4.4 Characteristics of OCD: Behavioural, Emotional and Cognitive

AQA 7182 · about 50 minutes · Write-in edition

Total Marks

Name: _____ Date: ____ / ____ / _____

At least four answers should be written in full sentences. Time guidance: 50 minutes for the whole pack.

1 Outline two emotional characteristics of OCD, giving a brief example for each in the context of a person with contamination fears.

(Total for Question 1 is 2 marks)

2 Vignette: Yusuf checks the locks on his front door five times every evening, often returning from bed to check again. His partner calls it excessive but Yusuf feels enormous relief after checking. Which behavioural characteristic is illustrated and how does it function to reduce anxiety? Give two marks.

(Total for Question 2 is 3 marks)

3 Explain how the cognitive characteristic of hypervigilance to threat can increase emotional distress in someone with OCD. Give two linked points and one real-world implication.

(Total for Question 3 is 6 marks)

4 Outline two cognitive characteristics of OCD, describing how they affect thought processes.

(Total for Question 4 is 3 marks)

5 Vignette: Amelia refuses to touch doorknobs at work and asks a colleague to open doors for her. She spends at least 30 minutes each day cleaning her hands until they bleed. Identify the two behavioural characteristics of OCD shown and justify your answer using evidence from the vignette.

(Total for Question 5 is 3 marks)

6 Vignette: Priya feels overwhelming disgust when she thinks she has touched money. She reports intense shame and avoids handling cash, feeling guilty even though she knows there is no health risk. Identify the emotional characteristics shown and explain how they differ from normal worry.

(Total for Question 6 is 4 marks)

7 Explain one strength and one limitation of using vignette case studies to assess whether a behaviour reflects an OCD characteristic, with brief why-it-matters statements.

(Total for Question 7 is 4 marks)

8 Outline and briefly evaluate how avoidance as a behavioural characteristic of OCD can maintain the disorder. Refer to the consequence for anxiety to support your evaluation.

(Total for Question 8 is 6 marks)

9 Discuss, using examples, how behavioural, emotional and cognitive characteristics of OCD can interact in a single case to maintain the disorder. Your answer should combine knowledge of the characteristics with application to an imagined case.

(Total for Question 9 is 10 marks)

Mark scheme · 4.4 Characteristics of OCD: Behavioural, Emotional and Cognitive

Question 1

identifies high anxiety and distress, e.g. intense fear or panic when touching perceived contaminants	**B1**
identifies feelings of disgust or excessive guilt, e.g. feeling dirty or morally responsible even after cleaning	**B1**

Answer: High anxiety and distress when exposed to perceived contamination; feelings of disgust or excessive guilt even after cleaning.

Question 2

identifies repetitive checking compulsion as the behavioural characteristic	**B1**
explains that the checking reduces Yusuf's anxiety temporarily by providing reassurance	**A1**
explains that this reduction is short lived, maintaining the cycle of compulsion and obsession	**A1**

Answer: Repetitive checking compulsion: Yusuf repeatedly checks locks and feels temporary relief; this relief reduces anxiety short term but maintains the compulsion cycle.

Question 3

explains hypervigilance: heightened attention to perceived threats or potential contamination	**M1**
explains first link: constant scanning for threat increases perceived frequency of danger cues, raising anxiety levels	**A1**
explains second link: hypervigilance leads to more intrusive thoughts and triggers compulsive checking/avoidance	**M1**
explains consequence: increased compulsions and avoidance then increase distress and reduce functioning	**A1**
gives a brief real-world implication, e.g. hypervigilance may make tasks like shopping or socialising intolerably stressful	**M1**
explains why this matters, e.g. demonstrating clinical importance of addressing attention bias in therapy	**A1**

Answer: Hypervigilance means constantly scanning for threats, which makes danger cues seem more frequent and raises anxiety; it also provokes more intrusive thoughts and compulsive checking or avoidance, increasing distress and impairing daily functioning, so addressing attention bias is clinically important.

Question 4

identifies obsessive, intrusive thoughts that are recurrent and unwanted	**M1**
explains that these intrusions are experienced as uncontrollable and cause distress	**A1**
identifies hypervigilance to threat or excessive insight into the irrational nature of the obsessions	**B1**

Answer: Recurrent intrusive obsessive thoughts that are unwanted and distressing; hypervigilance to perceived threat and often awareness that the thoughts are excessive or irrational.

Question 5

identifies compulsive, repetitive behaviours (compulsions) such as excessive hand washing	**B1**
identifies avoidance behaviour, refusing to touch doorknobs and relying on others	**B1**
justifies with reference to time spent cleaning and physical harm (hands bleeding) and the explicit avoidance of triggers in the vignette	**A1**

Answer: Compulsive repetitive behaviours and avoidance: Amelia repeatedly washes her hands for long periods (compulsion) and avoids touching doorknobs (avoidance), shown by asking a colleague to open doors and by washing until her hands bleed.

Question 6

identifies feelings of disgust and intense anxiety/distress related to touching money	**B1**
identifies excessive guilt or shame despite knowing there is no health risk	**B1**
explains that these emotions are excessive compared with normal worry because they are disproportionate to the objective danger	**A1**
explains that avoidance and persistent guilt impair functioning, unlike everyday fleeting worry which does not cause marked avoidance	**A1**

Answer: Disgust and excessive guilt: Priya feels intense disgust and shame about touching money and avoids handling cash. These emotions are disproportionate to the actual risk and lead to avoidance and impairment, unlike normal worry which is usually brief and proportionate.

Question 7

states a strength, e.g. vignettes allow precise application of diagnostic features to behaviour	**M1**
explains why this matters, e.g. helps students practise applying definitions and distinguishing OCD from normal behaviour	**A1**
states a limitation, e.g. vignettes lack richness of clinical assessment and contextual detail	**M1**
explains why this matters, e.g. may lead to over- or under-diagnosis since real-life impairment, duration and comorbidity are not shown	**A1**

Answer: Strength: vignettes let you apply diagnostic features directly, useful for practising classification. Limitation: they lack clinical depth and context, risking misclassification because duration, severity and comorbidity are not apparent.

Question 8

outlines avoidance: avoiding situations or objects that trigger obsessions, e.g. avoiding public toilets or pets	**M1**
explains maintenance mechanism: avoidance prevents exposure and disconfirms feared outcomes, so anxiety is not relearned or reduced long term	**A1**
states an evaluative strength, e.g. avoidance explains why symptoms persist and links to behavioural theory of negative reinforcement	**M1**
explains why this matters, e.g. avoidance reduces immediate anxiety which reinforces the avoidance, maintaining OCD	**A1**
states an evaluative limitation, e.g. avoidance may reduce measurable distress but also leads to functional impairment and social withdrawal	**M1**
explains why this matters, e.g. treatment needs to address avoidance by exposure, so avoidance complicates clinical management	**A1**

Answer: Avoidance involves staying away from triggers, which prevents disconfirmation of the feared outcome and so maintains anxiety through negative reinforcement. This explains persistence of symptoms and is consistent with behavioural theory, but avoidance also causes functional impairment and makes treatment harder because exposure is needed to break the avoidance cycle.

Question 9

Level 4 Detailed and accurate knowledge of behavioural, emotional and cognitive characteristics is shown. Discussion is balanced and explains how the characteristics interact with clear application to the imagined case. Evaluation is well developed, considering maintenance mechanisms and clinical implications. Specialist terms used accurately.	**8-10**
Level 3 Good knowledge and some detail. Discussion explains interactions and applies to the case but may be less thorough. Evaluation is present but may be less developed. Answer is mostly clear.	**5-7**
Level 2 Some knowledge of characteristics but limited detail. Interaction and application are attempted but are superficial. Little evaluative content.	**3-4**
Level 1 Very limited content, simple or list-like, with little or no attempt to link characteristics or apply them.	**1-2**
Level 0 No creditable content.	**0**

Indicative content:

- AO1: Define key characteristics briefly: behavioural (compulsions, repetitive acts, avoidance), emotional (anxiety, distress, disgust, guilt), cognitive (intrusive obsessions, insight, hypervigilance, cognitive strategies).
- AO2: Imagined case example, e.g. 'Erin believes door handles are contaminated. She feels disgust and intense anxiety when entering shops, has intrusive thoughts about becoming ill, checks her hands repeatedly and avoids public places.' Use this to illustrate interaction: intrusive thoughts lead to anxiety, which leads to compulsive hand washing and avoidance, which then prevents disconfirmation and maintains intrusive thoughts.
- AO1/AO2: Show bidirectional links: cognitive hypervigilance increases noticing of 'dirt' cues, raising emotional disgust and triggering compulsive cleaning; compulsions reduce anxiety short term reinforcing behaviour; avoidance reduces opportunities to learn the fear is unfounded.
- AO3: Evaluate maintenance mechanisms: negative reinforcement (anxiety reduction) and cognitive bias (attention to threat) explain persistence. Clinical implication: CBT with exposure and response prevention targets the behavioural and cognitive cycle, illustrating how understanding interactions informs treatment.
- AO3: Consider individual differences and limitations: not all sufferers show all characteristics or same severity; cultural and situational factors influence which triggers emerge; caution that vignettes may oversimplify real clinical assessment.