UNIVERSITY OF CAMBRIDGE INTERNATIONAL EXAMINATIONS

GCE Advanced Level

MARK SCHEME for the October/November 2011 question paper for the guidance of teachers

9698 PSYCHOLOGY

9698/33 Paper 3 (Specialist Choices), maximum raw mark 70

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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 is 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

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(b)	**EVALUATION ISSUES** [Assessing quality of data]	
	General evaluative comment OR issue identified OR evidence (max 2 marks if no analysis/cross ref).	1
	Any two from: general evaluative comment/issue/evidence (max 3 marks if no analysis/cross ref).	2
	Issue plus explanation of issue plus evidence.	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 (issues, evidence, analysis and cross-referencing) and argument.	1
	Structure sound and argument clear and coherent (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 the 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 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 term 'learning style'. [2]

Typically: the way in which a child learns best. May be formal or may be via discovery; it may be practically based or reflective. Learning styles are for learners and teaching styles are for teachers.

(b) Describe <u>two</u> learning styles. [6]

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.
- Curry's onion model (1983): instructional preference, informational processing style and cognitive personality style.
- Grasha's (1996) six categories for learning: independent, dependent, competitive, collaborative, avoidant and participant.

(c) Describe <u>one</u> teaching style. [3]

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 and feelings) styles. Evidence exists for each approach.
- Bennett (1976) found progress in three 'Rs' better in primary school using formal approach.
- Haddon and Lytton (1968) found creativity better when informal approach used.
- 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.

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2 (a) Explain, in your own words, what is meant by 'physical features of learning environments'. [2]

Typically: features of the architecture and contents of any area where education takes place.

(b) Describe <u>two</u> effects of physical features on performance. [6]

Many possible features to include here. Any two from:

- **Open plan** schools versus '**traditional**' designs. Traditional is formal; open plan is individualistic. Rivlin and Rothenberg (1976): open plan implies freedom, but is no different from traditional. Open plan offers too little privacy and too much noise. Conclusion: some children do better with traditional, others with open plan.
- Some studies refer to effect of number of **windows/light** (e.g. Ahrentzen, 1982).
- Some to effects of **temperature** (e.g. Pepler, 1972).
- **Classroom layout**: (a discovery learning room) with availability of resources; use of wall space: too much vs too little (e.g. Porteus, 1972).
- **Seating arrangements**: sociofugal vs sociopetal (rows vs horseshoe vs grouped).
- **Classroom capacity**: how many is room designed for and how many occupy room may lead to lack of privacy, crowding may lead to stress and poor performance.

(c) Describe how <u>one</u> physical feature could be changed to improve learning. [3]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Candidates are most likely to choose one of the features included in part (b) above.

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Section B

3 (a) Describe how the humanistic perspective has been applied to learning. [8]

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 his or her self); **communication** (attention to positive human relationships) and **personal values** (recognition and development of positive values).

- Maslow (1970) advocates **student-centred teaching** where teachers are learning facilitators rather than didactic instructors.
- Dennison (1969) advocates the **open classroom**.
- Dunn and 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.

(b) Evaluate how the humanistic perspective has been applied to learning. [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.

(c) Giving reasons for your answer, suggest how the humanistic perspective can be used to teach very young children. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Answers are most likely to focus on one or more aspects indicated in question part (a).

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4 (a) Describe what psychologists have found out about motivation and educational performance. [8]

Traditional theories of motivation could be considered (such as **Freud** and instinct theory, **Maslow's** hierarchy of needs, etc.) but these **must** be related to education in some way to be creditworthy (otherwise it could be an 'organisations' answer). Candidates can be motivated by many things and here they can legitimately write about self-efficacy, self-fulfilling prophecy, locus of control, attribution theory and similar aspects.
Most likely answers:

- **Behaviourist**: emphasise extrinsic praise and reward. Brophy (1981) lists guidelines for effective and ineffective praise.
- **Humanistic**: emphasise intrinsic motivation. The theories of Maslow (1970) self-actualisation, White (1959) competence motivation and Bandura's (1981) self-efficacy is relevant.
- **Cognitive**: attribution theory of Weiner (1974) is relevant as is Rotter's locus of control.
- Other: McClelland's (1953) achievement motivation and Birney's (1969) motivated due to fear of failure.

(b) Evaluate what psychologists have found out about motivation and educational performance. [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.

(c) Giving reasons for your answer, suggest ways in which students can be motivated to work for their examination in psychology. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Answers are most likely to focus on one or more aspects indicated in question part (a).

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PSYCHOLOGY AND ENVIRONMENT

Section A

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

Typically: candidates must focus on **weather**, relatively rapidly changing conditions rather than **climate**, the average weather conditions over a period of time.

(b) Describe <u>two</u> studies showing the negative effects of climate and/or weather on social behaviour. [6]

Social behaviour: **aggression**: the long hot summer effect and the view that heat causes riots (Goranson and King, 1970, and US riot commission, 1968, but only in 1967 and only in US). Baron and Bell (1976) propose negative affect-escape model to explain it and lab studies support. Many other studies on heat and aggression may be mentioned. Heat also may or may not affect **helping** (e.g. Page, 1978) and **attraction** (e.g. Griffit, 1970).

(c) Suggest <u>one</u> way in which the negative effects of climate and/or weather on social behaviour can be reduced. [3]

Most likely:

- Use of air conditioning; avoidance of extremes of temperature.
- Also Seasonal Affective Disorder treated using a lightbox (Watkins, 1977).
- Studies looking at acclimatisation may be a possibility and telling people about the negative effects gives perceived control.

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6 (a) Explain, in your own words, what is meant by the 'consequences of invasion' of personal space and territory. [2]

Typically: if personal space or territory is invaded then the person will experience negative cognitions and affect and their behaviour will be that they are more likely to seek escape from the invasion.

(b) Briefly describe <u>two</u> studies on the invasion of personal space. [6]

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

- Felipe and Sommer (1966). At a 1500-bed mental institution an experimental confederate approached and sat next to lone patients. Felipe and Sommer (1966) 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 (1978) stood close to pedestrians waiting to cross a road.

(c) Briefly describe <u>one</u> type of territory. [3]

Most likely: Altman (1975) outlines three types of territory:

- Primary territory: a private area owned by an individual (e.g. house);
- Secondary territory: an area that is used regularly but is shared with others (e.g. desk in a classroom);
- Public territory: can only be occupied temporarily on a 'first come, first served' basis (e.g. seat on bus).

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Section B

7 (a) Describe what psychologists have discovered about crowd behaviour. [8]

Sears et al. (1991) define a crowd as people in physical proximity to a common situation or stimulus. Additionally crowds must involve a number of interacting people; need not be face-to-face; need not be assembled in one place; but members must influence one another.

Brown (1965) classifies crowds according to their behaviours:
- acquisitive crowd: Mrs Vaught (1928) where banks closed;
- apathetic crowd: study of Kitty Genovese;
- expressive/peaceful crowd: Benewick and Holton (1987) interviewed people attending the visit of the Pope to Britain in 1982;
- baiting crowd: in 1964 there was the case of a man, standing on the ledge of a building ten storeys high. The crowd below of some 500 people shouted to him to jump off the ledge;
- aggressive crowd (often referred to as 'mob psychology');
- escaping crowd (panicky and non-panicky).

Explanations of aggressive crowd behaviour: **mob psychology** of **Le Bon** (1895): otherwise normally civilised people become 'barbarians' – wild and irrational, giving vent to irrational impulses. **Turner** (1974) proposed the **emergent norm theory. Zimbardo** (1969) outlined **deindividuation**: each person is nameless, faceless, anonymous and has diminished fear of retribution.

Laboratory studies of deindividuation: Zimbardo (1969) had participants wear laboratory coats and hoods that masked their faces. Similarly, Prentice-Dunn and Rogers (1983) gave participants the opportunity to give a 'victim' an electric shock. Milgram (1963) found that people were more willing to administer shocks when the participants could not see the victim and when the victim could not see them.

Deindividuation in children: Diener et al. (1976) looked at deindividuation in children, using Hallowe'en and Trick or Treat as the scenario.

Social constructionism and aggressive crowds: Reicher (1984b) cites violent incidents involving aggressive crowds. His classic example is the 'riot' that happened in the St Paul's district of Bristol in 1980.

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

NOTE: any evaluative point can receive credit; the hints are for guidance only.
- comparing and contrasting explanations;
- how psychologists gather their data;
- the ethics of various studies;
- generalisability from studies: sample ethnocentrism; method.

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(c) Giving reasons for your answer, suggest how people in an anti-social or aggressive crowd can be controlled. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Most likely answers will be based on study by Waddington et al. (1987) who argue that public disorder is predictable (not the outcome of mob psychology) and problems can be avoidable. Crowds should be perceived as collections of individuals who share a social purpose and who are interpreting what is going on around them.

Five recommendations for successful crowd control:
- Let the crowd self-police wherever possible.
- Effective liaison should take place between police and organisers.
- If police are involved they should use minimum force so are not perceived by crowd as causing trouble.
- Those involved in managing crowds should be trained in effective interpersonal communication.
- The police should be perceived as accountable and not able to do what they like.

8 (a) Describe what psychologists have discovered about natural disaster and/or technological catastrophe. [8]

Candidates may well begin with a definition (e.g. that of the American president) and a distinction between **disasters** (natural causes) and **catastrophes** (human causes). Catastrophes mean there is some human error/fault and blame can be attributed.

A focus on **methodology** would be pertinent. Lab studies are low in ecological validity or not ethical (e.g. Mintz (1951). Simulations are more true to life (e.g. simulation following Manchester aeroplane fire) but participants know it is a simulation. Actual events are better but not ethical to study as people may be injured, stressed, etc. and with no comparison or control. Candidates could look at how people behave **during** emergencies. Archea (1990) compared behaviours of people during earthquakes in Japan and America. Alternatively, LeBon (1895) suggested people behave like wild animals with primitive urges and stampede and are crushed (examples of fires where this has happened). Alternatively people may be crushed without stampeding (e.g. Hillsborough). Smelser (1964) suggested people don't panic if in a mine or submarine due to exit being unsafe. LaPierre (1938) looked at how panic develops. Alternatively Sime (1985) found in fire people seek companions first and do not behave as individual 'animals'. Candidates may focus on what can be done to **prevent panic** and look at evacuation messages (e.g. Loftus) or the follow me/follow directions dilemma of Sugiman and Misumi (1988). Another focus may be on **preparation for an event** or whether people think it will happen to them (e.g. Stallen, 1988) and study at Dutch chemical plant. Candidates may also look at **behaviour after an event**, typically post-traumatic stress (e.g. source and Herald of Free Enterprise). Some candidates may look at pre-traumatic stress.

(b) Evaluate what psychologists have discovered about natural disaster and/or technological catastrophe. [10]

NOTE: any evaluative point can receive credit; the hints are for guidance only.
- defining and categorising disaster and catastrophe;
- cultural differences in disaster/catastrophe behaviour;
- whether theories apply in real life;
- the methods psychologists use to gain their evidence.

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(c) Giving reasons for your answer, suggest ways in which psychologists can intervene in a disaster and/or catastrophe. [6]

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

- **preparation for an event** or whether people think it will happen to them (e.g. Stallen, 1988) and study at Dutch chemical plant;
- **attitudes** toward potential danger "it won't happen to me"; fear of flying, etc.;
- **evacuation messages** and plans for escape to **prevent panic** e.g. evacuation messages (e.g. Loftus) or the follow me/follow directions dilemma of Sugiman and Misumi (1988);
- **emergency plans** such as those issued by the FEMA for earthquakes;
- some candidates may look at pre-traumatic stress.

After:
behaviour after an event, typically post-traumatic stress (e.g. Herald of Free Enterprise information). Main solution is systematic desensitisation or some form of counselling. Social support may also be suggested, but this is often a weak alternative. Also PTSD in emergency workers is relevant.

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PSYCHOLOGY AND HEALTH

Section A

9 (a) Explain, in your own words, what is meant by 'theory of pain'. [2]

Typically: an analytic structure designed to explain an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. A nursing definition of pain is: "pain is whatever the experiencing person says it is, existing whenever he says it does".

(b) Outline <u>one</u> theory of pain. [3]

Most likely:
Specificity theory: Descartes (1644) captured idea of pain in his analogy of bell ringing: "pull the rope at the bottom and the bell will ring in the belfry". This theory proposes that there are pain receptors in bodily tissue which connect to a pain centre in the brain. The view was that there were four types of sensory receptor: warmth, cold, pressure and pain.

Gate control theory: Melzack (1965) – at the heart of the gate control theory is a neural "gate" that can be open and closed in varying degrees.

(c) Describe <u>two</u> ways of measuring chronic pain. [6]

Measures of pain include:
- self report/interview methods;
- rating scales e.g. visual analogue scale and category scale (much less likely for chronic);
- 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 and EEG.

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10 (a) Explain, in your own words, the difference between 'substance use' and 'substance abuse'. [2]

Substance use is 'normal' regular use where the person has not become physically or psychologically dependent on the substance.

Substance abuse is defined on the basis of three criteria (Rosenhan and Seligman, 1984):
- existence of a clear pathological use e.g. heavy daily use or inability to stop;
- heightened problems in social or occupational functioning e.g. loses job;
- existence of pathological use for at least a month.

(b) Describe <u>two</u> theories of substance abuse applied to a substance of your choice. [6]

Any two from:
- Smoking: **genetic** (e.g. Eysenck, 1980); **nicotine addiction/regulation model** (e.g. Schachter, 1980); **biobehavioural model** (e.g. Pomerleau, 1989); **opponent process model** (e.g. Solomon, 1980), cough is nasty so smoke which is nice; **social learning/modelling**; Tomkins (1966): positive affect, negative affect, habitual, addictive; Leventhal and Cleary (1980) why start smoking: tension control; rebelliousness; social pressure.
- Drinking alcohol: **tension reduction hypothesis** (e.g. Conger, 1956); **disease model** (a) Jellineks (1960) gamma and delta, (b) **alcohol dependency syndrome** (e.g. Edwards et al., 1977), 7 elements of dependency; **social learning/modelling**. Whereas disease model is genetic, social learning/modelling is learning so good for section (b) evaluation.
- Drugs: similar reasons to above. Note that types of drugs and their effects are not relevant and should receive no credit.
- Food (obesity): **age and metabolism**; '**gland problems'**; **heredity**: lots of twin studies and correlations with parents; the **set-point theory** where set-point is determined by fat consumed as a child determining need for fat later; restrained versus unrestrained eaters. Food (anorexia/bulimia) is biological, cultural and psychological revolving around body image in females. Lots of explanations to choose from and relate.

(c) Describe <u>one</u> difference between physical dependence and psychological dependence on a substance. [3]

- **Physical dependence** is a state in which the body has adjusted to the presence of a substance and incorporated it into the 'normal' functioning of the tissue of the body. This state has two characteristics: *TOLERANCE*: the process in which the body increasingly adapts to a substance and requires larger and larger doses of it to achieve the same effect; *WITHDRAWAL*: the unpleasant physical and psychological symptoms people experience when they stop using a substance.
- **Psychological dependence** is a state in which people feel a compulsion to use a substance for the pleasant effect it produces (without necessarily being physically dependent e.g. alcohol initially psychological dependence perhaps later leading to physical dependence).

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Section B

11 (a) Describe what psychologists have learned about lifestyles and health behaviour. [8]

Typically: the ways in which people live which may be harmful to their health or maintaining healthy existence through health protective behaviours. Candidates are likely to focus on one or more of three areas:

- **General:**
  Risk factors: behaviours associated with causes of death: **heart disease**: smoking, high cholesterol, lack of exercise, high blood pressure, stress; **cancer**: smoking, high alcohol use, diet, environmental factors; **stroke**: smoking, high cholesterol, high blood pressure, stress; **accidents**: alcohol use, drug abuse; **infectious diseases**: smoking, failing to get vaccinated.

  What do people do to protect their health? **Primary Prevention** (**health behaviour**) consists of actions taken to avoid disease or injury. **Secondary Prevention** (**illness behaviour**) is where actions are taken to identify and treat an illness or injury early with the aim of stopping or reversing the problem. **Tertiary Prevention** (**sick role behaviour**) ranges from seeing a practitioner and filling a prescription to when a serious injury or a disease progresses beyond the early stages and leads to lasting or irreversible damage.

- **Studies:**
  Harris and Guten (1979) American study which found the three most common health protective behaviours were eating sensibly, getting enough sleep and keeping emergency numbers by the phone.

  Turk et al. (1984) studied American nurses, teachers and college students. Found three highest in each category: Nurses: emergency numbers, destroying old medicines, having first aid kit; Teachers: watching weight, seeing dentist regularly, eating sensibly; Students: getting exercise, not smoking, spending time outdoors. Mechanic (1979) in a longitudinal study found little correlation (.1 or .2) between subjects tested when children and 16 years later.

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- **Models:**
  Becker and Rosenstock (1984) health belief model. Related studies: Champion (1994) used HBM to inform women about benefits of mammography. Hyman et al. (1994) perceived susceptibility is not a good predictor. Barriers and benefits better but ethnicity best. Aiken et al. (1994) regular place to go and practitioner recommendation much better predictor than HBM.

  Ajzen and Fishbein (1975) theory of reasoned action. Related studies: Montano et al. (1997) low income women questioned regarding attitude, subjective norm and intentions toward mammography. Found all significantly related to use. O'Callaghan et al. (1997) better predictor is past experience/behaviour.

  Ajzen (1985) Theory of planned behaviour. As above but adds **perceived behavioural control**.

  Weinstein et al. (1998) precaution adoption process model. Above merely identify variables. Stages people go through in their readiness to adopt a health-related behaviour.

  Prochaska et al. (1992) transtheoretical model. Five stages of behaviour change: *precontemplation* – no intention of changing. Isn't a problem. *Contemplation* – awareness of problem. Thoughts about changing but no action. *Preparation* – plans made to change behaviour. *Action* – plans put into action. *Maintenance* – attempt to sustain changes and resistance to relapse.

(b) Evaluate what psychologists have learned about lifestyles and health behaviour. [10]

NOTE: any evaluative point can receive credit; the hints are for guidance only.
- the methods used by psychologists;
- comparing and contrasting health belief theories;
- ethical issues involved in research;
- generalisation of results from participants used.

(c) Using psychological evidence, suggest ways in which people can be encouraged to improve their lifestyle and health behaviour. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Most likely:
- Basic such as 'eating healthily'; 'not smoking', etc. and 'going to doctor'.
- Those which are a little more psychologically informed and use psychological evidence e.g. **Harris and Guten** (1979) American study see above for details. Similarly **Turk et al.** (1984) again see part (a).

Alternatively candidates may consider:
- **Primary Prevention** (**health behaviour**) consists of actions taken to avoid disease or injury.
- **Secondary Prevention** (**illness behaviour**) is where actions are taken to identify and treat an illness or injury early with the aim of stopping or reversing the problem.
- **Tertiary Prevention** (**sick role behaviour**) ranges from seeing a practitioner and filling a prescription to when a serious injury or a disease progresses beyond the early stages and leads to lasting or irreversible damage.

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12 (a) Describe what psychologists have discovered about health and safety. [8]

Two types of answer:
General:

- **Theory A**: the person approach: accidents caused by the unsafe behaviour of people. Prevention is by changing the ways in which people behave; (fitting the person to the job).
- **Theory B**: the systems approach: accidents caused by unsafe systems at work. Prevention is by redesigning the work system; (fitting the job to the person).

Specific (lots of possibilities):

- people may think they are accident prone (personality) and so self-fulfilling prophecy may apply e.g. Robertson (2003);
- people have an illusion of invulnerability – it won't happen to them;
- people apply motion stereotypes and so do not consider alternatives;
- people make errors (they are human);
- people on shiftwork have low point e.g. 2–5 am.

Any appropriate suggestion can receive credit.

(b) Evaluate what psychologists have discovered about health and safety. [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.

(c) Giving reasons for your answer, suggest how accidents in the home could be reduced. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Two types of answer:
Under global heading of **'health and safety' campaigns** come many individual approaches which could take place in homes specifically. These can be based on:

- **Appeals to fear**/fear arousal (e.g. Janis and Feshbach, 1953, and Leventhal, 1967) is the traditional starting point. This is likely to be included because their *strong fear appeal* could be said to be unethical and is not the most effective. The Yale model (source of message/message/recipient) underlies so many attempts.
- **Providing information** via media (e.g. Flay, 1987), 3 approaches: provide negative info only; for those who want to be helped provide first steps; self-help via television audience. Study by Lewin (1992) producing the healthy heart manual also relevant.

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PSYCHOLOGY AND ABNORMALITY

Section A

13 (a) Explain, in your own words, what is meant by the 'behavioural model of abnormality'. [2]

Typically: collection of assumptions concerning the way abnormality is caused and treated. Includes medical, psychological (behavioural, psychodynamic, etc.).

(b) Describe the assumptions of the behavioural model of abnormality. [3]

Most likely:

- all behaviour is learned through the principles of classical conditioning (association) and operant conditioning (reinforcement);
- dysfunctional (maladaptive) behaviour is learned in exactly the same way;
- dysfunctional behaviour can be treated with behaviour therapies, or with behaviour modification, where maladaptive behaviours are replaced with adaptive behaviours.

(c) Describe <u>two</u> behavioural treatments of abnormality. [6]

There are a number of **behavioural** treatments:

- **Systematic desensitisation** is a therapy based on the principles of classical conditioning. It was developed by Wolpe in 1958, specifically for counter-conditioning fears, phobias and anxieties.
- **Cognitive behaviour therapy** changes the way a person thinks (the cognitive part) *and* the way a person behaves (the behavioural part). It may focus on how a person responds to a particular situation. This is done not by going back to the **cause** of the problem, but by focusing on the **present symptoms**. It works by looking at how a person **thinks** an event has affected how he/she **felt** and what he/she **did**. If negative thoughts can be reinterpreted or changed for more positive or realistic **thoughts**, then the person will **feel** better and their **behaviour** will change. Sensky (2000) has used cognitive behaviour therapy in the treatment of schizophrenia.
- **Token economy**: Paul and 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.

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14 (a) Explain, in your own words, what is meant by 'overcoming anxiety disorder'. [2]

Typically: anxiety disorders: a general feeling of dread or apprehensiveness accompanied by various physiological reactions such as increased heart rate, sweating, muscle tension, rapid and shallow breathing. Crucially any answer must also address the 'overcoming' part and acknowledge some form of overcoming, controlling or managing.

(b) Describe the characteristics of generalised anxiety disorder. [3]

Most likely:

- Generalised anxiety disorder (GAD) is an anxiety disorder that is characterised by **excessive, uncontrollable and often irrational worry** about everyday things that is disproportionate to the actual source of worry.
- This often **interferes** with **daily functioning**.
- Physical symptoms include fatigue, fidgeting, headaches, nausea, numbness in hands and feet, muscle tension, muscle aches, difficulty swallowing, bouts of difficulty breathing, trembling, twitching, irritability, sweating, insomnia, hot flushes, and rashes.
- These symptoms must be consistent and on-going, persisting at least 6 months, for a formal diagnosis of GAD.

(c) Describe <u>two</u> ways in which generalised anxiety disorder may be treated. [6]

- **Systematic desensitisation** is a therapy based on the principles of classical conditioning. It was developed by Wolpe in 1958, specifically for counter-conditioning fears, phobias and anxieties. The idea behind systematic desensitisation is to replace the conditioned fear, which is maladaptive, with one of relaxation, which is an adaptive and desirable response. The pairing of the feared stimulus with relaxation induces the desensitisation.
- Ost and Westling (1995) investigated the effectiveness of **cognitive behaviour therapy** (CBT) in the treatment of panic disorder. The out-patients in their sample were treated over 12 weekly sessions. The results revealed a significant reduction in the number of panic attacks in the patients, who were also panic-free at the follow-up. They also found that the treatment led to reductions in generalised anxiety, depression and cognitive misinterpretations.

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Section B

15 (a) Describe what psychologists have discovered about classifying and diagnosing abnormality. [8]

Many aspects could be included.

- Could be historical, moving from 'witchcraft' to the founders of modern classification.
- In 1896 Kraepelin created the first comprehensive system of classification of psychological disorders, the International Classification of Diseases and Related Health Problems. The ICD, now at version 10, listed *all* diseases, so a classification system just for psychological problems was devised in 1952 in the United States and is the Diagnostic and Statistical Manual of Mental Disorders or DSM VI which is now revised.
- Another aspect is classification. This could be general: neuroses and psychoses to a much more specific breakdown.
- There could be a focus on approaches: medical, psychological, behavioural, psychoanalytic, humanistic, etc.
- Another aspect could be diagnosing. The Rosenhan key study may feature here, with a look at type one and type two errors.
- Definitions of abnormal behaviour: **Deviation from statistical norms**: this is simply deviating from the norm or average as in a normal distribution curve. Anyone at either end of the curve is 'abnormal' or atypical. **Deviation from social norms**: the norms of a society have expectations of how people should think and how they should behave. **Deviation from ideal mental health**: if the characteristics of ideal mental health could be determined, then anyone not possessing those characteristics, or deviating from them, by definition would be abnormal. **Failure to function adequately**: suggests that people who experience personal distress or discomfort will seek the help of a health care professional.

(b) Evaluate what psychologists have discovered about classifying and diagnosing abnormality. [10]

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

- points about defining and categorising abnormality;
- cultural and individual differences in abnormality;
- comparing and contrasting explanations of cause;
- deterministic explanations;
- nature versus nurture;
- reliability of diagnosis.

(c) Giving reasons for your answer, suggest a treatment for a classified abnormality. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
The treatment suggested will depend on the classified abnormality chosen. This could be schizophrenia, abnormal affect, an anxiety disorder, etc. Treatments could be:

- medical, such as use of drugs or electro-convulsive therapy;
- behavioural, such as systematic desensitisation, cognitive behaviour therapy, token economy;
- alternative approaches, such as psychotherapy.

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16 (a) Describe what psychologists have found out about somatoform disorders. [8]

Typically: disorders in which physical symptoms are prominent but no cause can be found. Similarly: physical symptoms that mimic disease or injury for which there is no identifiable physical cause.

Types:

- **Hypochondriasis**: preoccupation and exaggerated concerns about health, or having a serious illness.
- **Conversion**: where patients present with neurological symptoms such as numbness, paralysis, or fits, but where no neurological explanation can be found.
- **Somatisation**: (Briquet's syndrome) patients who chronically and persistently complain of varied physical symptoms that have no identifiable physical origin.
- **Psychogenic pain**: reports of pain with no physical cause.
- Less likely but to be given credit (and definitions vary as to whether this is a somatoform disorder) is **body dysmorphic disorder**: in which the affected person is excessively concerned about and preoccupied by an imagined or minor defect in his or her physical features.

Explanations:

- **Psychoanalytic**: emotionally charged conflicts were repressed then converted into physical symptoms that serve as outlets.
- **Behavioural**: often maladaptive behaviour – possibly attention-seeking.

(b) Evaluate what psychologists have found out about somatoform disorders. [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;
- usefulness of therapies;
- implications of individual and society.

(c) Giving reasons for your answer, suggest ways in which somatoform disorders may be treated with non-medical approaches. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Most likely: cognitive behaviour therapy: an approach that aims to influence dysfunctional emotions, behaviours and cognitions through a goal-oriented, systematic procedure. Phillips found that for patients with BDD who were randomly assigned to Cognitive Behaviour Therapy or no treatment, BDD symptoms decreased significantly in those patients undergoing CBT. BDD was eliminated in 82% of cases at post-treatment and 77% at follow-up.

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PSYCHOLOGY AND ORGANISATIONS

Section A

17 (a) Explain, in your own words, what is meant by 'accidents in operator-machine systems'. [2]

Typically: 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). Alternatively: the interaction between workers and tools or devices to perform a task. Important addition to this question is the word 'accident', so this must be addressed in order to gain full marks.

(b) Give <u>one</u> example of an operator-machine system. [3]

Any relevant example can go here. These can range from a person using a hammer and a nail to very complex systems such as an air traffic controller. Modern technology has increased O-M systems so it may be a person working with a computer.

(c) Describe <u>two</u> types of error in operator-machine systems. [6]

Most likely:
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);
- timing errors – too quickly or too slowly.

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18 (a) Explain, in your own words, what is meant by 'temporal conditions of work environments'. [2]

Typically temporal (from tempes) means time. Most likely is shift-work. Also credited is any form of on-call system where a worker (e.g. doctor) can be on-call for long periods of time.

Also relevant are:
Compressed work weeks and **flexitime**. Pheasant outlines primary chronic fatigue, extremely Karoshi (Japanese for sudden death due to overload). Minor effects may be sleep disturbance, physical and mental.

(b) Describe <u>two</u> types of shiftwork. [6]

Most likely: short rotation or rapid rotation or 'continental' or 'metropolitan' approaches. Can have also have compressed work weeks or flexitime or 'on-call' system. Answers must be psychological for full marks.

(c) Describe <u>one</u> way in which temporal conditions of work environments may be improved. [3]

Two schools of thought:
Rapid rotation theory: based on frequent change and preferred by workers who only do same shift for short time. Two options: *metropolitan rota*: 2 early, 2 late, 2 night, 2 rest; *continental rota*: 2 early, 2 late, 3 night, 2 rest, then 2 early, 3 late, 2 night, 3 rest; etc.

Slow rotation theory: should change as infrequently as possible to minimise effects but not popular.

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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: 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. wages 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 human resource manager. Giving reasons for your answer, suggest how you would appraise the performance of employees. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
A performance appraisal is the process of assessing or evaluating workers/employees on various work-related dimensions; a formalised means of assessing worker performance. They are important to both employer and employee. 'Hard' appraisal includes quantifiable measures such as number of units produced in 1 hour. 'Soft' includes judgements or ratings done by line manager.

Most likely: specific job analysis techniques: 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 discovered about leadership and management. [8]

Many theories to choose from:

- **Universalist theories** of leadership: The *Great Man Theory* (Wood, 1913); McGregor (1960) *Theory X and Theory Y*.
- **Behavioural theories** of leadership: researchers at Ohio State University Halpin and Winer (1957) suggested *initiating structure* and *consideration*; researchers at the University of Michigan identified *task-oriented behaviours* and *relationship-oriented behaviours.* This extended into Blake and Moulton's (1985) *Managerial Grid*.
- **Charismatic** (or transformational) leaders have the determination, energy, confidence and ability to inspire followers.

Contingency theories of leadership: Fiedler's contingency model (Fiedler, 1967); House's (1971) *path-goal theory*; Vroom and Yetton (1973) proposed a *decision-making theory*; Dansereau et al. (1975) proposed a *leader-member exchange model*.

(b) Evaluate what psychologists have discovered about leadership and management. [10]

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

- comparing and contrasting theoretical explanations;
- the implications leadership style have for follower behaviour;
- examining theoretical strengths and weaknesses;
- how psychologists gain their evidence.

(c) If you owned a company, what leadership style would you use? Give reasons for your answer. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Any appropriate answer that is psychological; most likely one of the theories outlined above. Also acceptable is management style: **Tuckman** (1965) 4 stages: forming, storming, norming and performing. Also **Woodcock** (1979) outlines 4 stages of team development. **Zander's** (1982) achievement-orientated and help-orientated people is pertinent as could be **McGregor's** (1960) effective and ineffective groups. Most likely leadership style: **Lewin's** autocratic, democratic and laissez-faire styles.

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