes, so ignores other factors that may have caused the depression, such as a traumatic childhood. • Cognitive behavioural therapy aims to give the client the tools they need to reduce their depression so the client can use these tools in the future if further life events may lead to depression. • Johnsen and Friberg (2015) carried out a meta-analysis and found that CBT was not as effective in the treatment of depression now as it was in the 1970s when it was first used. • CBT can be more cost effective than other therapies such as psychoanalysis, as it can be done in group sessions or on the computer. • If the causes of depression are due to neurotransmitters, then cognitive behavioural therapy will not treat the depression, and anti-depressant medication would be more effective. • CBT is available on the NHS, so can be accessed by any patient, unlike other therapies which may only be accessed by those who can afford them. • CBT requires the patient to be able to express themselves, which patients with unipolar depression may not be able to do effectively. **Look for other reasonable marking points.**	

Level	Mark	Descriptor
AO1 (8 marks), AO3 (12 marks) Candidates must demonstrate a greater emphasis on evaluation/conclusion vs knowledge and understanding in their answer. Knowledge & understanding is capped at maximum 8 marks		
	0	No rewardable material.
Level 1	1–4 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) A conclusion may be presented, but will be generic and the supporting evidence will be limited. Limited attempt to address the question. (AO3)
Level 2	5–8 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Candidates will produce statements with some development in the form of mostly accurate and relevant factual material, leading to a superficial conclusion being made. (AO3)
Level 3	9–12 Marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning leading to a conclusion being presented. Candidates will demonstrate a grasp of competing arguments but evaluation may be imbalanced. (AO3)
Level 4	13–16 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical evaluation, containing logical chains of reasoning throughout. Demonstrates an awareness of competing arguments, presenting a balanced conclusion. (AO3)
Level 5	17–20 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical evaluation, containing logical chains of reasoning throughout. Demonstrates an awareness of competing arguments and presents a balanced response, leading to an effective nuanced and balanced conclusion. (AO3)

Q15.

Question Number	Indicative Content	Mark
	AO1 (4 marks), AO3 (4 marks) **Read the candidate response and apply the appropriate level.** **AO1** • A biological treatment is anti-psychotic drugs which aim to change the chemistry in the brain. • They block dopamine receptors so minimising the effect of dopamine. • A patient could take the anti-psychotics in syrup or tablet form. • If patients forget to take them then medical practitioners could inject the anti-psychotics. **AO3** • Anti-psychotics allow patients to stay in society rather than become institutionalised. • Emsley (2008) found 84% of patients on anti-psychotics had at least 50% reduction in symptoms if they were given early enough. • Anti-psychotics have serious side effects such as a decrease in motivation so schizophrenics may prefer not to take them. • Rosa et al (2005) found only 50% of patients complied with taking their anti-psychotics. **Look for other reasonable marking points.**	**(8)**

Level	Mark	Descriptor
Candidates must demonstrate an equal emphasis between knowledge and understanding vs evaluation/conclusion in their answer.		
	0	No rewardable material.
Level 1	1-2 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) A conclusion may be presented, but will be generic and the supporting evidence will be limited. Limited attempt to address the question. (AO3)
Level 2	3-4 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Candidates will produce statements with some development in the form of mostly accurate and relevant factual material, leading to a superficial conclusion being made. (AO3)
Level 3	5-6 Marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning, leading to a conclusion being presented. Candidates will demonstrate a grasp of competing arguments but evaluation may be imbalanced. (AO3)
Level 4	7-8 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical evaluation, containing logical chains of reasoning throughout. Demonstrates an awareness of competing arguments, presenting a balanced conclusion. (AO3)

Mark Scheme

Q1.

Question Number	Answer	Mark
(a)	**AO2 (3 marks)** Up to three marks for a description in relation to the scenario. For example: • Vihaan may decide to use research articles on the psychological therapy from a specific date, such as in the past five years (1). Vihaan should decide which mental disorders, such as schizophrenia, PTSD and bipolar disorder, he wants to research before he starts his meta-analysis (1). Once Vihaan has gathered the research articles, he should combine the results and analyse them to see how effective the psychological therapy is (1). **Look for other reasonable marking points.** **Generic answers score 0 marks.** **Answers must relate to the scenario.**	**(3)**

Question Number	Answer	Mark
(b)	**AO3 (2 marks)** One mark per explicit comparison. The answer must include at least one similarity **and** one difference otherwise max. one mark. For example: • Primary data is collected by the researcher such as treatment for schizophrenia whilst secondary data has already been collected by other researchers (1). Both primary and secondary data can be quantitative for example the number of hallucinations after treatment and can be analysed using statistical tests (1). **Look for other reasonable marking points.**	**(2)**

Q2.

Question Number	Answer	Mark
(a)	**AO2 (2 marks)** Up to two marks for a non-directional (two-tailed) alternate hypothesis. For example: • There will be a difference in the ability to complete domestic tasks as scored out of 32 between the two different mental disorders (2). • There will be a difference in the ability to complete domestic tasks between the different types of disorder (1). **Answers must relate to the scenario.** **Look for other reasonable marking points.** **Generic answers score 0 marks.**	**(2)**

Question Number	Answer	Mark
(b)	**AO2 (4 marks)** One mark for squaring the values of the domestic tasks score minus the mean (20.8) for each score, $(x - \bar{x})^2$ **8.2^2, -8.8^2, 4.2^2, -2.8^2, -0.8^2** One mark for calculating the sum of these values = **170.8** One mark for dividing this by 4 (n-1) = **42.7** One mark for calculating the square root = **6.5** to one decimal place	**(4)**

Q3.

Question Number	Answer	Mark
(a)	**AO1 (3 marks)** One mark for each statement For example anorexia nervosa: • A restriction in the amount of food eaten in order to reduce the amount of calories consumed (1). • Carrying out behaviours to stop weight gain such as excessive exercising (1). • An extreme fear of gaining weight (1). For example obsessive-compulsive disorder: • The obsessions cause anxiety or distress if the patient tries to ignore them (1). • Compulsive behaviour, such as excessively washing the hands, is carried out for more than an hour a day (1). • Intrusive repetitive thoughts about the obsession (1). For example unipolar depression: • The patient has lost interest or pleasure in activities for at least two weeks (1). • Sleeping patterns change, the patient may find it hard to sleep, or may sleep for longer periods of time (1). • A feeling of hopelessness that nothing will get better in the future (1). **Look for other reasonable marking points.**	**(3)**

Question Number	Answer	Mark
(b)	**AO1 (2 marks), AO3 (2 marks)** One mark for identification of each strength/weakness (AO1) One mark for justification of each strength/weakness (AO3) For example: Anorexia nervosa-genetic factors Strength: • Scott-Van Zeeland et al. (2013) concluded there was an association between the EPHX2 gene and anorexia (1) suggesting genes do play a role in the development of anorexia so giving the explanation validity (1). Weakness: • Research on twins has found a higher concordance rate for anorexia than in the general population but the concordance rate has never been found at 100% (1) therefore genetic factors cannot be the only explanation for anorexia, other factors must also be involved (1). Obsessive-compulsive-disorder brain structure	**(4)**
	Strength: • The use of scanning techniques, such as fMRI scans, gives data about the brain differences of those suffering with OCD compared to those who don't suffer from OCD (1) this gives objective data showing there are brain differences between the two groups increasing the reliability of the data used to support the explanation (1). Weakness: • The cognitive explanation would argue that OCD is caused by patients' biased thinking rather than by differences in brain functioning (1) as there is more than one possible explanation for OCD, this reduces the validity of the biological explanation (1). Unipolar depression-neurotransmitters Strength: • The fact that anti-depressants work for those who have unipolar depression is a strength (1) as it suggests that there must be an	

	imbalance in monoamines otherwise changing that imbalance would have no effect on the unipolar depression (1). Weakness: • It could be that unipolar depression causes a reduction in monoamines rather than a reduction in monoamines causing unipolar depression (1) as most research in humans has found a correlation between a reduction in monoamines and unipolar rather than a cause and effect (1). **Look for other reasonable marking points.**	

Q4.

Question Number	Indicative Content	Mark
	AO1 (4 marks), AO2 (4 marks) **AO1** • The original dopamine hypothesis states that excess dopamine in the brain causes symptoms of schizophrenia. • The revised dopamine hypothesis suggests excess dopamine in the mesolimbic areas through D2 receptors causes 'positive' symptoms such as hallucinations and delusions. • The revised dopamine hypothesis suggests a lack of dopamine in the prefrontal cortex through reduced D1 activation can lead to negative symptoms such as poverty of speech. • If glutamate production is blocked, then this can also cause schizophrenia as it then leads to an increase in the amount of dopamine in the brain. **AO2** • There are alternative explanations for schizophrenia such as the genetic explanation, which may apply to Hector as his mother also has schizophrenia. • Hector suffers from hallucinations as he can hear voices telling him what to do, therefore he may have excess dopamine in the mesolimbic system. • Hector may also have a lack of dopamine in his prefrontal cortex as he has disorganised thinking and cannot make connections between his thoughts. • Anti-psychotic drugs work by reducing the level of dopamine in the brain, so if the medication Hector's doctor gave him works, this suggests his schizophrenia may be caused by an excess of dopamine. **Look for other reasonable marking points.**	**(8)**

Level	Mark	Descriptor
AO1 (4 marks), AO2 (4 marks) Candidates must demonstrate an equal emphasis between knowledge and understanding vs application in their answer.		
	0	No rewardable material
Level 1	1–2 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) Provides little or no reference to relevant evidence from the context (scientific ideas, processes, techniques and procedures). (AO2)
Level 2	3–4 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Discussion is partially developed, but is imbalanced or superficial occasionally supported through the application of relevant evidence from the context (scientific ideas, processes, techniques and procedures). (AO2)
Level 3	5–6 Marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning. Candidates will demonstrate a grasp of competing arguments but discussion may be imbalanced or contain superficial material supported by applying relevant evidence from the context (scientific ideas, processes, techniques and procedures (AO2)
Level 4	7–8 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical balanced discussion, containing logical chains of reasoning. Demonstrates a thorough awareness of competing arguments supported throughout by sustained application of relevant evidence from the context (scientific ideas, processes, techniques or procedures). (AO2)

Q5.

Question Number	Indicative Content
	AO1 (8 marks), AO3 (12 marks) **E.g. Anorexia Nervosa.** **AO1** • When the ventromedial hypothalamus is stimulated by neurotransmitters it causes the person to feel full. • When the lateral hypothalamus is stimulated it causes the person to feel hungry and so they eat. • Therefore if the ventromedial hypothalamus is abnormally stimulated and the person feels full they won't eat. • Decreased levels of epinephrine has been associated with an anorexia. • Excess serotonin/norepinephrine in the ventromedial hypothalamus causes a person to stop eating. • The excess serotonin may cause increased anxiety in anorexics. • Elevated levels of opiods/endorphins/enkephalins are also associated with anorexia. • High levels of dopamine in anorexics are thought to stop them seeking pleasurable activities including eating. **AO3** • Lower levels of epinephrine in rats has led to them eating less and becoming more active showing the biological model is a good explanation. • However, the effects on humans may be different. • Studies have found that patients with anorexia have high levels of opioids in their spinal fluid so the biological explanation can explain anorexia nervosa. • However, it is not known if these high levels of opioids are a cause of anorexia or are because of the anorexia, therefore we cannot say that biology is the cause. • It has been found that the use of drugs to inhibit the opioids has led to anorexics gaining weight, therefore biology is a reason for anorexia nervosa. • Bailer et al (2005) found binge-purge anorexics have increased levels of serotonin. • Kaye (2011) found increased dopamine in anorexics led to anxiety rather than pleasure as in the non-anorexic control group. • It may not be due to neurotransmitters, but down to genes. • An alternative theory is that anorexia is caused because society values slimness equating it with being beautiful. • Or it could be due to cognitive factors. • Babarich et al (2014) found drugs that reduce anxiety do allow anorexics to gain weight. • Drug therapy does not address the reasons the person became anorexic in the first place.

	E.g. Obsessive-compulsive disorder. **AO1** • People who have OCD have a faulty connection between the orbitofrontal cortex and the thalamus. • The thalamus is over active due to the caudate nucleus not working

	properly. • The caudate nucleus manages repetitive behaviours, so an over active caudate nucleus increases repetitive behaviours. • This over activity is passed on to the orbitofrontal cortex. • The overactive orbitofrontal cortex causes the brain to become more alert to the environment. • This causes the person to carry out checking behaviours, a symptom of OCD. • Increased activity in the prefrontal cortex leads to the person becoming more fearful of acting appropriately in social situations. • This can lead to worries about being neat and tidy which can lead to the obsessive behaviour. **AO3** • Menzies et al (2007) found differences in grey matter in the orbitofrontal cortex in those suffering from OCD so brain differences can explain OCD. • McGuire et al found increased activity in the orbitofrontal cortex in sufferers of OCD when they were shown objects that would bring on their symptoms. • The use of anti-depressants to raise serotonin levels have been successful in treating OCD therefore if biology can remove the symptoms it can be deduced that biology caused the symptoms. • It can take up to 12 weeks for the anti-depressants to work, when they raise serotonin levels immediately suggesting it is not just biology that causes OCD. • Somoro et al (2007) found that antidepressants were more effective for sufferers of OCD than a placebo. • Kireev et al (2012) found other areas of the brain took over the functions of the anterior cingulate cortex. • Problems with the brain's processing may be a further symptom of OCD so it could be something other than biology that causes OCD. • Objective scanning techniques are used to measure the brain activity of those suffering OCD. • As OCD runs in families it could be due to genes that the brain functions differently. • The cognitive explanation says OCD is caused by self-doubt, the need for perfection and feelings of responsibility. • The biological explanation could explain why the thought patterns of those with OCD are different. • CBT is often used at the same time as drug therapy.

	E.g. Unipolar depression **AO1** • The monoamine hypothesis claims that low level of monoamines cause depression. • Monoamines consist of noradrenaline/norepinephrine, dopamine and serotonin. • Serotonin regulates the other neurotransmitters, so low levels of serotonin leads to lower levels of dopamine. • Low levels of serotonin cause erratic brain function and thought patterns. • Low levels of noradrenaline cause lower levels of alertness and arousal, symptoms of depression. • Low levels of dopamine cause lack of concentration and focus. • Low levels of monoamines could be caused because the reuptake

	mechanism recaptures the neurotransmitters before they reach the receptor sites. • Depressed people could release too much monoamine oxidase so the monoamines are broken down too fast. **AO3** • Drevets et al (1999) found reduced serotonin receptor-binding potential in unmedicated depressed patients. • Anti-depressants which increase the monoamines alleviate depression showing reduced monoamines are a possible cause. • Versiani et al (1999) found that patients who had noradrenaline reuptake inhibitors increased their mood if changing the biology can reduce symptoms there may be a biological cause. • However, the level of neurotransmitters rises very quickly once an individual is on medication. • Most evidence for abnormal levels of chemicals in the brain being a cause of depression is correlational so we cannot know if the change in chemicals cause unipolar depression or the other way round. • Bunney et al (1970) found that urinary levels of noradrenaline decreased during episodes of depression. • Bell et al (2001) depleted levels of tryptophan and found this caused a relapse of symptoms in depressed patients showing that changing the biology of a person can cause the symptoms of unipolar depression. • Delgado (2000) found that monoamine depletion did not make symptoms worse in depressed patients not taking medication. • Angoa-Perez (2014) found that mice without the gene for tryptophan did not show signs of depression. • There are alternative theories such as the cognitive therefore it is not the only explanation. • Delgado et al (1990) used a special diet to lower the level of tryptophan found that depressive symptoms returned for 67% of ppts. • Therefore whilst low levels of monoamines may be one cause of depression it cannot be said to be the only cause. **Look for other reasonable marking points.**

Level	Mark	Descriptor
Candidates must demonstrate a greater emphasis on assessment/conclusion vs knowledge and understanding in their answer. Knowledge & understanding is capped at maximum 8 marks.		
	0	No rewardable material.
Level 1	1–4 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) Generic assertions may be presented. Limited attempt to address the question. (AO3)
Level 2	5–8 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Candidates will produce statements with some development in the form of mostly accurate and relevant factual material, leading to a generic or superficial assessment being presented. (AO3)
Level 3	9–12 Marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning, leading to an assessment being presented which considers a range of factors. Candidates will demonstrate understanding of competing arguments/factors but unlikely to grasp their significance. The assessment leads to a judgement but this will be imbalanced. (AO3)
Level 4	13–16 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a logical assessment, containing logical chains of reasoning throughout which consider a range of factors. Demonstrates an understanding of competing arguments/factors but does not fully consider the significance of each which in turn leads to an imbalanced judgement being presented. (AO3)
Level 5	17–20 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical assessment, containing logical chains of reasoning throughout. Demonstrates a full understanding and awareness of the significance of competing arguments/factors leading to a balanced judgement being presented. (AO3)

Q6.

Question Number	Indicative content	Mark
	AO1 (8 marks), AO2 (4 marks), AO3 (8 marks) **AO1** • If the diagnosis of a mental health disorder is reliable then the same person will get the same diagnosis from two clinicians. • Intra rater reliability is when the same physician diagnoses the same patient with the same symptoms as having the same disorder at two different points in time. • A diagnosis is reliable if two different classification systems diagnose the same disorder for the same patient. • Validity refers to whether the classification systems accurately measure the mental disorder they say they are measuring. • If a classification system is not reliable then it cannot be a valid measurement of mental disorders. • When a diagnosis can be used to accurately predict the way the mental disorder will develop then it is said to have predictive validity. • If a psychiatrist diagnoses a mental disorder using a classification system and suggests a treatment based on that diagnosis that works the classification system can be said to be valid. • A valid classification system includes symptoms that are operationalised and measurable such as people with schizophrenia having to have two or more symptoms over a month.	**(20)**

	AO2 • Alba's symptoms such as losing interest in everyday life could apply to more than one mental health disorder so her diagnosis may not be reliable. • If a second psychiatrist agrees with the diagnosis of schizophrenia, then the diagnosis is reliable which should reassure Alba's mother. • By using two psychiatrists to diagnose Alba, if they have a reliable diagnosis of schizophrenia then it is more likely to be valid. • If the diagnosis of schizophrenia is valid then Alba's psychiatrist should be able to tell her mother how her schizophrenia will develop over the coming months. **AO3** • Morey (2019) found that DSM 5 was more reliable than DSM IV in diagnosing borderline	

	personality disorder so diagnosis of mental health disorders should be reliable if DSM V was used. • Diagnosis can be affected by what the patients tell the psychiatrist, so if a patient tells two psychiatrists different things this may affect the reliability of their diagnosis. • DSM 5 includes section 3 which advises cultural issues should be taken into account so these should have less of an effect on the reliability of diagnosis. • DSM 5 had a concordance rate of 0.46 for schizophrenia according to Reiger et al. (2013) so the reliability of diagnosis of mental health disorders such as schizophrenia may be questioned. • Rosenhan (1973) found that DSM was not valid as it could not tell that the pseudo patients did not have a mental health disorder so diagnosis of schizophrenia may not be valid. • Lee et al. (2006) found that the diagnosis of ADHD had concurrent validity when using DSM and other measures such as questionnaire data, so diagnosis may be valid. • Using two different classification systems to test for concurrent validity assumes one of the systems is valid when neither may be valid, so affecting the validity of diagnosis. • Stinchfield et al. (2015) found that DSM 5 led to fewer false negatives than DSM IV when diagnosing gambling disorder suggesting classification systems are valid. **Look for other reasonable marking points.**	

Level	Mark	Descriptor
AO1 (8 marks), AO2 (4 marks), AO3 (8 marks) Candidates must demonstrate an equal emphasis between knowledge and understanding vs judgement/conclusion in their answer. Application to the scenario is capped at maximum 4 marks.		
	0	No rewardable material.
Level 1	1–4 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) Provides little or no reference to relevant evidence from the context (scientific ideas, processes, techniques and procedures). (AO2) A judgement/decision may be presented, but will be generic and the supporting evidence will be limited. Limited attempt to address the question. (AO3)
Level 2	5–8 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Line(s) of argument occasionally supported through the application of relevant evidence from the context (scientific ideas, processes, techniques and procedures). (AO2) Candidates will produce statements with some development in the form of mostly accurate and relevant factual material leading to a judgement/decision being presented. Candidates will demonstrate a grasp of competing arguments but response may be imbalanced. (AO3)
Level 3	9–12 Marks	Demonstrates accurate knowledge and understanding. (AO1) Line(s) of argument supported by applying relevant evidence from the context (scientific ideas, processes, techniques and procedures). Might demonstrate the ability to integrate and synthesise relevant knowledge. (AO2) Displays a mostly developed and logical argument, containing mostly coherent chains of reasoning. Demonstrates an awareness of competing arguments, presenting a judgement/decision which may be imbalanced. (AO3)
Level 4	13–16 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Line(s) of argument supported throughout by sustained application of relevant evidence from the context (scientific ideas, processes, techniques or procedures). Demonstrates throughout the skills of integrating and synthesising relevant knowledge with consistent linkages to psychological concepts and/or ideas. (AO2) Displays a well-developed and logical argument, containing logical chains of reasoning throughout. Demonstrates an awareness of competing arguments and presents a balanced response, leading to a balanced judgement/decision. (AO3)
Level 5	17-20 Marks	Demonstrates accurate and comprehensive knowledge and understanding. (AO1) Line(s) of argument supported throughout by sustained application of relevant evidence from the context (scientific ideas, processes, techniques or procedures). Demonstrates consistently the skills of integrating and synthesising relevant knowledge with thorough, accurate linkages to psychological concepts and/or ideas. (AO2) Displays a well-developed and logical argument, containing logical chains of reasoning throughout. Demonstrates a full awareness of competing arguments and presents a fully balanced response, leading to an effective nuanced and balanced judgement/decision. (AO3)

Q7.

Question Number	Answer	Mark
(a)	**AO1 (4 marks)** Up to four marks for how a description of ICD is used for mental health For example: • The ICD is a diagnostic system that includes all diseases, physical and mental used by clinicians to diagnose service users (1). If the service user presents with a possible mental health disorder the clinician would use the section that focuses on mental and behavioural disorders (1). For each mental health disorder, it gives a clinician the main features and the symptoms needed to make a diagnosis (1), for example, the ICD 10 states that paranoid schizophrenia is dominated by relatively stable, paranoid delusions, often with hallucinations (1). **Look for other reasonable marking points.**	**(4)**

Question Number	Answer	Mark
(b)	**AO1 (1 mark), AO3 (1 mark)** One mark for identification of one strength (AO1). One mark for justification of one strength (AO3). For example: • Jakobsen et al. (2005) found there was good agreement in the diagnosis of schizophrenia between ICD 10 and other classification systems (1), showing that ICD 10 is reliable as it has consistent diagnoses with other classification systems (1). **Look for other reasonable marking points.**	**(2)**

Q8.

Question Number	Indicative Content	Mark
	AO1 (4 marks), AO3 (4 marks) **AO1** • In order to be valid a classification system must accurately diagnose a mental health disorder, and lead to the right treatment for the diagnosed mental health disorder. • If a classification system has concurrent validity then it should come up with the same diagnosis for the same symptoms at the same time as another classification system. • Predictive validity is when upon diagnosing a mental health disorder accurate predictions can be made about how the disorder will progress, and how it will respond to treatment. • To have a valid classification system then symptoms of a disorder have to be operationalised and measurable e.g. social withdrawal for schizophrenia. **AO3** • Rosenhan (1973) found that hospital staff could not accurately diagnose the fact that the pseudo-patients did not have a mental health disorder so the classification systems at the time were not valid. • Andrews et al. (1999) found that DSM IV and ICD had agreement rates for disorders such as depression, therefore it can be said that both systems have concurrent validity. • Powers et al. (2017) found that women who had suffered complex post traumatic disorder also had higher levels of alcohol and substance misuse as predicted by ICD 11, showing that ICD 11 does have good predictive validity. • Many mental health disorders are co-morbid so it may be hard for a clinician to accurately diagnose one disorder, therefore making the use of classification systems less valid as it is hard to operationalise the symptoms of one disorder. **Look for other reasonable marking points.**	**(8)**

Level	Mark	Descriptor
AO1 (4 marks), AO3 (4 marks) Candidates must demonstrate an equal emphasis between Knowledge and understanding vs assessment/conclusion in their answer.		
	0	No rewardable material.
Level 1	1–2 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) Generic assertions may be presented. Limited attempt to address the question. (AO3)
Level 2	3–4 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Candidates will produce statements with some development in the form of mostly accurate and relevant factual material, leading to a generic or superficial assessment being presented. (AO3)
Level 3	5–6 Marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning, leading to an assessment being presented which considers a range of factors. Candidates will demonstrate understanding of competing arguments/factors but unlikely to grasp their significance. The assessment leads to a judgement but this may be imbalanced. (AO3)
Level 4	7–8 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical assessment, containing logical chains of reasoning throughout. Demonstrates an awareness of the significance of competing arguments/factors leading to a balanced judgement being presented. (AO3)

Q9.

Question Number	Indicative content	Mark
	AO1 (4 marks), AO2 (4 marks) For example: Key question: Is the use of drugs an effective treatment for mental disorders? **AO1** • A lot of mental disorders are treated with drugs whilst the patients may be waiting for psychotherapy. • In 2018 over 70.9 million items were prescribed for mental disorders such as depression by the NHS in England. • Whilst prescriptions are not free the cost of anti-depressants to the NHS up to October in 2018 was £672.5 million. • The use of medication for mental disorders can keep people in work so that the government receives taxes and does not have to pay out some benefits. **AO2** • Drug treatments work by changing the levels of neurotransmitters in the brain to alleviate the symptoms of the mental disorder. • Drugs may reduce the level of the neurotransmitters in the brain, such as antipsychotics reducing the levels of dopamine. • When drugs are used to reduce the level of neurotransmitter, they may block the receptors so neurotransmitters such as dopamine cannot bind to the receptors. • Other drugs, such as anti-depressants increase the level of the neurotransmitter by stopping the reuptake of serotonin for example. **Look for other reasonable marking points.**	**(8)**

Level	Mark	Descriptor
AO1 (4 marks), AO2 (4 marks) Candidates must demonstrate an equal emphasis between knowledge and understanding vs application in their answer.		
	0	No rewardable material
Level 1	1–2 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) Provides little or no reference to relevant evidence from the context (scientific ideas, processes, techniques and procedures). (AO2)
Level 2	3–4 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Discussion is partially developed, but is imbalanced or superficial occasionally supported through the application of relevant evidence from the context (scientific ideas, processes, techniques and procedures). (AO2)
Level 3	5–6 Marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning. Candidates will demonstrate a grasp of competing arguments but discussion may be imbalanced or contain superficial material supported by applying relevant evidence from the context (scientific ideas, processes, techniques and procedures (AO2)
Level 4	7–8 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical balanced discussion, containing logical chains of reasoning. Demonstrates a thorough awareness of competing arguments supported throughout by sustained application of relevant evidence from the context (scientific ideas, processes, techniques or procedures). (AO2)

Q10.

Question Number	Answer	Mark
(a)	**AO1 (2 marks)** One mark for each statement of an aim. For example: • They aimed to see if neurotransmitters other than dopamine were implicated in causing schizophrenia (1). • They aimed to see what role glutamate has in causing schizophrenia (1). **Look for other reasonable marking points.**	**(2)**

Question Number	Answer	Mark
(b)	**AO1 (2 marks), AO3 (2 marks)** One mark for identification of each strength/weakness in relation to secondary data (AO1) One mark for justification of each strength/weakness (AO3) For example: Strength • If a mental health disorder is uncommon it may be hard to find enough patients to carry out research for primary data (1), so the use of secondary data allows a lot of different studies regarding the mental health disorder to be collated which may increase the diversity of the sample so increasing generalisability (1). Weakness • The secondary data collected may include studies that have used an old classification system such as DSM-III to diagnose the patients (1), therefore the results may not be true of updated classification systems and so may not be valid for mental health disorders at the present time (1). **Look for other reasonable marking points.**	**(4)**

Q11.

Question Number	Indicative Content	Mark
(a)	**AO2 (2 marks)** Up to two marks for an explanation of how Erik may obtain his sample. For example • Erik could use an opportunity sample (1) as he could use the patients on the ward at the time (1). **Answers must relate to the scenario.** **Generic answers score 0 marks.** **Look for other reasonable marking points.**	**(2)**

Question Number	Indicative Content	Mark
(b)	**AO2 (3 marks)** Up to three marks for a description of how Erik could collect primary data to record patients' behaviour. For example • Erik needs to decide if he is going to write down the behaviours displayed by the patients he sees or tally them (1). Erik can then set up video cameras to record the patients' behaviour (1). Erik may also sit down with a selection of patients and write down their experiences of being on a psychiatric ward (1). **Answers must relate to the scenario.** **Generic answers score 0 marks.** **Look for other reasonable marking points.**	**(3)**

Question Number	Indicative Content	Mark
(c)	**AO1 (2 mark), AO3 (2 marks)** One mark for identification of each strength/weakness up to a maximum of two marks (AO1) One mark for justification of each strength/weakness up to a maximum of two marks (AO3) For example • Cross-sectional studies are quicker to conduct than longitudinal studies (1) because they use a variety of participants at one point in time rather than waiting to follow them through their life (1). • One weakness is that the participants are different so they suffer from participant variables (1) which means the conclusions made could be due to individual differences between participants (1). **Look for other reasonable marking points.**	**(4)**

Q12.

Question Number	Indicative Content	Mark
	AO1 (4 marks), AO3 (4 marks) **AO1** • Different cultures have different attitudes to mental disorders and this can affect how mental disorders are diagnosed. • Some cultures have mental disorders that are specific to that culture such as amok in Malaysia. • Western cultures tend to see the mind and body as separate aspects of a person, but this is not true of other cultures. • There may also be issues with translation if the patient and psychiatrist speak a different language which can cause issues when diagnosing a mental disorder. **AO3** • Luhrmann et al. (2015) found that hearing voices was seen as a negative experience in America but a positive one in India, therefore this may change the way people react to others saying they can hear voices. • Lin (1996) found that when looking at the symptoms of schizophrenia, there were more similarities across different cultures than differences suggesting cultural differences would not lead to a difference in diagnosis. • Andrade et al. (2012) found that high social deprivation was associated with substance use disorders in São Paulo, showing that economic background can affect individual mental disorders. • Psychiatrists can over-compensate for cultural differences and not diagnose a mental disorder when in fact there was one, so cultural differences may not have caused any difference in the disorders just in the diagnosis. **Look for other reasonable marking points.**	**(8)**

Level	Mark	Descriptor
AO1 (4 marks), AO3 (4 marks) Candidates must demonstrate an equal emphasis between Knowledge and understanding vs assessment/conclusion in their answer.		
	0	No rewardable material.
Level 1	1–2 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) Generic assertions may be presented. Limited attempt to address the question. (AO3)
Level 2	3–4 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Candidates will produce statements with some development in the form of mostly accurate and relevant factual material, leading to a generic or superficial assessment being presented. (AO3)
Level 3	5–6 Marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning, leading to an assessment being presented which considers a range of factors. Candidates will demonstrate understanding of competing arguments/factors but unlikely to grasp their significance. The assessment leads to a judgement but this may be imbalanced. (AO3)
Level 4	7–8 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical assessment, containing logical chains of reasoning throughout. Demonstrates an awareness of the significance of competing arguments/factors leading to a balanced judgement being presented. (AO3)

Q13.

Question Number	Indicative Content
	AO1 (4 marks), AO2 (4 marks) **AO1** • Deviance is when behaviour is considered abnormal in society. • Deviance may change across time and place as social norms change. • Behaviour that interferes with a person's everyday life is one way to diagnose mental disorders. • Dysfunction can affect their working life. **AO2** • Alice's talking to herself in public can be said to be deviant. • Alice has stopped going out with friends, dysfunction. • The fact that Alice only eats white food may be classed as deviant, as most people eat food regardless of the colour. • Only going out at night time is dysfunctional as it limits the activities that Alice can participate in. **Look for other reasonable marking points.**

Candidates must demonstrate an equal emphasis between knowledge and understanding vs application in their answer. Read the candidate response and apply the appropriate level.		
Level	**Mark**	**Descriptor**
	0	No rewardable material
Level 1	1–2 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) Provides little or no reference to relevant evidence from the context (scientific ideas, processes, techniques and procedures). (AO2)
Level 2	3–4 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Discussion is partially developed, but is imbalanced or superficial occasionally supported through the application of relevant evidence from the context (scientific ideas, processes, techniques and procedures). (AO2)
Level 3	5–6 Marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning. Candidates will demonstrate a grasp of competing arguments but discussion may be imbalanced or contain superficial material supported by applying relevant evidence from the context (scientific ideas, processes, techniques and procedures (AO2)
Level 4	7–8 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical balanced discussion, containing logical chains of reasoning. Demonstrates a thorough awareness of competing arguments supported throughout by sustained application of relevant evidence from the context (scientific ideas, processes, techniques or procedures). (AO2)

Q14.

Question Number	Indicative Content	Mark
	AO2 (4 marks) Up to four marks for explanation of the reliability of diagnosis. For example: • If Philip's friend was diagnosed using DSMV and was diagnosed with schizophrenia then the reliability is 0.46 (Regier et al. 2013) so he is right to be worried about the diagnosis (1). However if he had PTSD/binge eating disorder then the reliability is good to very good (APA 2012) (1). If DSM-IV was used and Philip's friend has a mood/anxiety disorder then the reliability would be good to excellent so Philip does not have to worry (1). If ICD 10 was used Philip is right to be concerned because there was found to be only a 36% agreement for eating disorders (Nicholls et al. 2000). (1) **Answers must relate to the scenario.** **Generic answers score 0 marks.** **Look for other reasonable marking points.**	**(4)**

Q15.

Question Number	Answer	Mark
(a)	**AO2 (3 marks)** Up to three marks for description of distress and danger in relation to the scenario. For example: • Victoria is distressed as she is upset by the lack of money and the effect this has on her children (1). The fact that she is upset because she has to stay in the house also suggests her behaviour is causing her to be distressed (1). Victoria's fear of birds can be seen to be causing her danger as she may be involved in an accident when crossing the road (1). **Answers must relate to the scenario.** **Look for other reasonable marking points.**	**(3)**

Question Number	Answer	Mark
(b)	**AO1 (1 mark), AO3 (1 mark)** One mark for identification of a weakness. (AO1) One mark for justification of the weakness. (AO3) For example: • Some behaviours may be considered dangerous but not a symptom of a mental disorder by some people, such as car racing (1) therefore using danger may be subjective because it depends on the psychiatrist's perception of why the person is taking part in something that is dangerous (1). **Look for other reasonable marking points.**	**(2)**

Q16.

Question Number	Answer	Mark
(a)	**AO2 (1 mark)** One mark for a definition of dysfunction in relation to the scenario. For example: • Dysfunction occurs when a mental disorder means that Lena cannot successfully carry out everyday life as she cannot go to work (1). **Look for other reasonable marking points.** **Generic answers score 0 marks.** **Answers must relate to the scenario.**	**(1)**

Question Number	Answer	Mark
(b)	**AO2 (2 marks), AO3 (2 marks)** One mark for identification of each weakness in relation to scenario (AO2). One mark for justification of each weakness (AO3). For example: • There is subjectivity when deciding what is dysfunctional so Lena's psychiatrist will base the diagnosis on their own professional opinion (1), which means that not going to work may be classified as dysfunctional by one clinician and not another, affecting reliability of Lena's diagnosis (1). • Using dysfunction on its own does not take into account the reasons for the dysfunction such as not going out with friends (1), so Lena may not go out with friends as they may now have different interests, this does not mean she has a mental disorder (1). **Look for other reasonable marking points.** **Generic answers score 0 marks.** **Answers must relate to the scenario.**	**(4)**

Q17.

Question Number	Indicative content	Mark
	AO1 (4 marks), AO3 (4 marks),	**(8)**
	AO1 **Psychological treatments** For depression/OCD/anorexia nervosa could include: • Humanistic therapies such as person-centred counselling, which look at how the core of the person (their organismic self) can be at odds with the self-concept given by conditions of worth from others. • Cognitive therapies, which focus on maladaptive thinking and how these can be readjusted through counselling. • Cognitive behavioural therapies, which involve focusing on thinking, feeling and behaviour and the consequences of this to see if there can be intervention in one of these areas (e.g. tools such as the downward arrow technique are used to uncover core beliefs). • Deconditioning therapies can be used with OCD.	
	Biological treatments For depression/OCD/anorexia nervosa could include: • Drug therapy such as antidepressants, which alter neurotransmitter functioning, can be used for OCD as well as for depression. Also relevant for anorexia nervosa (depression and anxiety often go with anorexia nervosa so medication can be prescribed). Tricyclic antidepressants can be used for moderate or severe depression, but drugs might not be used for mild depression. • Anorexia nervosa could include controlling diet. • Exercise is sometimes offered as a treatment for depression. • ECT is used for some conditions, in particular depression. **AO3** **Biological treatments** • If the cause of the mental disorder is a biochemical imbalance, then the use of drugs to address this should be effective. Many drug treatments, e.g. use of antidepressants, exist that are effective and this is evidence in support.	

Question Number	Indicative content	Mark
cont.	• The fact that these drugs are in use shows that they have passed clinical trials and must have been shown to be effective. • Medication is considered widely effective for certain conditions (such as moderate to severe depression, OCD where SSRIs can work and anorexia nervosa if either depression or OCD are features of that person's presenting issues (which they can be)). • However, medication has unpleasant side effects, which can mean the patient does not continue with the medication and, therefore, it is not effective even though the belief is that the drugs would treat the biochemical imbalance. • The Department of Health and Human Services (1991) found that for depression 50% of people improved on medication and 30% improved with a placebo (so there is more at work here, as thinking they were taking medication helped them to improve or they improved to an extent over time anyway). It might be that there is another factor, or it might be that there is still a change in biochemical balance, but this is brought about by psychological effects rather than biological ones.	

	Psychological treatments • The effective use of cognitive therapy in conditions such as depression supports psychologists' beliefs that behaviours are affected by psychological factors, e.g. early childhood experiences. Anorexia nervosa can be treated by cognitive analytic therapy (CAT), which is about reformulation of view of the past, for example. There have also been studies showing effectiveness of CBT. • Freud argues that early childhood experiences can cause adult mental health disorders such as in depression where sufferers spend their energy on repressing anger at a loved one who died, resulting in a lack of energy. Accepting that the loved one has died, through psychological treatment (such as CBT), reduces the symptoms of depression in many cases, which supports Freud's ideas.	

Question Number	Indicative content	Mark
cont.	• Freud also argued that anorexia nervosa can have a psychological element such as being about a wish not to get pregnant, and focusing on that can improve the outcome for clients, again supporting Freud's ideas. • However talking through the reasons for anxiety does not always have a positive impact on mood. Some people have therapy for many years and never see an improvement in their levels of anxiety, suggesting that psychological factors are not the cause. • The use of deconditioning to treat OCD shows that it might have been caused by conditioning events in the past. **Combined treatments** • For anorexia nervosa drug treatment is not considered successful unless treating depression or OCD as well – if drugs are offered, they tend to be SSRIs. • Drug therapy is considered effective for moderate to severe depression; milder depression might be more effectively treated by self-help, exercise or counselling, according to the NHS website. This supports the idea that both biological and psychological factors might be involved in causing mental disorders.	

	Issues with the evidence exist, such as: • Clinical trials tend to randomly allocate people to either the treatment condition or a waiting condition (where the people will get the treatment just later) to look for the effectiveness of treatment, so there are good controls and evidence is considered scientific if it shows effectiveness. • However, individual differences can affect the effectiveness of treatment and such randomised control trials might not highlight individual differences, so general effectiveness might mask individual lack of effectiveness. • Meta-analysis can be useful as it looks at results from a lot of studies about the effectiveness of a particular treatment, and if findings match (such that the studies find the treatment to be effective – CBT is evidenced based in this way), then there is reliability in the findings. **Look for other appropriate marking points, related to chosen disorder.**	

Level	Mark	Descriptor
AO1 (4 marks), AO3 (4 marks) **Candidates must demonstrate an equal emphasis between knowledge and understanding vs assessment/conclusion in their answer.**		
Level 0	0	No rewardable material.
Level 1	1–2 marks	Demonstrates isolated elements of knowledge and understanding. (AO1) Generic assertions may be presented. Limited attempt to address the question. (AO3)
Level 2	3–4 marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Candidates will produce statements with some development in the form of mostly accurate and relevant factual material, leading to a generic or superficial assessment being presented. (AO3)
Level 3	5–6 marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning. Leading to an assessment being presented which considers a range of factors. Candidates will demonstrate understanding of competing arguments/factors but unlikely to grasp their significance. The assessment leads to a judgement but this may be imbalanced. (AO3)
Level 4	7–8 marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical assessment, containing logical chains of reasoning throughout. Demonstrates an awareness of the significance of competing arguments/factors leading to a balanced judgement being presented. (AO3)

Q18.

Question Number	Indicative Content
	AO1 (8 marks), AO3 (12 marks) e.g. Williams et al (2013) **AO1** • Williams et al aimed to find out if patients a combination of cognitive bias modification with internet based CBT would be effective in treating depression. • Applicants for the study completed an online questionnaire about symptoms, and those who had the criteria for major depressive disorder were included in the sample. • The experimental group did a CBMI treatment and then did a post treatment questionnaire. • The experimental group then had a 10 week course of iCBT the others were on a waiting list. • 65% of ppts. who had the combined treatment had a significant reduction in their depression • They concluded combined intervention is effective in improving depression and anxiety symptoms in patients with depression.
	AO3 • They used internet recruitment so were able to gain participants from all over Australia. • The ppts. completed online screening questionnaires using established measures such as PHQ9 increasing validity. • The online screening questionnaires were compared with a diagnostic telephone call if they got through increasing reliability. • Participants were given the right to withdraw as at different stages of the study participants dropped out. • Other mental disorders such as substance misuse as well as depression were excluded from the sample so the researchers can be sure that other mental disorders did not affect the results of the study. • The study was approved by the human rights ethics committee of St. Vincent's hospital in Sydney. • As a follow up was not carried out it is not known if the improvements would last long term. • The final questionnaire was self-report and not diagnostic so may be subject to demand characteristics. • The CBM-I may have increased motivation to complete ICBT and it is the increase in the completion of iCBT that caused the improvements not the CBM-I. • Due to the restrictive inclusion criteria it lacks generalisability to those with depression such as those over 65. • Of the 69 ppts. who started the treatment only 44 completed so it may not have worked for the 25 who withdrew which would affect the validity of the results. • Those who agreed to take part had a positive approach to internet based intervention so it may not be effective for those who favour face to face intervention. **Look for other reasonable marking points.**

Candidates must demonstrate a greater emphasis on evaluation/conclusion vs knowledge and understanding in their answer. Knowledge & understanding is capped at maximum 8 marks		
Level	**Mark**	**Descriptor**
	0	No rewardable material.
Level 1	1–4 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) A conclusion may be presented, but will be generic and the supporting evidence will be limited. Limited attempt to address the question. (AO3)
Level 2	5–8 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Candidates will produce statements with some development in the form of mostly accurate and relevant factual material, leading to a superficial conclusion being made. (AO3)
Level 3	9–12 Marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning, leading to a conclusion being presented. Candidates will demonstrate a grasp of competing arguments but evaluation may be imbalanced. (AO3)
Level 4	13–16 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a developed and logical evaluation, containing logical chains of reasoning throughout. Demonstrates an awareness of competing arguments, presenting a balanced conclusion. (AO3)
Level 5	17–20 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical evaluation, containing logical chains of reasoning throughout. Demonstrates an awareness of competing arguments and presents a balanced response, leading to an effective nuanced and balanced conclusion. (AO3)

Q19.

Question Number	Indicative Content
	AO1 (4 marks), AO3 (4 marks) **AO1** • The interviews can be in the form of open questions • They can be in the form of closed questions • Interviews can be semi structured where the psychiatrist has a set of questions that have to be asked, but they can add questions to follow what they see as important themes. • Interviews can be unstructured where the psychiatrist decides what questions to ask based on the patient's previous answers. **AO3** • If the questions are open then psychiatrists may need to decide on important themes and this can be subjective. • Open questions allow the patients to express how they are feeling fully which can lead to further insight into their problems. • If an unstructured interview is used there is a lack of reliability as no patient will have exactly the same questions. • If the interviews are recoded, e.g. Valentine et al (2010) then others can play back those recording to check the interpretation of the results so increasing reliability. **Look for other reasonable marking points.**

Candidates must demonstrate an equal emphasis between knowledge and understanding vs evaluation/conclusion in their answer. Read the candidate response and apply the appropriate level.		
Level	**Mark**	**Descriptor**
	0	No rewardable material.
Level 1	1-2 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) A conclusion may be presented, but will be generic and the supporting evidence will be limited. Limited attempt to address the question. (AO3)
Level 2	3-4 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Candidates will produce statements with some development in the form of mostly accurate and relevant factual material, leading to a superficial conclusion being made. (AO3)
Level 3	5-6 Marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning. leading to a conclusion being presented. Candidates will demonstrate a grasp of competing arguments but evaluation may be imbalanced. (AO3)
Level 4	7-8 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical evaluation, containing logical chains of reasoning throughout. Demonstrates an awareness of competing arguments, presenting a balanced conclusion. (AO3)

Q20.

Question Number	Indicative content	Mark
	AO1 (4 marks), AO3 (4 marks) **AO1** • We aimed to find out if attitudes to mental health had changed over the past five years. • We found a current magazine article online and an online article about mental health from a newspaper that was published five years ago. • We created a tally chart of words that had positive meanings, such as "inspiring", and words that had negative meanings such as "aggressive". • We found that both the newspaper and magazine article had positive attitudes to mental health and there was no difference in the modern and older article.	**(8)**
	AO3 • Because both articles focussed on well-known celebrities our content analysis may not have met our aim of looking at attitudes to mental health in general. • As both articles can be found online other people could carry out the same content analysis to see if they get similar results in regards to attitudes to mental health. • When we cross checked our results we found that there was little difference in the totals of positive and negative words so we had good inter-rater reliability. • Over the past few years there has been more of a focus on mental health, so if we had used an article from over fifteen years ago we might have found that attitudes to mental health had changed, reducing the credibility of our practical. **Answers must relate to their practical investigation from clinical psychology**	

Level	Mark	Descriptor
AO1 (4 marks), AO3 (4 marks) Candidates must demonstrate an equal emphasis between knowledge and understanding vs evaluation/conclusion in their answer.		
	0	No rewardable material.
Level 1	1-2 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) A conclusion may be presented, but will be generic and the supporting evidence will be limited. Limited attempt to address the question. (AO3)
Level 2	3-4 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Candidates will produce statements with some development in the form of mostly accurate and relevant factual material, leading to a superficial conclusion being made. (AO3)
Level 3	5-6 Marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning leading to a conclusion being presented. Candidates will demonstrate a grasp of competing arguments but evaluation may be imbalanced. (AO3)
Level 4	7-8 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical evaluation, containing logical chains of reasoning throughout. Demonstrates an awareness of competing arguments, presenting a balanced conclusion. (AO3)