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PSYCHOLOGY **9990/31**

Paper 3 Specialist Options: Theory **October/November 2019**

MARK SCHEME

Maximum Mark: 60

Published

This mark scheme is published as an aid to teachers and candidates, to indicate the requirements of the examination. It shows the basis on which Examiners were instructed to award marks. It does not indicate the details of the discussions that took place at an Examiners' meeting before marking began, which would have considered the acceptability of alternative answers.

Mark schemes should be read in conjunction with the question paper and the Principal Examiner Report for Teachers.

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Generic Marking Principles

These general marking principles must be applied by all examiners when marking candidate answers. They should be applied alongside the specific content of the mark scheme or generic level descriptors for a question. Each question paper and mark scheme will also comply with these marking principles.

GENERIC MARKING PRINCIPLE 1:

Marks must be awarded in line with:

- the specific content of the mark scheme or the generic level descriptors for the question
- the specific skills defined in the mark scheme or in the generic level descriptors for the question
- the standard of response required by a candidate as exemplified by the standardisation scripts.

GENERIC MARKING PRINCIPLE 2:

Marks awarded are always **whole marks** (not half marks, or other fractions).

GENERIC MARKING PRINCIPLE 3:

Marks must be awarded **positively**:

- marks are awarded for correct/valid answers, as defined in the mark scheme. However, credit is given for valid answers which go beyond the scope of the syllabus and mark scheme, referring to your Team Leader as appropriate
- marks are awarded when candidates clearly demonstrate what they know and can do
- marks are not deducted for errors
- marks are not deducted for omissions
- answers should only be judged on the quality of spelling, punctuation and grammar when these features are specifically assessed by the question as indicated by the mark scheme. The meaning, however, should be unambiguous.

GENERIC MARKING PRINCIPLE 4:

Rules must be applied consistently e.g. in situations where candidates have not followed instructions or in the application of generic level descriptors.

GENERIC MARKING PRINCIPLE 5:

Marks should be awarded using the full range of marks defined in the mark scheme for the question (however; the use of the full mark range may be limited according to the quality of the candidate responses seen).

GENERIC MARKING PRINCIPLE 6:

Marks awarded are based solely on the requirements as defined in the mark scheme. Marks should not be awarded with grade thresholds or grade descriptors in mind.

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Generic levels of response marking grids

Table A
The table should be used to mark the 8 mark part (a) 'Describe' questions (2, 4, 6 and 8).

Level	Marks	Level descriptor
4	7–8	• Description is accurate, coherent and detailed and use of psychological terminology is accurate and comprehensive. • The answer demonstrates excellent understanding of the material and the answer is competently organised.
3	5–6	• Description is mainly accurate, reasonably coherent and reasonably detailed and use of psychological terminology is accurate but may not be comprehensive. • The answer demonstrates good understanding of the material and the answer has some organisation.
2	3–4	• Description is sometimes accurate and coherent but lacks detail and use of psychological terminology is adequate. • The answer demonstrates reasonable (sufficient) understanding but is lacking in organisation.
1	1–2	• Description is largely inaccurate, lacks both detail and coherence and the use of psychological terminology is limited. • The answer demonstrates limited understanding of the material and there is little, if any, organisation.
0	0	• No response worthy of credit.

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Table B
The table should be used to mark the 10 mark part (b) 'Evaluate' questions (2, 4, 6 and 8).

Level	Marks	Level descriptor
4	9–10	• Evaluation is comprehensive and the range of issues covered is highly relevant to the question. • The answer demonstrates evidence of careful planning, organisation and selection of material. • There is effective use of appropriate supporting examples which are explicitly related to the question. • Analysis (valid conclusions that effectively summarise issues and arguments) is evident throughout. • The answer demonstrates an excellent understanding of the material.
3	7–8	• Evaluation is good. There is a range of evaluative issues. • There is good organisation of evaluative issues (rather than 'study by study'). • There is good use of supporting examples which are related to the question. • Analysis is often evident. • The answer demonstrates a good understanding of the material.
2	4–6	• Evaluation is mostly accurate but limited. Range of issues (which may or may not include the named issue) is limited. • The answer may only hint at issues but there is little organisation or clarity. • Supporting examples may not be entirely relevant to the question. • Analysis is limited. • The answer lacks detail and demonstrates a limited understanding of the material. Note: • If the named issue is not addressed, a maximum of 5 marks can be awarded. • If only the named issue is addressed, a maximum of 4 marks can be awarded.
1	1–3	• Evaluation is basic and the range of issues included is sparse. • There is little organisation and little, if any, use of supporting examples. • Analysis is limited or absent. • The answer demonstrates little understanding of the material.
0	0	• No response worthy of credit.

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Psychology and abnormality

Question	Answer	Marks
1(a)	**Explain what is meant by 'schizophrenia'.** Award 1 mark for a basic explanation of the term/concept. Award 2 marks for a detailed explanation of the term/concept. For example: Schizophrenia is a mental health disorder that involves positive and negative symptoms (1). Positive symptoms include things such as hallucinations and delusions (1). Negative symptoms might include speech poverty and flattening of mood (1). It is a break from reality where the person experiences symptoms such as hallucinations and delusions (1). Hallucinations are a positive symptom of schizophrenia (1). Types of schizophrenia are no longer on the syllabus, but can be credited, only up to a maximum of 1 mark if this is all that is given (e.g. simple, paranoid, catatonia, delusional disorder, etc.) Other appropriate responses should also be credited.	**2**
1(b)	**Describe the genetic explanation of schizophrenia, as outlined by Gottesman and Shields (1972).** Award 1–2 marks for a basic answer with some understanding of the topic area. Award 3–4 marks for a detailed answer with clear understanding of the topic area. For example: Schizophrenia appears to have a genetic cause as shown by Gottesman and Shields in their review of studies of adoption, siblings and twins with schizophrenia (1). All adoption studies found an increased incidence of schizophrenia in adopted children with a schizophrenic biological parent (1). Biological siblings of children with schizophrenia showed a much higher percentage of schizophrenia (1). All twin studies found a higher concordance rate for schizophrenia in monozygotic (MZ) than dizygotic (DZ) twins (1). In Gottesman and Shield's own study the rate was 58% for identical twins, and 12% for non-identical twins (1). There is a heavy genetic input into the onset of schizophrenia (1). Other appropriate responses should also be credited.	**4**

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Question	Answer	Marks
1(c)	**Explain <u>one</u> similarity and <u>one</u> difference between cognitive and genetic explanations of schizophrenia.** Comparison will be for the cognitive explanation as outlined by Frith (1992) and the genetic explanation as outlined by Gottesman and Shields (1972). **Similarities** Both Gottesman and Frith believe that there is a **biological basis** for schizophrenia. Gottesman focusses on genetics and Frith also believes that genetics plays a part in the development of schizophrenia. Gottesman found a high concordance rate between MZ twins. Frith suggests that brain structure and biochemical processes also influence the development of the disorder. This shows that both explanations suggest a biological basis for the disorder. Both suggest **nature** is important in the development of schizophrenia – Gottesman suggests schizophrenia has a strong genetic cause and Frith suggests that schizophrenia cognitive difficulties are linked to genetics, brain structure and biochemical processes. Offer an **individual** explanation of schizophrenia. Gottesman suggests that one's individual genetic make-up causes schizophrenia and not environmental factors. Frith suggests it is the person's individual faulty mental processing (likely caused by biological factors) that lead to the development of the disorder and not environmental or social factors. Both explanations are backed up by **experiments**. Gottesman and Shields did many studies on twins and families to prove the genetic explanation of schizophrenia. Frith did a lab study where schizophrenic participants were unable to identify whether items that had been read aloud were done by a computer, the experimenter or themselves which shows the attention difficulties patients with schizophrenia have. **Differences** Frith also brings in a **cognitive** explanation of why the symptoms occur which is not done by Gottesman and Shields. Gottesman and Shields focus on the genetic cause of the disorder. Frith adds to this explanation by explaining the symptoms of the disorder due to faulty mental processing. Genetic explanation is **more reductionist** than the cognitive explanation. Gottesman and Shields just focus on the genetic cause of the disorder and do not consider other biological processes or cognitive explanations. Frith considers both biological causes and how these could lead to cognitive deficits such as faulty mental processing.	**6**

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Question	Answer	Marks
1(c)	Mark according to the levels of response criteria below: Level 3 (5–6 marks) • Candidates will show a clear understanding of the question and will include one similarity and one difference. • Candidates will provide a good explanation with clear detail. Level 2 (3–4 marks) • Candidates will show an understanding of the question and will include one appropriate similarity in detail or one appropriate difference in detail. OR one similarity and one difference in less detail. • Candidates will provide a good explanation. Level 1 (1–2 marks) • Candidates will show a basic understanding of the question and will attempt a similarity and/or difference. This could include both but just as an attempt. • Candidates will provide a limited explanation. Level 0 (0 marks) No response worthy of credit. Other appropriate responses should also be credited.	

Question	Answer	Marks
2(a)	**Describe the treatment and management of depression.** Treatment and management of depression, including the following: • Biological: chemical/drugs (MAO, SSRIs) • Electro-convulsive therapy • Cognitive restructuring (Beck, 1979) • Rational emotive behaviour therapy (Ellis, 1962) **Biological: chemical/drugs (MAOI, SSRIs)** MAOI – older antidepressants not frequently used today. Inhibit monoamine oxidase. This is responsible for breaking down norepinephrine, serotonin and dopamine. The other more common medication prescribed is selective serotonin reuptake inhibitors (SSRIs). These can help improve depression by increasing the levels of serotonin in the brain. This can occur in two ways as the SSRI will increase the amount of serotonin in the blood stream as well as prevent it being reabsorbed and broken down once it crosses a synapse in the brain. **Electro-convulsive therapy** Involves passing electricity through the brain to induce a seizure. Can be bilateral or unilateral. The electric current is applied once the patient has been sedated. The seizure is monitored by the doctor and can last up to a minute. Patients may be given 6 to 12 sessions over a number of weeks. **Cognitive restructuring (Beck, 1979)** This is where the patient participates in a number of therapy sessions over weeks and/or months to alleviate their symptoms of depression. As it is believed the depressive symptoms are due to faulty thinking the therapist will help the patient to identify their faulty thinking and then correct these thinking patterns to more helpful ways of viewing themselves, the world and the future. Initially the patient and therapist will identify what the thinking patterns are, and the patient will be helped to come up with alternative thoughts. The patient then goes away between sessions and practices these alternative thoughts which should then lead to more helpful behaviours. **Rational emotive behaviour therapy (Ellis, 1962)** This follows the ABC model: Activating agent – what is the behaviour and/or attitude of the patient towards events in their lives. Beliefs – what is the belief of the patient toward the event. Cognitive – what types of thoughts does the patient have with regard to the event. Ellis believes if a person has constant negative beliefs about events in their lives, they are likely to suffer from depression. The goal of therapy is to identify the unhelpful thoughts and replace them with more rational and constructive thoughts. The patient will go away between sessions and practice developing more helpful thoughts about life experiences. Mark according to the levels of response descriptors in Table A. Other appropriate responses should also be credited.	**8**

Question	Answer	Marks
2(b)	**Evaluate the treatment and management of depression, including a discussion of ethics.** A range of issues could be used for evaluation here. These include: • **Named issue** – **Ethics** – Candidates can consider both the ethics of the treatments (e.g. side effects, cost, etc.) or the ethics of the research that investigates the treatment and management of depression. For example, both the drug and ECT treatment have side effects that will be unpleasant for the patient whereas the therapies have no side effects but may be too costly for a patient to afford and therefore they are prevented from feeling better which is unethical. Or the ethics of research where the participants experience side effects or not and/or whether there is a placebo group who is not being given the treatment and therefore may not improve in terms of their depression and this is unethical. Many studies offer the placebo/control condition the opportunity to have the treatment at a later date which is more ethical. • Validity. • Application of psychology to everyday life (with reference to treatments). • Nature versus nurture debate with reference to the various treatments. • Comparisons of different treatments. • Reductionist/holistic nature of the treatments. • Deterministic nature of the treatments. • Appropriateness of treatments (e.g. cost, time, side-effects). • Research support for effectiveness of treatments. • Evaluation of research that shows support for effectiveness of treatments. Mark according to the levels of response descriptors in Table B. Other appropriate responses should also be credited.	**10**

Psychology and consumer behaviour

Question	Answer	Marks
3(a)	**Explain what is meant by the term 'choice heuristics' in consumer decision-making.** Award 1 mark for a basic explanation of the term/concept. Award 2 marks for a detailed explanation of the term/concept. For example: These are mental shortcuts that enable the consumer to decide what to buy quickly (1), e.g. availability (likelihood of product being available and also free from fault) (1) and representativeness (making comparisons between similar, available products) (1). Other types can also be credited e.g. anchoring. Other appropriate responses should also be credited.	**2**
3(b)	**Outline <u>two</u> aims of the study by Wansink et al. (1998) on consumer decision-making.** Award 1–2 marks for a basic answer with some understanding of the topic area. Award 3–4 marks for a detailed answer with clear understanding of the topic area. For example: Aims Study 1 – To investigate whether multiple-unit pricing (or an example 2 for $1.50) increased sales in a supermarket (2). Study 2 – To investigate whether giving consumers high purchase quantity limits (e.g. limit 3 per customer) increase sales (2). Study 3 – To investigate whether suggestive selling anchor (e.g. slogans – 'Snickers – buy for freezer') and discount level increased sales (2). Study 4 – To investigate whether internal/self-generated anchors moderate/limit the impact of anchor-based promotions (2). Other appropriate responses should also be credited.	**4**

Question	Answer	Marks
3(c)	**Explain the validity of the study by Wansink et al. (1998).** Points could include: Study 1 – Good ecological validity as a one-week study in a supermarket but cannot generalise to other types of shops/products. Good population validity as in 86 supermarkets. Good internal validity as each store randomly assigned to one of two conditions (single or multiple promotion condition). Study 2 – Good ecological validity as in 3 supermarkets but cannot generalise to the types of shops/products. Good population validity 914 customers in 3 supermarkets (but all from Iowa, USA – lowers the population validity). Study 3 – Lower ecological validity as a shopping scenario study. Some population validity as 120 participants but all undergraduates from one university. Study 4 – Some population validity as 139 participants but all undergraduates from a large university. Lower ecological validity as a shopping scenario study. All 4 studies – Good face validity as investigating anchoring in all four studies Poor temporal validity as supermarket shopping has changed and many customers now purchase their products online. Poor validity as just uses quantitative data so no reasoning behind consumer choice is given – just the increase in sales (studies 1 and 2) or intended purchase quantities (studies 3 and 4). Although a small amount of qualitative data was collected in study 4, it was not for the purpose of analysing purchasing decisions. Credit any explanation of the validity of any of the four studies by Wansink et al.	**6**

Question	Answer	Marks
3(c)	Mark according to the levels of response criteria below: Level 3 (5–6 marks) • Candidates will show a clear understanding of the question and will explain at least two points regarding validity. • Candidates will provide a good explanation with clear detail. Level 2 (3–4 marks) • Candidates will show an understanding of the question and will explain one point about validity in detail or two or more in less detail. • Candidates will provide a good explanation. Level 1 (1–2 marks) • Candidates will show a basic understanding of the question and will attempt an explanation. • Candidates will provide a limited explanation. Level 0 (0 marks) No response worthy of credit. Other appropriate responses should also be credited.	

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Question	Answer	Marks
4(a)	**Describe what psychologists have discovered about communication and advertising models.** Communication and advertising models, including the following: • Changing attitudes and models of communication (source, message, etc.) • AIDA model (and updates of it) • Hierarchy of effects model **Changing attitudes and models of communication (source, message, etc.)** This model explains how advertisements attempt to change and influence consumers so that they purchase their product. Source – where the message is coming from and how trustworthy and credible this source is to the consumer. It could be presented by an expert or by a celebrity. Message – how the information in the advertisement is presented to the consumer e.g. is it a one or a two-sided argument. Audience – what type of consumers may purchase the product. The advertisement needs to be tailored to them, e.g. If it is young or old consumers. Credit can also be given to the Yale Model of Communication linked to advertising (attention, comprehension and acceptance). **AIDA model (and updates of it)** Behavioural model of advertising. Four stages including: Attention (or awareness) – must attract the attention of the consumer. Interest – to make the advertisement get the viewers to want to know more about the product. Desire – to maintain or increase a feeling of need for the product. Action – for the consumer to go out and purchase the product. Updates – CAB model (Cognition, Affect and Behaviour); TIREA scale (Thought, Interest, Risk, Engagement and Action); REAN model (Reach, Engage, Activate and Nurture); NAITDASE (Need, Attention and Interest, Trust, Desire and Action of purchase); DAGMAR (Defining Advertising Goals for Measured Advertising Results). **Hierarchy of effects model** Six stages: Awareness – Becomes aware of the product through advertising. Knowledge – Information about the product that the consumer needs to become aware of (simple for some products such as food and more complex for other products such as a car). Liking – Makes sure the consumer likes the product and also more than similar products. Preference – Similar to liking. Likes the product more than the competitions. Conviction – Strengthens desire to purchase (e.g. through a discount or free offer) Purchase – Go and buy the product. Mark according to the levels of response descriptors in Table A. Other appropriate responses should also be credited.	**8**

Question	Answer	Marks
4(b)	**Evaluate what psychologists have discovered about communication and advertising models, including a discussion about applications to everyday life.** A range of issues could be used for evaluation here. These include: • **Named issue** – applications to everyday life – there are some practical applications about what to consider when advertising a product (e.g. to give a special offer to new consumers for the Hierarchy of effects model and use a persuasive person in the advertisement in the models of communication). • Reductionism • The models are theoretical and require evidence to back up the point. In order to be applicable to consumer behaviour this evidence must be about consumers and also test consumers in a wide variety of business environments. • Determinism. • Ethnocentric to the West. Mark according to the levels of response descriptors in Table B. Other appropriate responses should also be credited.	**10**

Psychology and health

Question	Answer	Marks
5(a)	**Explain what is meant by 'self-reports' as a subjective measure of non-adherence to medical advice.** Award 1 mark for a basic explanation of the term/concept. Award 2 marks for a detailed explanation of the term/concept. For example: Asking the patient if they are following the medical advice (1) given to them by their practitioner (1). Asking the medical practitioner if the patient (1) is following the medical advice they have given to them (1). Other appropriate responses should also be credited.	**2**
5(b)	**From the health belief model by Becker and Rosenstock (1974):**	
5(b)(i)	**State <u>two</u> beliefs of this model.** Award one mark for each correct point, e.g. perceived vulnerability (1), costs and benefits (1), and perceived susceptibility (1). Other appropriate responses should also be credited.	**2**
5(b)(ii)	**Explain how <u>one</u> of these beliefs applies to non-adherence to medical advice.** Award 1 mark for a basic answer with some understanding of the topic area e.g. not clearly linking the model to an explanation of why patients don't adhere to medical advice. Award 2 marks for a detailed answer with clear understanding of the topic area e.g. clear links to why patients don't adhere to medical advice. For example: 2 mark responses Patients will weigh up cost and benefits of following medical advice. If the costs outweigh the benefits the patient is likely to not follow the medical advice. The patients might perceive that they are not vulnerable to getting that particular health problem and would therefore not follow medical advice to reduce their risk of developing the problem. For example, if they do not think they are vulnerable to heart problems the patient may choose to continue to eat in an unhealthy way and take no exercise. Other aspects of the model can be referred to. Credit can be given to examples. Other appropriate responses should also be credited.	**2**

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Question	Answer	Marks
5(c)	**Explain <u>one</u> strength and <u>one</u> weakness of the health belief model, as applied to non-adherence to medical advice.** **Strengths** • Does take into account individual differences as perceived costs and benefits will be different for every patient. • Could be used to suggest that practitioners emphasise both cost and benefits with their patients to try to get them to follow their advice more closely so has good applications. • Holistic model – provides a comprehensive model of reasons for adherence and non-adherence. Takes into account factors such as the individual's perceptions and modifying factors to predict the likelihood of action. • Practical application for the patient. The patient could be made aware of the health belief model and apply this to their decisions about medical advice. **Weaknesses** • Theoretical model without evidence from non-adherence to medical advice to back it up. • Could be seen as culturally biased as it assumes a traditional practitioner–patient relationship and ignores alternative health practitioners and cultural variations that might affect adherence. Mark according to the levels of response criteria below: Level 3 (5–6 marks) • Candidates will show a clear understanding of the question and will discuss one strength and one weakness. • Candidates will provide a good explanation with clear detail. Level 2 (3–4 marks) • Candidates will show an understanding of the question and will discuss one appropriate weakness in detail or one appropriate strength in detail. OR one weakness and one strength in less detail. • Candidates will provide a good explanation. Level 1 (1–2 marks) • Candidates will show a basic understanding of the question and will attempt a discussion of either a strength or a weakness. There could also be a discussion of both a strength and a weakness but just as an attempt. • Candidates will provide a limited explanation. Level 0 (0 marks) No response worthy of credit. Other appropriate responses should also be credited.	**6**

Question	Answer	Marks
6(a)	**Describe what psychologists have discovered about patient and practitioner diagnosis and style.** Patient practitioner diagnosis and style, including the following – • Practitioner style: doctor and patient-centred (Byrne and Long, 1976, Savage and Armstrong, 1990). • Practitioner diagnosis: type I and type II errors. • Disclosure of information (Robinson and West, 1992). **Doctor and patient-centred (Byrne and Long, 1976, Savage and Armstrong, 1990)** Byrne and Long analysed 2500 recordings of medical consultations in a variety of countries, including England and Australia. They discovered the two distinctive practitioner styles. Features of the doctor-centred style: • Doctor asked closed questions (patient could only answer 'yes' or 'no'). • Doctor ignored patients' attempts to elaborate on their answers. • Doctor placed most focus on the first problem described by the patient. • Doctor made links between symptoms and their diagnosis without discussion or alternatives. • Everything was based on 'fact' rather than two-way communication. • Impersonal atmosphere. • Patient was overall passive during the consultation. Features of the patient-centred style: • Doctor asked open-ended questions. • Patient was given chances to give descriptions and elaborate on answers. • Doctor used less medical jargon; patient could understand diagnosis and treatment options. • Patient had the chance to participate in decision-making. • Personal atmosphere. • Patient was very active during the consultation. **Savage and Armstrong (1990)** Savage and Armstrong compared a patient-centred style (sharing consultative process) with the doctor-centred style (traditional doctor-led process). All the patients involved in the study reported that they were highly satisfied with the consultation. However, straight after the consultation and one week later, it was found that they preferred the doctor-led style. It is possible that this is due to people being more familiar with the traditional method; adjusting to a newer consultation style could take time for patients and their doctors. **Practitioner diagnosis: type I and type II errors** Type I error – well patient diagnosed as ill. Type II error – ill patient diagnosed as well. The Type I and II errors are also known as the 'false positive' and 'false negative', respectively. [Note that Rosenhan reversed these definitions.]	**8**

Question	Answer	Marks
6(a)	**Disclosure of information (Robinson and West, 1992)** Robinson and West conducted a study on patients at a genito-urinary clinic. They discovered that the patients gave more information to a computer than to the doctor they met afterwards. For example, they admitted to having more sexual partners and revealed more symptoms. This suggests that computers can be used to help patients communicate more comfortably and openly. Mark according to the levels of response descriptors in Table A. Other appropriate responses should also be credited.	
6(b)	**Evaluate what psychologists have discovered about patient and practitioner diagnosis and style, including a discussion about validity.** • **Named issue** – Validity (probably around the data collection method used) e.g. self-report methods used in all three of the studies and collected primary data from the participants. It could be subjective, and also open to bias. Type I and type II error rely on the self-report of the patients which can be inaccurate. The doctor can also misinterpret the description of symptoms given by the patient. Patients may not be honest, show demand characteristics, etc. • Determinism. • Reliability of data collection methods. • Strengths and weaknesses of method and/or design. • Sampling and generalisations. • Situational/individual explanations. • Ethics. Mark according to the levels of response descriptors in Table B. Other appropriate responses should also be credited.	**10**

Psychology and organisations

Question	Answer	Marks
7(a)	**Explain what is meant by 'open plan offices'.** Award 1 mark for a basic explanation of the term/concept. Award 2 marks for a detailed explanation of the term/concept. For example: An office with no interior walls or low partitions (1), with no separate rooms or offices (1). Other appropriate responses should also be credited.	**2**
7(b)	**Describe the findings of the study by Cowpe (1989) of a safety promotion campaign to avoid chip pan fires.** Award 1–2 marks for a basic answer with some understanding of the topic area. Award 3–4 marks for a detailed answer with clear understanding of the topic area. For example: The results of the campaigns show 'net' declines in each area where the safety advertisements were shown of between 7 and 25% over a twelve-month period (2). The largest reduction in chip-pan fires was during the campaign (1). Questionnaires showed a significant increase in awareness of chip pan fires and safety measures to be taken – confidence in ability to cope with a chip-pan fire improved (1). The greatest change in chip-pan fire was reported during and immediately following the advertising campaign and this did reduce once the campaign had finished (1). Other appropriate responses should also be credited.	**4**

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Question	Answer	Marks
7(c)	**Explain <u>one</u> strength and <u>one</u> weakness of the study by Cowpe (1989) of a safety promotion campaign to avoid chip pan fires.** **Strengths** • Useful (applications to everyday life) as it shows the effectiveness of advertising campaigns and also the reduction in terms of cost to human life as well as the cost to the state for emergency services. • Good ecological validity as the advertisements were released as normal. • Good sample size – 5 regions in the UK. • Longitudinal so can investigate change in behaviour over time. • Quantitative data – can make comparisons between before and after the safety promotion campaign. • Data is from government/fire service statistics of chip pan fires reported so is free from experimenter bias. **Weaknesses** • Poor temporal validity as it was done in 1970s–1980s and in the modern day we have a lot more access to different types of media (also chip pans are not really used today). • Ethnocentric to the UK, there could have been other factors that led to the reduction in chip pan fires other than the advertising campaign (e.g. improvements in the safety features on the chip pan or less use of gas stoves). • Quantitative data – do not know the full reasoning behind the reduction in chip pan fires. • Some chip pan fires may not have been reported. Mark according to the levels of response criteria below: Level 3 (5–6 marks) • Candidates will show a clear understanding of the question and will discuss one strength and one weakness. • Candidates will provide a good explanation with clear detail. Level 2 (3–4 marks) • Candidates will show an understanding of the question and will discuss one appropriate weakness in detail or one appropriate strength in detail. OR one weakness and one strength in less detail. • Candidates will provide a good explanation. Level 1 (1–2 marks) • Candidates will show a basic understanding of the question and will attempt a discussion of either a strength or a weakness. There could also be a discussion of both a strength and a weakness but just as an attempt. • Candidates will provide a limited explanation. Level 0 (0 marks) No response worthy of credit. Other appropriate responses should also be credited.	**6**

Question	Answer	Marks
8(a)	**Describe what psychologists have discovered about cognitive theories about motivation to work.** Cognitive theories about motivation to work, including the following: 1. Goal setting theory (Latham and Locke, 1984) 2. VIE (expectancy) theory (Vroom, 1964) 3. Equity theory (Adams, 1963) **Goal setting theory (Latham and Locke, 1984)** They showed that there was a relationship between how difficult and specific a goal was and people's performance of a task. He found that specific and difficult goals led to better task performance than vague or easy goals. To motivate, goals must have – 1. Clarity – measureable and unambiguous. 2. Challenge – challenging enough to feel a sense of achievement when accomplished. 3. Commitment – goals are understood and agreed upon with the employee 4. Feedback – feedback provides opportunities to clarify expectations, adjust goal difficulty, and gain recognition. 5. Task complexity – the employee should be capable of completing the task set. In addition, give sufficient time to meet the goal or improve performance and provide enough time for the person to practice or learn what is expected and required for success. **VIE (expectancy) theory (Vroom, 1964)** This theory suggests how the actions and behaviours of individuals are done to maximise pleasure and minimise pain. Individuals are therefore more likely to be motivated to do certain acts, if they expect that rewards can be obtained, and that these rewards can be obtained without too much trouble and pain. **Valence** Valence is the strength of preference for obtaining a particular outcome. Valence will be positive when the individual prefers to attain some outcome to not attaining it. If the individual is indifferent, valence will be zero. Great valence will therefore strengthen e.g. an employee's motivation for attaining a particular outcome, which makes it important for managers and employers to discover what is valued by the employees. If an extrinsic factor, such as recognition, is seen as a valuable outcome by an employee, managers may use this information to motivate his/her employee. **Instrumentality** Instrumentality refers to the belief that doing a task will result in the attainment of some valued reward. If instrumentality is high, an employee believes that certain actions will result in the attainment of the rewards valued by him/her. Instrumentality refers to the importance of that e.g. employees see a clear path to rewards and goal attainment, and that they trust that managers will reward their actions as promised. If recognition is seen as valuable by an employee, the manager must thus assure that the employee believes that he/she will get this reward, if the task is accomplished satisfactorily.	**8**

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Question	Answer	Marks
8(a)	**Expectancy** Expectancy relates to the confidence have in themselves in accomplishing a certain task or assignment satisfactorily. If the individual does not regard himself as competent enough to do a certain job, the individual will not see it as feasible to get the desired rewards, and hence demotivate the employee. According to Vroom, the strength of motivation to perform a certain task can be calculated using this formula: Motivation = Valence × Expectancy × Instrumentality **Managers can use the VIE-model accordingly:** Firstly, managers have to find out which rewards the employees want, and which rewards are seen as valuable by the employees (valence). Secondly, managers have to create instrumentality, in which managers must convince the employees about that the accomplishments of certain tasks, will generate the rewards valued by the employees. Thirdly, managers must ensure that the employees have the necessary capabilities to accomplish the given task, so that the employees expect that they will be able to accomplish it, and thus get rewarded. **Equity theory (Adams, 1963)** 'Equity Theory focuses upon a person's perceptions of fairness with respect to a relationship. During a social exchange, an individual assesses the ratio of what is output from the relationship to what is input in the relationship, and also the ratio of what the other person in the relationship outputs from the relationship to what is input into the relationship. Equity Theory posits that if the person perceives that there is inequality, where either their output/input ratio is less than or greater than what they perceive as the output/input ratio of the other person in the relationship, then the person is likely to be distressed.' – Adams. For organisations this is where an employee/employer judges the employees net worth to the company and whether they are equal to the other employees in the same company. They will judge their input to the company and also what they receive for this input in return. In addition, they will compare this judgement to the other employees of the company. If they perceive they are putting in more than they are getting out in comparison to the others in the organisation, the employee will not feel motivated as if the opposite were true. Mark according to the levels of response descriptors in Table A. Other appropriate responses should also be credited.	

Question	Answer	Marks
8(b)	**Evaluate what psychologists have discovered about cognitive theories about motivation to work, including a discussion about determinism.** A range of issues could be used for evaluation here. These include: • **Named issue – determinism**. For all three theories, motivation of an employee is due to their own free will. The involvement of the employer in this motivation with incentives, targets, etc. and can help to motivate, but it is down to the employee if they feel motivated or not. – Locke and Latham is somewhat deterministic as it is often the employer who sets the targets and it can be out of the control of the employee. However, many organisations do involve the employee in setting the targets and making sure they are specific for that individual. – VIE theory is less deterministic as it is the employee's choice about what they find maximises their pleasure and minimises their pain. Once this is discovered by the employer, however, they can put things in place (e.g. pay, conditions of service, etc.) that would be likely to benefit the employee and this is therefore more deterministic as it is causing the motivation of the employee. – Similar to VIE theory the equity theory also involves the free will of the employee as they are judging for themselves whether they feel their contribution is equivalent to the other employees in the company. • Cultural bias of cognitive theories of motivation to work. • Any appropriate evaluation issue of evidence of which leadership style theory is based (no requirement to evaluate any evidence in this response). • Reductionist nature of theory. • Individual/situational debate. • Applications to everyday life. Mark according to the levels of response descriptors in Table B. Other appropriate responses should also be credited.	**10**