UNIVERSITY OF CAMBRIDGE INTERNATIONAL EXAMINATIONS

GCE Advanced Level

MARK SCHEME for the May/June 2010 question paper

for the guidance of teachers

9698 PSYCHOLOGY

9698/32 Paper 32 (Specialist Choices), maximum raw mark 70

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UNIVERSITY of CAMBRIDGE
International Examinations

Section A

Q	Description	Marks
(a)	No answer or incorrect answer.	0
	Some understanding, but explanation brief and lacks clarity.	1
	Clear, accurate and explicit explanation of term.	2
	max mark	2
(b)	***Part (b)*** *could require one aspect in which case marks apply once.* ***Part (b)*** *could require two aspects in which case marks apply twice.*	
	No answer or incorrect answer.	0
	Answer anecdotal or of peripheral relevance only.	1
	Answer appropriate, some accuracy, brief.	2
	Answer appropriate, accurate with elaboration.	3
	max mark	3 or 6
(c)	***Part (c)*** *could require one aspect in which case marks apply once.* ***Part (c)*** *could require two aspects in which case marks apply twice.*	
	No answer or incorrect answer.	0
	Answer anecdotal or of peripheral relevance only.	1
	Answer appropriate, some accuracy, brief.	2
	Answer appropriate, accurate with elaboration.	3
	max mark	3 or 6
	Maximum mark for **Section A**	11

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Section B

Q	Description	marks
(a)	**KNOWLEDGE (1)** [Terminology and concepts]	
	Some appropriate concepts and theories are considered. An attempt is made to use psychological terminology appropriately.	1
	Range of appropriate concepts and theories are considered. The answer shows a confident use of psychological terminology.	2
	KNOWLEDGE (2) [Evidence]	
	Some basic evidence is described and/or it is of peripheral relevance only and/or it is predominantly anecdotal.	1
	Appropriate psychological evidence is accurately described but is limited in scope and detail.	2
	Appropriate psychological evidence is accurately described and is reasonably wide ranging and detailed.	3
	Appropriate psychological evidence is accurately described and is wide ranging and detailed.	4
	UNDERSTANDING [What the knowledge means]	
	Some understanding of appropriate concepts and/or evidence is discernible in the answer.	1
	The answer clearly identifies the meaning of the theory/evidence presented.	2
	Maximum mark for part **(a)**	8
(b)	**EVALUATION ISSUES** [Assessing quality of data]	
	General evaluative comment OR issue identified.	1
	Two instances of general evaluative comment OR one issue + evidence.	2
	Two (or more) issues are identified, explained and some appropriate evidence is used in support.	3
	Two (or more) issues with elaboration and illustrative evidence.	4
	ANALYSIS [Key points and valid generalisations]	
	Key points (of evidence/study) are identified for a given issue (or number of issues), but no valid generalisations/conclusions are made.	1
	Key points (of evidence/study) are identified for a given issue (or number of issues), and valid generalisations/conclusions are made.	2
	CROSS REFERENCING [Compare and contrast]	
	Two or more pieces of evidence are offered for a given issue but the relationship between them is not made explicit.	1
	Two or more pieces of evidence are offered for a given issue and the relationship between them (comparison or contrast) is explicit.	2
	ANALYSIS [Structure of answer]	
	The essay has a basic structure/organisation.	1
	Structure/organisation is sound and argument clear and coherent (includes issues, evidence, analysis and cross referencing).	2
	Maximum mark for part **(b)**	10

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(c)	**APPLICATION** [Applying to new situations and relating to theory/method]	
	A suggestion (to apply psychological knowledge to the assessment request) has been attempted.	1
	A suggestion (to apply psychological knowledge to the assessment request) has been applied effectively. One detailed or several applications considered.	2
	KNOWLEDGE (2) [Evidence]	
	Basic evidence is referred to but not developed and/or it is of peripheral relevance only and/or it is predominantly anecdotal.	1
	Appropriate psychological theory/evidence is explicitly applied.	2
	UNDERSTANDING [What the knowledge means]	
	Some understanding (of relationship between application and psychological knowledge) is evident in the answer OR there is clear understanding of the suggested application(s).	1
	The answer shows a clear understanding of the relationship between psychological knowledge and the suggested application AND there is clear understanding of the suggested application(s).	2
	Maximum mark for question part **(c)**	6
	Maximum mark for **Section B**	24

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PSYCHOLOGY AND EDUCATION

Section A

1 (a) Explain, in your own words, what is meant by the 'humanistic' approach to education. [2]

For the **humanistic approach** (e.g. Rogers, 1951) every individual is the centre of a continually changing world of experience. Four features are at the heart: **affect** (emphasis on thinking and feeling, not just information acquisition); **self concept** (children to be positive about themselves); **communication** (attention to positive human relationships) and **personal values** (recognition and development of positive values).
Any one these aspects (or other appropriate aspect) for 2 marks.

(b) Describe *two* ways in which the humanistic approach has been applied in education. [6]

- Maslow (1970) advocates **student-centred teaching**, where teachers are learning facilitators rather than didactic instructors
- Dennison (1969) advocates the **open classroom**
- Dunn & Griggs (1988) propose that each child has a **personal and unique learning style** and so traditional education should change radically, providing a 'staggering range of options'
- Johnson et al (1984) believe students see education to be competitive when it should be **co-operative**, involving circles of knowledge, learning together and student team learning

(c) Describe *one* difference between the humanistic approach and another approach to education. [3]

Any difference between humanistic and another approach e.g. cognitive and behaviourist acceptable. For 3 marks, both approaches must be mentioned.

2 (a) Explain, in your own words, what is meant by 'disruptive behaviour' in school. [2]

Typical: behaviour that proves unacceptable to the teacher (Fontana, 1995).

(b) Describe *one* type of disruptive behaviour. [3]

Major types are:
- **conduct** (e.g. distracting, attention-seeking, calling out, out-of-seat)
- **anxiety & withdrawal**
- **immaturity** and **verbal and physical aggression**
- **bullying**

Persistently disruptive children are often labelled as EBD (emotional & behavioural difficulties).

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(c) Describe *one* way in which disruptive behaviour may be prevented and one way in which it may be corrected. [6]

There are a number of **preventative** strategies:

- care for children: know their names and other relevant information
- give legitimate praise (Marland, 1975)
- use humour
- establish 'with-it-ness' (Kounin, 1970)
- shape the learning environment
- maintain classroom activity (Stodolsky, 1984 lists 17 activities!)
- maintain democratic procedures (e.g. Webster, 1968)
- set rules
- Fontana (1981) lists 16 common-sense aspects of classroom management

There are a number of **corrective** strategies: the modification of the behaviour of children that has already happened (rather than trying to prevent behaviour from happening). Alternatively, responding to the child who has misbehaved in a way that will lessen the likelihood of that misbehaviour recurring.

- **Reasoning** – presenting to the child reasons for not engaging in deviant behaviour and/or reasons for engaging in alternative behaviour. Parke (1974) found reference to actual object more successful in younger children for example. Is this preferable to punishment?
- **Behaviour modification techniques** –

a **Positive reinforcement**. Can be intrinsic (internal) and so not directly under teacher control (but teacher could create situation leading to satisfaction, etc) and extrinsic (external): attention, praise, stars, etc. Bijou and Sturges (1959) classify extrinsic reinforcers into five categories: consumables, manipulatables, visual & auditory stimuli, social stimuli and tokens. O'Leary & Becker (1967) used tokens to eliminate deviant responses with much success, although others (Kazdin & Bootzin, 1972) did not. Premack (1965) outlines the 'Premack Principle', where children behaving appropriately engage in a reinforcing activity – one that the child enjoys.
Michael (1967) describes 7 principles one should be wary of when attempting to control behaviour through consequences.

b **Modelling**. Punishing one student may inhibit the same behaviour in another; rewarding one student may lead to copying behaviour by another.

c **Punishment**. Can be (1) presentation of unpleasant consequences such as facial gestures, reprimands, detention, time-out, physical punishment, etc. (2) removal of pleasant consequences. Many studies illustrate all these variations. For example Bratner & Doherty (1983) distinguish three types of time out: isolation, exclusion and non-exclusion.

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Section B

3 (a) Describe what psychologists have discovered about special educational needs. [8]

One type may be children who are **gifted**; a second may be children at the other end of the scale who have **learning difficulties or disabilities**. Typically: SEN is where a child has a significantly greater difficulty in learning than most children of the same age, or a child has a disability that needs different educational facilities from those that schools generally provide. SEN includes any type of learning abnormality and most typically this would include **autism**, **dyslexia** (and related difficulties e.g. **dyscalculia**), **ADHD** (attention deficit with/without hyperactivity) or any other learning abnormality. The focus could be on the suggested causes of such abnormalities or could be on the problems a typical child may have in a classroom.

- **Dyslexia** this accounts for 80% of all learning difficulties. Features: Letter reversal or rotation – the letter 'd' may be shown as 'b' or 'p'; Missing syllables - 'famel' for 'family'; transposition of letters – 'brid' for 'bird'; Problems keeping place when reading; problems pronouncing unfamiliar words
- **Dyscalculia** affects mathematical performance affecting around 1% of the population.
- **Dyspraxia** involves problems with fine and/or gross motor co-ordination leading to problems with physical activities in subjects like science and physical education
- **Dysgraphia** is a disorder of writing which can involve the physical aspects of writing, e.g. pencil grip and angle. It might also involve poor spelling and difficulties transferring thoughts to paper

Special needs can include giftedness. A definition of giftedness is problematic. Some believe it is **exceptional performance** on an intelligence test. Others believe giftedness is a more **specific ability** such as in sport or music. Bridges (1969) and Tempest (1974) outline **signs of giftedness**, Bridges with seven (read at 3 years of age; enormous energy) and Tempest with nine (likely to be highly competitive; able to deal with abstract problems). Hitchfield (1973) found teachers were not good at identifying giftedness and Torrance (1970) claims 'society is savage toward creative thinkers'. Ogilvie (Schools Council Report on gifted children in primary schools, 1973) suggested provision was inadequate.

(b) Evaluate what psychologists have discovered about special educational needs. [10]

NOTE: any evaluative point can receive credit; the hints are for guidance only.

- the strengths and weaknesses of psychological perspectives
- the implications for teachers
- whether theory applies in practice
- comparing/contrasting differing approaches
- the methods used to gather data
- competing explanations
- the implications for children

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(c) Giving reasons for your answer, suggest how one specific learning difficulty or disability may be overcome. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.

- Focus on different types of schooling: mainstream (integration) or specialist (segregation). Advantages and disadvantages of both.
- Focus on what is done in class.

a Powell (2000) lists a number of strategies for children with autism.

b Selikowitz (1998) lists strategies for overcoming dyslexia.

c Hornsby and Shear's (1976) Alpha-to-Omega scheme is an example of a highly structured multi-sensory approach that has been particularly successful in treating dyslexia. The pupil is taught step-by-step, beginning with single letter sounds linked to letter names and letter shapes. Pupils then progress to learning single syllable words followed by complex multi-syllabic words. Teaching drills are multi-sensory using sight and hearing to write and read.

4 (a) Describe what psychologists have discovered about teaching and learning styles. [8]

Typically: the way in which a child learns best. This may be formal or may be via discovery; it may be practically based or reflective. Learning styles are for learners and teaching styles are the way in which teachers present material to be learned. Anything that could be considered a teaching approach or style is acceptable.

- Lefrancois outlines a **'teaching model'**, pointing out what is desired before, during and after teaching. He also outlines 28 recommended behaviours for effective teaching.
- Fontana suggests the debate is between **formal** (subject emphasis and to initiate children in essentials) and **informal** (emphasis on child, teacher identifying child's needs) **styles**. A study on this was carried out by Bennett (1976) and followed up by Aitken et al (1981). Similarly Flanders (1970) suggests **direct** (lectures, etc) versus **indirect** (accepts that children have ideas & feelings) styles. Evidence exists for each approach.
- Bennett (1976) found progress in three 'R's' to be better in primary school using a formal approach.
- Haddon & Lytton (1968) found creativity to be better when using an informal approach.
- Based on the work of Lewin et al, Baumrind (1972) outlines three styles: authoritarian, authoritative (i.e. democratic) and laissez-faire. Baumrind believes the authoritative style is most effective.
- It could be argued that learning styles are determined by approach to, or perspective on, learning and so candidates could consider styles adopted if following a **behaviourist** or **cognitivist** or **humanist** approach.
- Learning styles have direct implications for teaching styles. Possible styles include lecturing, discussing, reciting, dictating, questioning, guided discovery, peer tutoring, etc. Advantages and disadvantages of each are relevant.
- An alternative is to consider Kolb's (1976) learning styles whereby a preferred learning style can be identified through a learning kite. Four styles are possible: dynamic, imaginative, analytical and common-sense.

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(b) Evaluate what psychologists have discovered about teaching and learning styles. [10]

NOTE: any evaluative point can receive credit; the hints are for guidance only.

- the implications of learning styles for teachers
- the implications of teaching styles for pupils
- the usefulness of the evidence
- individual differences in styles
- how psychologists gain their evidence

(c) Giving reasons for your answer, suggest how a teacher can manage individual differences in learning styles. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.

Fontana suggests the debate is between **formal** (subject emphasis and to initiate children in essentials) and **informal** (emphasis on child, teacher identifying child's needs) styles. Similarly Flanders (1970) suggests **direct** (lectures, etc) versus **indirect** (accepts that children have ideas & feelings) styles. Bennett (1976) found progress in three 'R's' to be better in primary school using a formal approach. Haddon & Lytton (1968) found creativity to be better when using an informal approach. Crucially these are general styles that need to be adapted for individual differences. A teacher needs to differentiate and cater for the needs of individual learners.

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PSYCHOLOGY AND ENVIRONMENT

Section A

5 (a) Explain, in your own words, what is meant by 'density and crowding'. [2]

Typically: Density refers to physical conditions (may be social or spatial). Crowding is a psychological state determined by perceptions of restrictiveness when exposed to spatial limitations. (Stokols, 1972).

(b) Describe *one* way in which density can be measured and one way in which crowding can be measured. [6]

Measuring density:
- spatial: amount of space a set number of people have
- social: number of people in a given amount of space

Measuring crowding:
As this is a psychological state of mind, then a questionnaire, interview or observation of behaviour.

(c) Describe *one* animal study on density and crowding. [3]

Most likely:
- Dubos (1965) claimed lemmings jump off a cliff (but they don't!)
- Christian (1960) where deer died on James Island due to stress caused by crowding and high social density
- Calhoun (1962) who bred far too many rats in a behavioural sink

6 (a) Explain, in your own words, what is meant by the term 'cognitive map'. [2]

Typically: a cognitive map is a pictorial and semantic image in our head of how places are arranged (Kitchin, 1994).

(b) Describe *one* way in which cognitive maps can be measured. [3]

Methods: main one is sketch map.
Sketch maps: Lynch identified five common elements: 1. *Paths:* roads, walkways, rivers (i.e. routes for travel); 2. *Edges:* non-travelled lines e.g. fences, walls; 3. *Districts:* larger spaces; 4. *Nodes:* places, junctions, crossroads, intersections where people meet; 5. *Landmarks:* distinctive places people use for reference points e.g. tallest building, statue, etc.

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(c) Describe *two* types of error commonly made when drawing cognitive maps. [6]

Most likely:

- Euclidean bias: people assume roads etc are grid-like: they are not. E.g. Sadalla & Montello (1989)
- Super-ordinate – scale bias: We group areas (e.g. counties) together and make judgement on area rather than specific place. E.g. Stevens & Coupe (1978)
- Segmentation bias: e.g. Allen & Kirasic (1985). We estimate distances incorrectly when we break a journey into segments compared to estimate as a whole
- Maps are often incomplete: we leave out minor details
- We distort by having things too close together, too far apart or misaligning. E.g. people over-estimate the size of familiar areas
- We augment – add non-existent features

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Section B

7 (a) Describe what psychologists have learned about personal space. [8]

Candidates may begin with definitions or look at types: alpha personal space = objective, externally measurable distance; beta personal space = subjective experience of space.

They could look at the functions of personal space such as **overload** (Scott, 1993), **intimacy equilibrium** (Argyle & Dean, 1965), **ethological model** (Evans & Howard, 1973), **proxemics** (Hall, 1966), **privacy regulation** (Altman, 1975). Candidates may make a distinction between territory and personal space.

Candidates may look at how personal space is **measured**: simulation; stop-distance; naturalistic observation or direct invasion of space.

Many studies could be included. Three '**classics**' are:

- Felipe and Sommer (1966). At a 1,500-bed mental institution an experimental confederate approached and sat next to lone patients. Felipe and Sommer (1966) also performed a more ethical study in a library.
- Middlemist, Knowles, and Matter (1976) looked at the effects of invasion on physiological arousal, performing a study in a three-urinal men's lavatory!
- Konecni et. al. (1975) and (in a similar study) Smith and Knowles (1979) stood close to pedestrians waiting to cross a road.

(b) Evaluate what psychologists have learned about personal space. [10]

NOTE: any evaluative point can receive credit; the hints are for guidance only.

- the strengths and weaknesses of the methods used by psychologists to gain their evidence
- issues relating to individual and/or cultural differences
- the implications the evidence has for society
- comparing and contrasting theoretical explanations

(c) Giving reasons for your answer, suggest ways in which people can defend their primary territory. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Primary territory is usually the home, and people may defend this with their life.

- Newman (1976) would suggest creating zones of territorial influence (e.g. building a fence) and opportunities for surveillance
- Less likely, but also a possibility: can block off streets: control and identify both people and cars (so recognise anything different and less access for burglars); can build houses so more opportunities for surveillance. In the study by Shumaker et al (1982), residents of cul-de-sacs felt safer than residents of 'through streets'

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8 (a) Describe what psychologists have found out about architecture and behaviour. [8]

Most likely:

Social behaviour – helping

- Amato (1983) study in 55 different Australian communities. A man limped down a street then screamed, fell over and clutched his leg which began bleeding profusely. In a small town (under 1,000 inhabitants) 50% stopped to help. In a city of 20,000–30,000 this dropped to 25%, and was down to 15% in major cities with over 1 million inhabitants.
- Milgram (1977) city handshake study, where undergraduate students approached a stranger and extended their hand in a friendly gesture (as if to initiate a handshake). Only 38.5% of city dwellers reciprocated compared to 66% in rural areas.

Social behaviour – crime

- Zimbardo (1969) de-individuation: Zimbardo left a car in the Bronx (urban) and in Palo Alto (suburban). He found that in the Bronx, the car was stripped within 24 hours, while the car left in Palo Alto was untouched.

Health

- Soderberg (1977) measured rates of HIV infection, comparing urban, semi-urban and rural blood donors. Sample: 3474 males & 1287 females in Tanzania. Between March 1988 & April 1991, all blood donors at the Ilemba Luteran Hospital were tested for HIV infection. All were also asked details of age, city/village, occupation and marital status. The highest rate of infection was seen in urban areas. Soderberg suggested that city people exhibit riskier behaviours.

Urban renewal and building design

- Pruitt-Igoe project: This was a public housing project in which 12,000 persons were relocated into 43 buildings, 11 stories high, containing 2,762 apartments, & covering 57 acres. After 3 years there was a very high crime rate. Accounts exist of gangs forming and that rape, vandalism, & robbery were common. Since crime frequently took place in elevators and stairwells, the upper floors were abandoned. By 1970, 27 of the 43 buildings were empty. The whole estate was demolished in 1972.
- Newman (1976): certain buildings are likely to be vandalised/burglarised because of their design. Crucial aspects include zone of territorial influence and opportunities for surveillance.

Community environmental design

- Studies by Whyte (1980) and Brower (1983) may be included.

(b) Evaluate what psychologists have found out about architecture and behaviour. [10]

NOTE: any evaluative point can receive credit; the hints are for guidance only.

- comparing social with physical explanations
- the ethics of urban renewal
- comparing theories of gentrification [renovating areas for middle/upper class use]
- how psychologists gained their evidence (e.g. the 'single variable' versus the 'urban/rural' approach)

(c) Giving reasons for your answer, suggest what architectural design features would contribute to reducing crime. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Most likely a reversal to what happened to Pruitt-Igoe (see part **(a)** above).
Could increase opportunities for surveillance (Newman).
Can block off streets: control and identify both people and cars (so recognise anything different and less access for burglars); can build houses so more opportunities for surveillance. In the study by Shumaker et al (1982), residents of cul-de-sacs felt safer than residents of 'through streets'.

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PSYCHOLOGY AND HEALTH

Section A

9 (a) Explain, in your own words, what is meant by the term 'measuring stress'. [2]

Two aspects required here: a comment on measures of stress and a comment on stress itself. There are two main measures of stress: physiological and psychological – see details in **9(c)**.

(b) Describe *one* cause of stress. [3]

Any appropriate example of stress here.

Most likely:
life events; daily hassles; personality type; work, examinations, etc.

(c) Suggest *two* ways in which the cause of stress described in (b) can be measured. [6]

Measures of stress include:
Psychologically by Questionnaire based on life events
Holmes & Rahe (1967) *Social Readjustment Scale*.
Psychologically by Questionnaire based on daily hassles
Kanner et al (1981) *Hassles and Uplifts checklist*.
Shaffer (1992) Hassles for students
Psychologically by Questionnaire based on personality
Friedman & Rosenman (1974) *Type A personality* and all subsequent work
Psychologically by Questionnaire based on other causal factors (such as work) e.g. Professional Life Stress Scale.

10 (a) Explain, in your own words, what is meant by 'methods for promoting health'. [2]

Typically: techniques or strategies used to help people live more healthily.

(b) Describe *two* methods for promoting health that could be used in worksites. [6]

Any two from the following (which are general, and can be applied in a worksite):

- **appeals to fear**/fear arousal (Janis & Feshbach, 1953; Leventhal, 1967) is the traditional starting point. The Yale model (source of message/message/recipient) underlies many attempts.
- providing information via media (e.g. Flay, 1987) – 3 approaches: 1. provide negative information only; 2. for those who want to be helped provide first steps; 3. self help via television audience.
- behavioural methods: provision of instructions, programmes, diaries to use as reinforcers.

NB method not related to worksites = 2 marks max OR health promotion in worksite with no method = 2 marks max.

(c) Suggest *one* problem when promoting health in worksites. [3]

Any appropriate problem to receive credit.

- If a fear-arousal technique is used, scaring people may not be ethical
- Many people have optimistic bias ('it won't happen to me') and so ignore the advice

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Section B

11 (a) Describe what psychologists have learned about the patient-practitioner relationship. [8]

Answers could focus on:

Interpersonal skills: non-verbal communication
- Argyle (1975) emphasises the importance of non-verbal communication.
- Classic study is McKinstry and Wang (1991), looking at the way a medical practitioner is dressed.

Interpersonal skills: Verbal communication
- Ley (1988) investigated what people remember of real consultations by speaking to people after they had visited the doctor. They were asked to say what the doctor had told them to do and this was compared with a record of what had actually been said.
- McKinlay (1975) carried out an investigation into the understanding that women had of the information given to them by health workers in a maternity ward. On average, each of the terms was understood by less than 40% of the women.

Patient-practitioner diagnosis and styles
- Savage & Armstrong (1990) compared a sharing consulting style (patient-centred) with a directive consulting style (doctor-centred).
- Marteau (1990) found patients prefer 10% chance of survival rather than 90% chance of non-survival.
- Robinson & West (1992) found people gave more information to a computer than to a doctor.

Over-use of services
- Munchausen's Syndrome and hypochondriasis

Under-use of services
- Pitts (1991a) suggests: Persistence of symptoms; we are likely to take a 'wait and see' approach if we get ill and only seek advice if the symptoms last longer than expected. Expectation of treatment: we are only likely to seek medical advice if we think it will do some good.
- Safer (1979) found people delayed seeking treatment for up to two months.

(b) Evaluate what psychologists have learned about the patient-practitioner relationship. [10]

NOTE: any evaluative point can receive credit; the hints are for guidance only.
- how psychologists gained their evidence
- reasons why proposal of theories/models is difficult in this area
- implications the evidence has for health care
- psychological perspectives related to counselling situations.

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(c) Giving reasons for your answer, suggest ways in which people can be encouraged to use health services. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Some people misuse health services (e.g. those with hypochondriasis) but some people underuse. For example **Safer** (**1979**) found that people delayed seeking treatment for up to two months. So how can people be encouraged to use?

- **changing physician behaviour** (DiMatteo & DiNicola, 1982) such as changing communication style (Inui et al, 1976); change information presentation techniques (Ley et al, 1982).
- **educating** the public as to what is appropriate. A health promotion campaign? Use of fear appeal, providing information.

12 (a) Describe what psychologists have discovered about pain. [8]

Candidates could include types, theories, measures or management of pain.

Theories of pain include:
- **Specificity theory (**Descartes, 1644): but clinical, physiological and psychological evidence suggests this theory is wrong.
- **Gate control theory** (Melzack, 1965): widely accepted as the best explanation to date.

Types of pain:
- **Acute pain**: following tissue damage the individual adopts behaviour involving protection and care of the damaged area. After a relatively brief time period the pain subsides, the damage heals and the individual returns to a pre-damage state.
- **Chronic pain**: following tissue damage the pain does not subside (even though the damage is apparently healed) and may continue for many months or years.

Measures of pain include:
- self report/interview methods
- rating scales: e.g. visual analogue scale and category scale
- pain questionnaires: e.g. MPQ (McGill Pain Questionnaire); MMPI often used too but is not pain specific.
- behavioural assessment: e.g. UAB
- psycho-physiological measures: use of EMG, ECG & EEG.

Management of pain includes:
- **Medical** – use of surgical or chemical means: peripherally acting analgesics such as aspirin; centrally acting analgesics e.g. morphine or local anaesthetics.
- **Psychological** – cognitive: attention diversion, non-pain imagery or cognitive redefinition. Also biofeedback.
- **Alternative** such as physical therapy: tens, hydrotherapy and acupuncture.

(b) Evaluate what psychologists have discovered about pain. [10]

NOTE: any evaluative point can receive credit; the hints are for guidance only.
- comparing and contrasting different approaches
- the relationship between theory and practice
- the assumptions made about human nature
- how psychologists gain their evidence in this area

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(c) Suggest how the pain experienced by a person in a hospital bed could be measured using psychological techniques. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.

- self report/interview methods
- rating scales: e.g. visual analogue scale and category scale
- pain questionnaires: e.g. MPQ (McGill Pain Questionnaire); MMPI often used too but is not pain specific
- behavioural assessment: e.g. UAB
- psycho-physiological measures: use of EMG, ECG & EEG

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PSYCHOLOGY AND ABNORMALITY

Section A

13 (a) Explain, in your own words, what is meant by the term 'treatments for schizophrenia'. [2]

Two aspects required here: awareness of the nature of schizophrenia (1 mark) e.g. from Greek schzein (split) and phren (mind) and awareness of treatments (1 mark). psychosurgery – once popular, but now highly unlikely;
ECT very common and still used today; chemotherapy – very popular; behaviour therapy – less likely, but some token economy used.

(b) Describe *one* type of schizophrenia. [3]

There are 5 main types:

- **hebephrenic**: incoherence, disorganised behaviour, disorganised delusions and vivid hallucinations
- **simple**: gradual withdrawal from reality
- **catatonic**: impairment of motor activity, often holding same position for hours/days
- **paranoid**: well-organised, delusional thoughts (& hallucinations), but high level of awareness
- **undifferentiated/untypical**: for all the others who do not fit the above!

(c) Describe *one* explanation and *one* treatment for the type of schizophrenia in (b). [6]

There are a number of **explanations**:

Behavioural: due to conditioning and observational learning.
Psychodynamic: regression to oral stage.
Families: also blamed for schizophrenia; as are twins.
Cognitive: breakdown in ability to selectively attend to stimuli in language, etc.
Genetics: also plays a role.
NB explanation and treatment can be different approaches.

Treatments:

- Sensky (2000) has used cognitive behavioural therapy in the treatment of schizophrenia
- Paul & Lentz (1977) found that the use of tokens was successful in reducing bizarre motor behaviours and in improving social interactions with staff and other patients
- The first generation of **antipsychotics** (or neuroleptics) began in the 1950s, e.g. chlorpromazine. Then came **atypical anti-psychotics** which acted mainly by blocking dopamine receptors. The third generation of drugs, such as Aripiprazole, are thought to reduce susceptibility to metabolic symptoms present in the second generation atypical antipsychotics

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14 (a) Explain, in your own words, what is meant by the term 'obsessive-compulsive disorder'. [2]

Typically:
- obsessions – recurring thoughts that interfere with normal behaviour
- compulsions – recurring actions which the individual is forced to enact
- obsessive-compulsive = irresistible thoughts or actions that must be acted on

(b) Describe *one* explanation for obsessive-compulsive disorder. [3]

Most likely:
Psychoanalytic: traced to anal stage.
Behavioural: hypercritical, demanding parents reward similar behaviour in children.
Superstition – must go through rituals (O'Leary & Wilson).
Chemical: OCDs have increased activity in frontal lobe of left hemisphere.

(c) Describe *one* treatment for obsessive-compulsive disorder and one treatment for an anxiety disorder. [6]

OCD:
- behavioural therapy, cognitive therapy and medications are first-line treatments for OCD
- psychodynamic psychotherapy may help in managing some aspects of the disorder

Anxiety:
- cognitive behavioural therapy is most common
- medications commonly prescribed include benzodiazepines, such as alprazolam and diazepam; antidepressants, including SSRI; and possibly atypical antipsychotics such as quetiapine

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Section B

15 (a) Describe what psychologists have learned out about abnormal affect. [8]

Typically: abnormal affect concerns disorders of mood and emotion, most typically depression and mania or manic depression (bipolar).

Types:

- **mania** – person displays spontaneity, activity, has outbursts of exuberance, has heightened good humour and talkative and entertaining. They are often full of good ideas, plans and have grand visions. They are full of energy; appear to be physically inexhaustible.
- **Depression**: person is extremely despondent, melancholic and self deprecating. They may be physically lethargic; struggle to think out simple problems. They believe they are utterly worthless and have hopeless guilt.
- **Seasonal affective disorder**: summer and winter versions also a legitimate possibility.

Causes:

- The **biopsychosocial model** proposes that biological, psychological, and social factors all play a role to varying degrees in causing depression.
- The **diathesis–stress model** posits that depression results when a pre-existing vulnerability, or diathesis, is activated by stressful life events.
- **Monoamine hypothesis**: depression arises when low serotonin levels promote low levels of norepinephrine.
- Depression also runs in families and the closer the **genetic relationship**, the more likely people are to be diagnosed with the disorder. Oruc et al (1998): first degree relatives of people diagnosed with depression are two or three times more likely to be diagnosed with depression than those who are not first degree relatives.
- Psychological: Beck proposed the **cognitive model of depression** with a triad of negative thoughts comprising cognitive errors about oneself, one's world, and one's future; recurrent patterns of depressive thinking, or schemas; and distorted information processing.

(b) Evaluate what psychologists have learned out about abnormal affect. [10]

NOTE: any evaluative point can receive credit; the hints are for guidance only.

- points about defining and categorising abnormality
- cultural and individual differences
- comparing and contrasting explanations of cause
- implications of individual and society

(c) Giving reasons for your answer, suggest ways in which abnormal affect can be treated. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.

- The catecholamine hypothesis of affective disorders where the chemical imbalance hypothesis for mental health disorders, especially for depression, was outlined. There are four main types of drug that relieve the symptoms of depression: Tricyclics; MAOIs (Monoamine oxidase inhibitors); SSRIs (Selective Serotonin Reuptake Inhibitors); SNRIs (Serotonin and Noradrenaline Reuptake Inhibitors).
- **ECT** (electroconvulsive therapy)/electroplexy is very common for severe depression.
- Beck et al (1979) believe in **cognitive restructuring.** Ellis (1962) outlined rational emotive therapy which was developed into rational emotive behaviour therapy **(REBT).**
- SAD treated using a light box (Watkins, 1977). Studies looking at acclimatisation may be a possibility and telling people about the negative effects gives perceived control.

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16 (a) Describe what psychologists have found out about abnormal avoidance and need. [8]

Candidates can focus on either avoidance or need or both.

Need: will include problems such as compulsive gambling, pyromania and kleptomania but any other need is legitimate.

Avoidance: any phobia is appropriate here as would be elective withdrawal.

Candidates may focus on suggested explanations or on typical behaviour/symptoms.

- **Kleptomania** is the condition of not being able to resist the urge to collect or hoard things. People with this disorder are compelled to steal things, generally things of little or no value.
- **Pyromania** is an impulse to deliberately start fires to relieve tension and typically includes feelings of gratification or relief afterward. Pyromaniacs start fires to induce euphoria, and often tend to fixate on institutions of fire control like fire stations and fire-fighters.
- **Problem gambling** is an urge to gamble despite harmful negative consequences or a desire to stop. Severe problem gambling may be diagnosed as clinical **pathological gambling** if the gambler meets certain criteria.

Kleptomania is frequently thought of as being a part of obsessive-compulsive disorder, since the irresistible and uncontrollable actions are similar to the frequently excessive, unnecessary and unwanted rituals of OCD. *Compulsive* gambling also.

(b) Evaluate what psychologists have found out about abnormal avoidance and need. [10]

NOTE: any evaluative point can receive credit; the hints are for guidance only.

- points about defining and categorising abnormal behaviours
- cultural and individual differences in need/avoidance
- comparing and contrasting explanations
- implications for person with abnormal need/avoidance

(c) Giving reasons for your answer, suggest how an abnormal need may be treated. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
NB Question focuses on abnormal need, not avoidance.
Kleptomania has several different treatments. Cognitive behavioural therapy is recommended as an adjuvant to medication.

Some medications that are used for people diagnosed with kleptomania are selective serotonin reuptake inhibitors, mood stabilizers and opioid antagonists.

Behaviour modification is the usual treatment for pyromania. Other treatments include seeing the patient's actions as an unconscious process and analyzing it to help the patient get rid of the behaviour. Often, this treatment is followed by a more psychodynamic approach that addresses the underlying problems that generated the negative emotions causing the mania. Treatment appears to work in 95% of children that exhibit signs of pyromania; treatment includes family therapy and community intervention. Selective serotonin reuptake inhibitors (SSRIs) are also used to treat this condition.

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PSYCHOLOGY AND ORGANISATIONS

Section A

17 (a) Explain, in your own words, what is meant by the term 'personnel screening'. [2]

Typically: the process of reviewing information about job applicants to select workers.

(b) Describe *one* psychometric test used in personnel screening. [3]

Screening tests. These could test:
- cognitive ability
- mechanical ability
- motor/sensory ability
- job skills/knowledge
- personality
- test specific to job/organisation

(c) Describe *two* problems with psychometric tests used in personnel screening. [6]

Most likely:
- One problem is that the test may not be valid – it does not measure the aspect of the job that it is supposed to measure.
- Another problem is that the test may not be reliable – results from one person may not be comparable to results from another person.
- Third is that these involve self reports – a person may not tell the truth.
- Any other appropriate problem to receive credit.

18 (a) Explain, in your own words, what is meant by the 'communication process'. [2]

Typically: This is the passage of information between one person or group to another person or group. Candidates may well begin with a definition of communication and what it involves: sender, message and receiver (e.g. Hurier model for effective listening); encoding, channel and decoding. Candidates may consider the varieties of communication: phone, face-to-face, meeting, memo, newsletter, employee handbooks, reports, e-mail, voice-mail, teleconference, etc.

Another set of factors are:
- Organisational structures: downward, upward and horizontal/lateral
- Barriers: filtering, censoring, exaggeration (knowledge is power!)
- Breakdown: impression management; self confidence; competence; mistrust; defensiveness; under-communication

(b) Briefly describe *two* types of communication channel. [6]

The communication channel: the characteristics of the vehicle of transmission of a message that affect communication. Candidates may consider the varieties of communication: phone, face-to-face, meeting, memo, newsletter, employee handbooks, reports, e-mail, voice-mail, teleconference, etc.

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(c) Describe *one* way in which communication flow could be improved. [3]

Most likely:

- **Machin** (1980) suggests the expectations approach
- **Marchington** (1987) suggests 'team-briefing'
- Also: employee suggestion systems; grievance systems; open-door policies; employee surveys; participative decision making; corporate hotlines; brown bag meetings; skip-level meetings
- Candidates may refer to **Tesser & Rosen's** (1985) MUM effect; the reluctance to tell superiors of something bad

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Section B

19 (a) Describe what psychologists have found out about human resource practices. [8]

Human resource management (HRM) is the *strategic* and *coherent* approach to the *management* of an organisation's most valued assets – the people working there who individually and collectively contribute to the achievement of the objectives of the business.

Three aspects:

Job analysis techniques:
Job analysis is the systematic study of the tasks, duties and responsibilities of a job. It results in a job description and a job specification (information about the human characteristics needed).

- FJA [functional job analysis] technique examining sequence of tasks in a job.
- PAQ [positional analysis questionnaire] uses structured questionnaire to analyse jobs.
- CIT [critical incidents technique] uses examples of successful or unsuccessful job performance.

***Performance appraisal**:* the process of assessing or evaluating workers/employees on various work related dimensions.

Reward systems: e.g. *wage*s or *salary; employee benefits* administration, etc.

(b) Evaluate what psychologists have found out about human resource practices. [10]

NOTE: any evaluative point can receive credit; the hints are for guidance only.
- issues concerning reliability and validity
- assumptions made by appraisal techniques
- implications of HRM practices for leader-worker relationships
- the usefulness of HRM practices

(c) You are a newly appointed human resource manager. Giving reasons for your answer, suggest what job analysis technique you will use in the company. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Most likely: candidates will chose one (or more) of the techniques above. To repeat: job analysis is the systematic study of the tasks, duties and responsibilities of a job. It results in a job description and a job specification (information about the human characteristics needed).

- FJA [functional job analysis] technique examining sequence of tasks in a job.
- PAQ [positional analysis questionnaire] uses structured questionnaire to analyse jobs.
- CIT [critical incidents technique] uses examples of successful or unsuccessful job performance.

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20 (a) Describe what psychologists have found out about human factors in work design. [8]

Human factors are concerned with the design of tools, machines, work systems and work places to fit the skills and abilities of workers. In industry, operator-machine systems are central. Chapanis (1976) outlines the '**operator-machine system**: human systems: senses, information processing/decision-making and controlling; machine system: controls, operation and display (feeding back to senses). Each factor can be considered in much more detail. **Displays**: these can be visual or auditory and factors determine which is most appropriate. **Decision-making** is also important as are the **controls** themselves. Controls can be of many types, but should be matched to the operator's body; they should be clearly marked and they should mirror the machine actions they produce. Keyboard controls on computers can also be considered.

Errors in operator-machine are important. There can be errors of:
Omission (failing to do something), commission (performing an act incorrectly), sequence errors (doing a step out of order) and timing errors (too quickly, slowly). Errors such as these can be rectified either by 1. **changing the design** or 2. **selecting people** who can operate the systems. Workspace design: three main types here: seated, standing and combined!

(b) Evaluate what psychologists have found out about human factors in work design. [10]

NOTE: any evaluative point can receive credit; the hints are for guidance only.
- matching machine to person or matching person to task
- individual differences
- methods for assessing machine-operator systems
- how psychologists gather evidence in this area

(c) Giving reasons for your answer, suggest how safety in operator-machine systems can be improved. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Most likely: a health-promotion/safety behaviour strategy such as the token economy system used by Fox et al (1976) on quarry workers. Also can be changing working conditions to improve physical and psychological working conditions. Could also be changing shift patterns from rapid rotation to a slow rotation pattern. Also a possibility is to design machines to match people or train people to match the machine.

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