SimplyPsychology

Mark scheme — A-level Psychology 7182/1

Paper 1 · Section D focus paper · Clinical Psychology and Mental Health

A-level topic mock · 2026 · Maximum mark: 48

Clinical Psychology and Mental Health is A-level only (AQA spec 4.1.4) — it is not assessed at AS. Indicative content is not exhaustive; credit any other valid points. Levels-based questions (Q10 and Q11) require holistic judgement using the descriptors. Specialist vocabulary (deviation from ideal mental health, deviation from social/cultural norms, failure to function adequately, statistical infrequency, two-process model, systematic desensitisation, flooding, Beck's negative triad, Ellis's ABC model, CBT, SSRIs) follows AQA's 2025 *Subject specific vocabulary*.

D Clinical Psychology and Mental Health

0 1

AO1 · 1 mark · multiple choice

> *Which one of the following best describes statistical infrequency as a definition of abnormality?*

Answer: C — Behaviour that occurs very rarely in the general population.

A = deviation from social/cultural norms; B = failure to function adequately; D = deviation from ideal mental health.

0 2

AO1 · 1 mark · multiple choice

> *Which one of the following is a cognitive characteristic of depression?*

Answer: C — Selective attention to negative information.

A = behavioural (activity level); B = emotional (mood); D = behavioural (sleep change).

0 3

AO1 · 1 mark multiple choice

> *Which one of the following best describes Beck's negative triad?*

Answer: B — Three negative thoughts about: the self, the world and the future.

A describes Ellis's irrational beliefs (mustabatory thinking); C describes the biological approach; D is not a real construct.

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0 4

AO1 · 3 marks short answer

> *Outline deviation from ideal mental health as a definition of abnormality. Refer to at least one of Jahoda's (1958) criteria in your answer.*

Marks for this question: AO1 = 3 marks

- **2 marks** for an accurate outline: abnormality is defined as the **absence** of criteria for psychological wellbeing. **Jahoda (1958)** proposed six criteria; failing to meet several of these makes the person abnormal.
- **1 mark** for one of Jahoda's six criteria: *positive self-attitudes / good self-esteem; self-actualisation; autonomy / independence; accurate perception of reality; environmental mastery (coping with everyday demands); resistance to stress.*

1 mark only if the definition is given but no criterion identified, or vice versa.

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0 5

AO2 · 4 marks application

> *Identify three characteristics of OCD shown by Marcus. State whether each is behavioural, emotional or cognitive.*

Marks for this question: AO2 = 4 marks

- **1 mark** for each of three correctly identified characteristics linked to the stem.
- **1 mark** for accurate classification (behavioural / emotional / cognitive) of those characteristics.

Indicative content (credit any three):

- **Behavioural — compulsions**: "two hours every morning washing his hands"; "washing routine"; carries out the ritual repeatedly. The hand-washing is a textbook compulsion.
- **Behavioural — avoidance** (if mentioned): credit a candidate who identifies this from the stem, though it is implicit rather than explicit.
- **Emotional — anxiety**: "anxiety only fades after he has washed his hands several times"; the obsessions cause severe and persistent anxiety.
- **Cognitive — obsessions**: "repeatedly worries that he might have touched something dirty" — the recurrent intrusive thoughts about contamination.
- **Cognitive — insight / awareness of irrationality**: "he knows his fears about contamination are exaggerated, but he cannot stop himself" — the cognitive recognition that the behaviour is excessive.

Top-band answers will use the technical terms (obsessions, compulsions, anxiety, insight) AND correctly classify the domain.

0 6

AO2 · 4 marks application

> *Use the two-process model to explain how Hannah's phobia of dogs was acquired and how it is being maintained.*

Marks for this question: AO2 = 4 marks

- **4 marks** — Clear, coherent explanation engaging effectively with both halves of the stem (acquisition AND maintenance); uses accurate behaviourist terminology.
- **3 marks** — Both halves covered but one less developed.
- **2 marks** — One mechanism explained accurately and linked to the stem.
- **1 mark** — Brief, partial answer.

Indicative content:

- **Acquisition — classical conditioning**:
  - *Before conditioning*: dog bite (UCS) → fear and pain (UCR). The dog itself (NS) initially produced no fear response.
  - *During conditioning*: the dog (NS) was paired with being bitten (UCS).
  - *After conditioning*: dogs (CS) now produce fear (CR) — even without being bitten again. Hannah's bite at age 6 conditioned the dog–fear association.
- **Maintenance — operant conditioning (negative reinforcement)**:
  - Hannah's avoidance behaviour (crossing the road; refusing to visit homes with dogs) **removes** the anxiety-provoking stimulus.
  - The "sense of relief…which lasts for several hours" is the reward — anxiety reduction **negatively reinforces** avoidance.
  - Every successful avoidance strengthens the avoidance habit, so the phobia persists 19 years later despite no further negative experiences with dogs.

*Top-band answers will explicitly use the terms **classical conditioning, UCS/CS/CR, negative reinforcement** AND link to specific features of Hannah's case (the original bite, the avoidance behaviour, the relief).*

0 7

AO1 · 4 marks short answer

> *Outline the procedure of systematic desensitisation (SD) as a treatment for phobias. Refer to the use of relaxation and the hierarchy in your answer.*

Marks for this question: AO1 = 4 marks

- **1 mark** for identifying SD as a behavioural treatment (Wolpe 1958) based on **counter-conditioning** / **reciprocal inhibition** — fear and relaxation cannot coexist.
- **1 mark** for the **relaxation training** stage: the therapist teaches deep-relaxation techniques (progressive muscle relaxation, controlled breathing, visualisation).
- **1 mark** for the **anxiety hierarchy**: therapist and client construct a graded list of feared situations from least to most anxiety-provoking (e.g. cartoon picture of a spider → being in the same room as a spider).
- **1 mark** for the **graded exposure** step: client works up the hierarchy, practising relaxation at each level until anxiety subsides. Only when one level is mastered does the client progress to the next.

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0 8

AO1 · 3 marks short answer

> *Outline the neural explanation of OCD.*

Marks for this question: AO1 = 3 marks

- **1–2 marks** for accurate description of neurotransmitter abnormalities:
  - **Low serotonin** levels are implicated in OCD — disrupting mood regulation. Indirect evidence: SSRIs (which increase serotonin) reduce OCD symptoms.
  - Some research also implicates **elevated dopamine** in compulsive behaviour.
- **1–2 marks** for accurate description of brain structures (the "worry circuit"):
  - The **orbitofrontal cortex (OFC)** sends "worry" signals (e.g. "your hands are dirty").
  - The **caudate nucleus** (in the basal ganglia) normally suppresses minor worry signals — in OCD it is under-active.
  - The **thalamus** relays signals back to the OFC, creating a self-reinforcing loop.
  - Brain-imaging studies (PET, fMRI) consistently show increased activity in this circuit in OCD patients.

Award up to 3 marks total across the two areas. Full marks possible from either area alone if sufficiently detailed.

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0 9

AO1 · 3 marks short answer

> *Briefly outline drug therapy as a treatment for OCD. Refer to SSRIs in your answer.*

Marks for this question: AO1 = 3 marks

- **1 mark** for identifying SSRIs (Selective Serotonin Reuptake Inhibitors), e.g. **fluoxetine (Prozac)**, as the first-line drug treatment for OCD.
- **1–2 marks** for accurate mechanism: SSRIs **block the reuptake** of serotonin into the presynaptic neuron. More serotonin remains in the synaptic gap, available to bind to postsynaptic receptors and normalise the disrupted serotonin system in the worry circuit.
- **1 mark** for additional detail, e.g. typical dose (20 mg fluoxetine daily); effects take 3–4 months for full benefit; often combined with CBT; alternatives include tricyclics (clomipramine) and SNRIs (venlafaxine) when SSRIs fail.

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AO1, AO3 · 8 marks 8-mark

> *Discuss flooding as a treatment for phobias. Refer to at least one strength and one limitation in your answer.*

Marks for this question: AO1 = 4 marks, AO3 = 4 marks

Level	Marks	Descriptor
4	7–8	Knowledge of flooding is accurate and well detailed. Evaluation includes at least one strength and one limitation, both effectively explained. Clear, coherent, focused; specialist terminology used effectively.
3	5–6	Knowledge generally accurate; evaluation mostly effective but limited in places. Reasonable structure.
2	3–4	Some accurate knowledge. Evaluation limited; mainly descriptive.
1	1–2	Knowledge limited or muddled. Little or no evaluation.
0	0	No relevant content.

Indicative AO1 content:

- **What flooding is**: immediate, prolonged exposure to the phobic stimulus with no opportunity to escape (typically one long session, 2–3 hours). Can be *in vivo* (real-life) or *in vitro* (imagined, virtual reality).
- **Mechanism**: prevents the person from avoiding the stimulus, so avoidance cannot be negatively reinforced. The fear response eventually extinguishes — the person learns the feared stimulus is harmless because nothing bad happens during prolonged exposure (**extinction**).
- **Informed consent** is essential — the experience is highly distressing.

Indicative AO3 content (any combination of strengths/limitations):

- **Strength — cost-effective and fast**: a single 2–3 hour session achieves what SD takes weeks to deliver, making flooding considerably cheaper for the NHS and providing rapid relief.
- **Strength — effective for specific phobias**: Ougrin (2011) compared flooding with cognitive therapies and found flooding equally or more effective in the short term, particularly for circumscribed specific phobias.
- **Limitation — traumatic for patients**: patients experience intense fear during exposure; high attrition (dropout) rates are well documented. If patients leave before extinction occurs, the partial avoidance may strengthen the phobia.
- **Limitation — ethical concerns**: the procedure causes significant short-term distress, requiring careful informed consent and clinical safeguards. Some patients view flooding as too aversive to attempt.
- **Limitation — less effective for complex phobias**: flooding works best for specific phobias with concrete, identifiable triggers. It is much less effective for social phobia or agoraphobia, which involve cognitive and interpersonal elements not addressed by extinction alone.

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AO1, AO2, AO3 · 16 marks 16-mark

> *Discuss the cognitive approach to explaining and treating depression. Refer to the case of Priya as part of your discussion.*

Marks for this question: AO1 = 6 marks, AO2 = 4 marks, AO3 = 6 marks

Level	Marks	Descriptor
4	13–16	Knowledge of both explanation (Beck/Ellis) and treatment (CBT) is accurate and generally well detailed. Application to Priya is effective and integrated across the stem. Discussion is thorough with strong evaluation. Clear, coherent and focused.
3	9–12	Knowledge evident with some accuracy. Application mostly effective. Discussion mostly effective but limited in places.
2	5–8	Some accurate knowledge of explanation OR treatment. Application limited. Discussion superficial.
1	1–4	Knowledge limited; little or no application or discussion.
0	0	No relevant content.

Indicative AO1 content — must cover both *explanation* and *treatment*:

- **Beck's cognitive theory (1967)**:
  - **The negative triad**: simultaneous negative views of the SELF, the WORLD and the FUTURE.
  - **Negative self-schemas**: developed through early experiences; filter all incoming information negatively.
  - **Cognitive biases** (faulty information processing): selective abstraction, overgeneralisation, magnification, minimisation, personalisation.
- **Ellis's ABC model (1962)**:
  - **A** — Activating event.
  - **B** — Belief (rational or irrational; "mustabatory thinking").
  - **C** — Consequence (healthy or unhealthy emotional/behavioural response).
  - Later extended to **D** — Disputing irrational beliefs, and **E** — Effects.
- **Cognitive Behaviour Therapy (CBT)**:
  - Identifying and challenging negative/irrational thoughts (Ellis's **disputes**: logical, empirical, pragmatic).
  - **Behavioural activation** — scheduling pleasurable and achievement-oriented activities to counteract withdrawal and provide evidence against negative beliefs.
  - Homework: thought diaries, behavioural experiments.
  - Active, directive, time-limited (typically 6–20 weeks).

Indicative AO2 content — engagement with Priya:

- **Negative triad**: "I'm a complete failure" = negative view of the SELF. "I'll never amount to anything" = negative view of the FUTURE. Withdrawing from friends and lectures suggests a negative view of the WORLD. Priya's thinking maps directly onto all three components of Beck's triad.
- **Ellis's ABC**: *A* = failing the maths exam; *B* = irrational belief "I'm a complete failure / I'll never amount to anything" (overgeneralisation + magnification — one exam ≠ a complete failure); *C* = depression, withdrawal from lectures and friends, loss of interest in violin.
- **CBT — disputing**: the therapist will challenge Priya's belief "I'm a complete failure" using logical disputes ("Does one failed exam logically mean you fail at everything?"), empirical disputes ("What evidence do you have that you'll never amount to anything?") and pragmatic disputes ("How useful is this belief?").
- **CBT — behavioural activation**: "gradually re-introduce activities she used to enjoy" is exactly the behavioural-activation element. Re-introducing the violin and seeing friends will provide positive experiences that disprove her negative beliefs about the self and future.
- **Negative self-schema**: Priya's reaction (one failed exam → "complete failure") suggests a pre-existing negative self-schema is filtering the event into a catastrophic interpretation.

Indicative AO3 content:

- **Strength — research support for Beck (Grazioli and Terry 2000)**: 65 pregnant women assessed for cognitive vulnerability before birth — those with high cognitive vulnerability were more likely to develop post-natal depression. Negative thinking *precedes* depression, supporting Beck's causal claim.
- **Strength — effectiveness of CBT (March et al. 2007)**: 327 adolescents with depression — 81% improved on CBT alone, 81% on antidepressants alone, 86% on combined treatment. CBT is at least as effective as drugs.
- **Strength — economic value**: NICE recommends CBT as a first-line treatment for moderate depression; the IAPT programme has applied this at national scale, reducing reliance on long-term medication and improving return-to-work rates.
- **Limitation — direction of causality (Lewinsohn 1973)**: negative thinking may be a *consequence* rather than a *cause* of depression. Cognitive explanations claim a causal direction that cannot be established from correlational data alone.
- **Limitation — doesn't explain all depression**: Beck's theory does not explain severe biological symptoms (extreme fatigue, sleep disruption, somatic pain) or psychotic features (delusions of worthlessness).
- **Limitation — Ellis better fits reactive depression**: the ABC model assumes an identifiable activating event. Endogenous depression (no clear trigger) is harder to explain with this framework.
- **Limitation — socially sensitive / blames the patient**: cognitive explanations risk attributing depression to the patient's own faulty thinking, ignoring genuine life circumstances (poverty, abuse, chronic illness) where negative thoughts may be rational responses. CBT therapists need to balance challenging irrational thinking with validating real distress.
- **Limitation — CBT not suitable for severe depression**: CBT requires active engagement, motivation and cognitive functioning. Severely depressed patients may need drug treatment first to stabilise mood before engaging with CBT.

Top-band answers will (1) describe both Beck and Ellis as cognitive explanations AND CBT as the cognitive treatment; (2) explicitly map Priya's three quoted thoughts onto Beck's triad (self/future) and label her exam failure as Ellis's "A"; (3)

connect "challenging negative thoughts" to disputing and "gradually re-introduce activities" to behavioural activation; (4) include at least two pieces of evaluative evidence (strengths and limitations) with named studies; and (5) reach a clear conclusion (typically that CBT is well-evidenced but works best combined with attention to biological and social factors).

END OF MARK SCHEME · Maximum mark: 48