GCE 2005
January Series

ASSESSMENT and QUALIFICATIONS ALLIANCE

Mark Scheme

Psychology B Specification

PYB4 Child Development and Options: Psychology of Atypical Behaviour or Health Psychology or Contemporary Topics

Mark schemes are prepared by the Principal Examiner and considered, together with the relevant questions, by a panel of subject teachers. This mark scheme includes any amendments made at the standardisation meeting attended by all examiners and is the scheme which was used by them in this examination. The standardisation meeting ensures that the mark scheme covers the candidates' responses to questions and that every examiner understands and applies it in the same correct way. As preparation for the standardisation meeting each examiner analyses a number of candidates' scripts: alternative answers not already covered by the mark scheme are discussed at the meeting and legislated for. If, after this meeting, examiners encounter unusual answers which have not been discussed at the meeting they are required to refer these to the Principal Examiner.

It must be stressed that a mark scheme is a working document, in many cases further developed and expanded on the basis of candidates' reactions to a particular paper. Assumptions about future mark schemes on the basis of one year's document should be avoided; whilst the guiding principles of assessment remain constant, details will change, depending on the content of a particular examination paper.

Further copies of this Mark Scheme are available to download from the AQA Website: www.aqa.org.uk

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PYB4

Quality of Written Communication

Where candidates are required to produce extended written material in English, the scheme of assessment must make explicit reference to the assessment of the quality of written communication. Candidates should:

- select and use a form and style of writing appropriate to purpose and complex subject matter;
- organise relevant information clearly and coherently, using specialist vocabulary when appropriate;

  and

- ensure text is legible, and spelling, grammar and punctuation are accurate, so that meaning is clear.

The assessment criteria for quality of written communication apply only to questions with 12 marks. The following criteria should be applied in conjunction with the mark scheme.

The awards of marks within a particular mark band can be achieved only if the criteria for the mark scheme and quality of written communication bands have been met.

The quality of written communication bands must be regarded as part of the appropriate mark scheme band even though they are listed separately in the mark scheme. If a candidate satisfies only part of the criteria, for either the mark scheme or the quality of written communication, then s/he cannot be awarded marks in that band. The next lower band must then be considered.

General Approach

Apply the principles below *only* to questions which require a banded mark scheme according to 'Guidelines for Mark Schemes'. This means questions worth twelve marks or more.

Band 1	Excellent Quality of Communication	The candidate will express complex psychology ideas extremely clearly and fluently. Sentences and paragraphs will follow on from one another smoothly and logically with appropriate use of psychological terminology. Presentation of psychological concepts and arguments will be consistently relevant and well structured. There will be few, if any errors of grammar, punctuation and spelling.
Band 2	Average Quality of Communication	The candidate will express moderately complex psychological ideas clearly and reasonably fluently, through well-linked sentences and paragraphs. Some, but not consistent, use of psychological terminology. Presentation of psychological concepts and arguments will be generally relevant and well structured. There may be occasional errors of grammar, punctuation and spelling.

Band 3	Below Average Quality of Communication	The candidate will express straightforward psychological ideas clearly, if not always fluently. Sentences and paragraphs may not always be well connected. Use of psychological terminology may be limited. Presentation of psychological concepts and arguments may sometimes stray from the point or be weak. There may be some errors of grammar, punctuation and spelling, but not such as to suggest a weakness in these areas or to obscure the psychological meaning.
Band 4	Poor Quality of Communication	The candidate will express simple psychological ideas clearly, but may be imprecise and awkward in dealing with complex or subtle concepts. Use of mainly non-specialist language with little, if any, reference to psychological terminology. Presentation of psychological concepts and arguments may be of doubtful relevance or obscure. Errors in grammar, punctuation and spelling may be noticeable and intrusive, suggesting weaknesses in these areas and obscuring the psychological meaning.

SECTION A: Child Development

1 **Total for this question: *20 marks***

(a) Explain **one** way in which children between 15 and 21 months have been shown by psychologists to have developed self-awareness. *(3 marks)*

[AO1 = 1, AO2 = 2]

AO1 One mark giving a valid way. Most candidates will refer to self-recognition as in the mirror/rouge spot studies or studies of photo of self.

AO2 Up to 2 marks for elaborated explanation, including an explanation as to how the child's behaviour indicates awareness of self, ie elaboration of procedure or noting differential responses.

(b) Describe **one** study of sex differences in children's friendships. Indicate why the study was conducted, the method used, results obtained and conclusion drawn. *(5 marks)*

[AO1 = 5, AO2 = 0]

AO1 Any study in which sex differences in children's friendships were investigated is acceptable. Examples include Lever 1976, Leaper 1991, Buhrmester 1996. Also accept Serbin's study of increasing cross-sex play as it implies the pre-existence of differences/Maccoby preference for same-sex playmate (max 3 unless explicitly expressed in terms of sex differences).

1 mark for aim (must go beyond stem)
1 mark for method
1 mark for results
1 mark for conclusion
1 mark for additional detail (credit evaluation if adds to description)

(c) Discuss Bowlby's theory of maternal deprivation. Refer to the work of **at least one** other researcher in your answer. *(12 marks)*

[AO1 = 4, AO2 = 8]

AO1 Up to 4 marks for knowledge of Bowlby's theory of maternal deprivation. Candidates will usually refer to a critical period for attachment, monotropy, and likely negative outcomes such as delinquency, affectionless psychopathy, low IQ etc. Any other relevant information should be given credit.

AO2 Up to 8 marks for discussion and comment on Bowlby's theory. Candidates might refer to the need to differentiate between privation and deprivation, the need for a single relationship, the critical period. Candidates will usually offer evidence which either supports Bowlby (Bowlby 1946, Goldfarb 1943) or contradicts his theory (Rutter 1970, Schaffer and Emerson 1964, Freud and Dann 1951 etc). Credit may also be given for wider issues such as the implications of Bowlby's WHO report for individuals and for child care policy and practice. Credit references to other researches as part of discussion, eg Rutter, Schaffer, Clarke + Clarke. Allow up to 2 marks for any one study.

Maximum 7 marks if no reference to another researcher

Mark Bands

12 – 10 marks **Excellent answers**

Bowlby's theory is thoroughly described showing sound, detailed and accurate knowledge and understanding. There is clear and appropriate reference to the work of another researcher. Discussion is full and well balanced with appropriate analysis. Any references to research are accurate. Evaluative comment is not simply stated but is presented in the context of the discussion as a whole. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks **Good to average answers**

Answer shows knowledge and understanding of Bowlby's theory and there is an attempt to present a balanced discussion. Some analysis is evident and the answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. Any references to research should be relevant but are perhaps not linked so clearly to the discussion as for the top band. Answers without reference to another researcher are limited to the bottom of this band.

6 – 4 marks **Average to poor answers**

Answer shows some knowledge and understanding of the area. There must be some discussion for 5/6 marks. Answers in this band are likely to be mostly descriptive and there is likely to be irrelevance and/or inaccuracy. Any references to research are lacking in detail. Answers constituting reasonable description with minimal focus on the question are likely to be in this band.

3 – 1 marks **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief, perhaps unfinished answer will come into this band.

Total AO1 marks for Question 1: 10
Total AO2 marks for Question 1: 10
Total marks for Question 1: 20 marks

2 **Total for this question: *20 marks***

(a) Outline **two** characteristics of Piaget's formal operational stage of cognitive development. *(4 marks)*

[AO1 = 4, AO2 = 0]

AO1 One mark for each characteristic of the formal operational stage identified plus a further mark each for an outline. Likely answers: abstract reasoning; the ability to form hypotheses; use of deductive/inductive reasoning; the ability to use metaphor. Accept examples showing implicit knowledge of characteristics. Max 1 mark each for characteristics that are in common with the previous stages, eg not egocentric.

(b) Lesley and Kathryn are nursery school teachers. They each take a very different approach to their work. Lesley is influenced by the cognitive developmental theory of Piaget, but Kathryn is influenced by the cognitive developmental theory of Vygotsky.

Identify which teacher would encourage children to explore their environment and find out things for themselves without any instruction. Explain why this approach to learning is consistent with the work of **one** of the developmental theorists named above. *(4 marks)*

[AO1 = 2, AO2 = 2]

AO1 Up to 2 marks for relevant knowledge of Piaget's theory, eg active/discovery learning giving opportunities for assimilation/accommodation and schema adaptation; schema extension via action on the world; notion of readiness as an explanation for why a child cannot be hurried; child as scientist.
Not all points are necessary for full marks.

AO2 One mark for identifying Lesley. One mark for noting how exploration/finding out/no instruction in the text is central to Piaget's theory.

Explanations of why the example could not be consistent with Vygotsky (and therefore must be consistent with Piaget) should be credited.

(c) Discuss Bruner's theory of cognitive development. Refer to empirical evidence in your answer. *(12 marks)*

[AO1 = 4, AO2 = 8]

AO1 Up to 4 marks for knowledge and understanding of Bruner's theory. Candidates will probably refer to the following: modes of representation; the importance of language for increased ability to deal with abstract concepts; role of social interaction with peers/parents; scaffolding. Max 1 mark for just naming 1, 2 or 3 modes or max 3 marks for just describing modes.

AO2 Up to 8 marks for discussion of Bruner's theory. AO2 marks should be awarded for evidence either supporting or contradicting Bruner and for more general evaluative comment. For example, candidates might refer to the implications of Bruner's approach for the curriculum, or might compare Bruner's work with that of other developmental theorists, eg by contrasting with Piaget or comparing with Vygotsky. Expect Bruner and Kenney, Kuhlman, etc as evidence. Max 2 marks for any one study.

Maximum 6 marks if no evidence given

Mark Bands

12 – 10 marks **Excellent answers**

Bruner's theory is thoroughly described showing sound, detailed and accurate knowledge and understanding. There is accurate and appropriate reference to evidence. Discussion is full and well balanced with appropriate analysis. Evaluative comment is not simply stated but is presented in the context of the discussion as a whole. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks **Good to average answers**

Answer shows knowledge and understanding of Bruner's theory and there is an attempt to present a balanced discussion. Some analysis is evident and the answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. There is reference to relevant evidence, perhaps not linked so clearly to the discussion as for the top band.

6 – 4 marks **Average to poor answers**

Answer shows some knowledge and understanding of the area. There must be some discussion for 5/6 marks. Answers in this band are likely to be mostly descriptive and there is likely to be irrelevance and/or inaccuracy. Any references to research are lacking in detail. Answers constituting reasonable description with minimal focus on the question are likely to be in this band.

3 – 1 marks **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief, perhaps unfinished answer will come into this band.

Total AO1 marks for Question 2: 10
Total AO2 for Question 2: 10
Total marks for Question 2: 20 marks

3 **Total for this question: *20 marks***

(a) Name and outline **two** of Gilligan's levels of moral development. *(4 marks)*

[AO1 = 4, AO2 = 0]

AO1 One mark for each level identified, either by name or through brief description. One further mark each for brief outline of each level. Accept outlines implicit in example. Candidates may refer to the abortion dilemma responses as an expansion of their answers.

Levels are: Self-interest/self oriented - limited sense of morality where what is right is what is best for the actor
Self-sacrifice/others oriented - morality involves putting welfare of others first
Non-violence/Universal care - emphasis on not hurting others

(b) Explain Gilligan's ideas about *ethic of care* in relation to moral development. *(4 marks)*

[AO1 = 2, AO2 = 2]

AO1 Up to 2 marks for knowledge of what Gilligan meant by 'ethic of care', ie that female moral reasoning emphasises care and concern for others or responsibility for others over legal rights and justice.

AO2 Up to 2 marks for discussion of how Gilligan argued that there is a difference between males and females, women's morality was no less sophisticated than men's but male reasoning was justice based, leading to a higher categorisation of male morality according to Kohlberg.

Not all of the above is necessary for full marks, eg reference to male reasoning not essential.

(c) Discuss a psychoanalytic explanation of moral development. *(12 marks)*

[AO1 = 4, AO2 = 8]

AO1 Up to 4 marks for knowledge and understanding of a psychoanalytic explanation of morality: role of the superego as moderator of the id; advent of morality around age of 4/5 years; as a consequence of identification with same-sex parent in the Phallic stage; Oedipus/Electra complex; conscience/internal parent; ego ideal.

AO2 Up to 8 marks for discussion and evaluation of a psychoanalytic explanation. Candidates will be likely to refer to some of the following: the lack of evidence, eg that males are more moral than females as Freudian theory would predict; evidence to the contrary, ie evidence for guilt in pre-Phallic stage children; neglect of environmental influences such as conditioning and modelling; the existence of moral reasoning in children who do not have a same-sex parent with whom to identify; the discounting of other explanations, eg cognitive. Max 4 AO2 marks if the only discussion/comment is general evaluation of the psychoanalytic approach.

Mark Bands

12 – 10 marks **Excellent answers**

A psychoanalytic explanation is thoroughly described showing sound, detailed and accurate knowledge and understanding. Discussion is full and well balanced with appropriate analysis. Evaluative comment is not simply stated but is presented in the context of the discussion as a whole. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks **Good to average answers**

Answer shows knowledge and understanding of a psychoanalytic explanation and there is an attempt to present a balanced discussion. Some analysis is evident and the answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding.

6 – 4 marks **Average to poor answers**

Answer shows some knowledge and understanding of the area. There must be some discussion for 5/6 marks. Answers in this band are likely to be mostly descriptive and there is likely to be irrelevance and/or inaccuracy. Answers constituting reasonable description with minimal focus on the question are likely to be in this band.

3 – 1 marks **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief, perhaps unfinished answer will come into this band.

Total AO1 marks for Question 3: 10
Total AO2 marks for Question 3: 10
Total marks for Question 3: 20 marks

4 **Total for this question: *20 marks***

(a) Briefly explain **one** possible cause of autism. *(3 marks)*

[AO1 = 1, AO2 = 2]

AO1 One mark for a possible cause of autism, eg genetics, refrigerator/cold parenting, lack of theory of mind, lack of central coherence.

AO2 Up to 2 marks for explanation/analysis of the given cause. For example, if the candidate gives genetics as the cause then appropriate comment might refer to mechanisms of inheritance, concordance rates. Candidates may legitimately gain marks here for noting that causes may not be mutually exclusive, eg that the genetic cause might result in processing deficits such as lack of ToM.

(b) Describe **one** study in which autism was investigated. Indicate why the study was conducted, the method used, results obtained and conclusion drawn. *(5 marks)*

[AO1 = 5, AO2 = 0]

AO1 Any study of autism is acceptable, including differences in the behaviour of children with autism and non-autistic children, studies of treatment. Most candidates will refer to studies which demonstrate processing differences such as the Sally Ann study (Baron-Cohen et al 1985) or the visuo-spatial processing study (Shah and Frith 1993).

1 mark for aim (must go beyond stem)
1 mark for method
1 mark for results
1 mark for conclusion
1 mark for additional detail (credit evaluation if adds to description)

(c) Discuss how giftedness might be defined. Refer to psychological theory **and/or** evidence in your answer. *(12 marks)*

[AO1 = 4, AO2 = 8]

AO1 Up to 4 marks available for knowledge of how giftedness has been defined by psychologists. Candidates may offer one definition or more than one and may gain full credit either way. Answers might include: reference to statistical definitions (Terman) - IQ as a means of identifying gifted individuals; Gardner's multiple intelligences approach; Renzulli's 3 ringed model (1986); giftedness in specific domains, eg mathematics/music; giftedness as information processing (Sternberg 1988).

AO2 Up to 8 marks for discussion, analysis and/or expansion of the ways of defining giftedness. For example, candidates might refer to the limitations of Terman's unitary phenomenon approach, eg the arbitrary cut-off point for giftedness or the distinction between garden variety and highly gifted. Multi-factorial approaches might be cited as alternatives. Candidates might evaluate the multiple intelligences approach in terms of strengths (can be measured through objective behaviour) and weaknesses (appropriateness of referring to a person with just one exceptional skill as 'gifted'). References to evidence should be credited as AO2 with a maximum of 2 AO2 marks for accounts of case studies. Credit also application of theory/evidence.

Maximum 6 marks if no reference to theory or evidence

Mark Bands

12 – 10 marks **Excellent answers**

How giftedness might be defined is clearly described showing sound, detailed and accurate knowledge and understanding. There is clear and appropriate reference to theory and/or evidence. Discussion is full and well balanced with appropriate analysis. Any references to research are accurate. Evaluative comment is not simply stated but is presented in the context of the discussion as a whole. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks **Good to average answers**

Answer shows knowledge and understanding of how giftedness might be defined and there is an attempt to present a balanced discussion. Reference to theory and/or evidence is apparent. Some analysis is evident and the answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. Points are perhaps not linked so clearly to the discussion as for the top band.

6 – 4 marks **Average to poor answers**

Answer shows some knowledge and understanding of the area. There must be some discussion for 5/6 marks. Answers in this band are likely to be mostly descriptive and there is likely to be irrelevance and/or inaccuracy. Any references to research are lacking in detail. Answers constituting reasonable description with minimal focus on the question are likely to be in this band.

3 – 1 marks **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief, perhaps unfinished answer will come into this band.

Total AO1 marks for Question 4: 10
Total AO2 for Question 4: 10
Total marks for Question 4: 20 marks

SECTION B: Psychology of Atypical Behaviour

5 **Total for this question: *20 marks***

(a) State what is meant by the *sick role* and explain how it might affect clinical assessment of atypical behaviour. *(3 marks)*

[AO1 = 1, AO2 = 2]

AO1 One mark for knowledge of the sick role, ie the behaviours that are assumed/expected by a person who defines themselves as sick/a patient.

AO2 Up to 2 marks for explanation of how assumption of the sick role might affect assessment. Possible answers: patient may exaggerate symptoms; leads to passivity; expectation of cure; lack of responsibility for own condition.

Vague answer - 1 mark. For 2 marks candidates may offer two separate points or one point with expansion.

(b) Describe **one** study in which the diagnosis or classification of atypical behaviour was investigated. Indicate why the study was conducted, the method used, results obtained and conclusion drawn. *(5 marks)*

[AO1 = 5, AO2 = 0]

AO1 A whole range of studies would be appropriate here but expect to see studies by Rosenhan 1973 (labelling), Temerlin 1970 (psychiatric training) and Lewis 1990 (race).

1 mark for aim (must go beyond stem)
1 mark for method
1 mark for results
1 mark for conclusion
1 mark for additional detail (credit evaluation if adds to description)

(c) Discuss ways of defining abnormality. Refer to Kristen in your answer. *(12 marks)*

[AO1 = 4, AO2 = 8]

AO1 Award up to 4 marks for knowledge of definitions of abnormality: violation of social norms; violation of cultural norms; statistical infrequency; maladaptiveness; distress. Marks will usually be for each criterion briefly explained. Per definition – 1 for vague, brief answer; 2 for thorough answer.

AO2 Award up to 8 marks for discussion and application. Candidates can gain up to 5 marks for straightforward discussion of the criteria given under AO1. Examples: statistical infrequency cannot be used to determine whether or not depression is abnormal as depression affects large numbers of people; maladaptiveness as a criterion assumes that certain behaviours/ways of living are to be valued and others are not; distress as a criterion presupposes that people should not experience distress and unhappiness even though it is an appropriate response for many people in many circumstances.

Three marks should be reserved for application to the text, for example: distress - Kristen is not unhappy; maladaptiveness - Kristen seems about to lose her job; violation of social norms - curtains closed all day; statistical infrequency - most people don't behave like Kristen.

Mark Bands

12 – 10 marks **Excellent answers**

Criteria for abnormality are clearly described showing sound, detailed and accurate knowledge and understanding. Discussion is full with appropriate analysis. There is clear and appropriate reference to the stem. Evaluative comment is not simply stated but is presented in the context of the discussion as a whole. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks **Good to average answers**

Answer shows knowledge and understanding of how abnormality might be defined and there is some useful discussion. Some analysis is evident and the answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. There may be some appropriate reference to the stem. Points are perhaps not linked so clearly to the discussion as for the top band.

6 – 4 marks **Average to poor answers**

Answer shows some knowledge and understanding of the area. There must be some discussion/application for 5/6 marks. Answers in this band are likely to be mostly descriptive and there is likely to be irrelevance and/or inaccuracy. Any references to research are lacking in detail. Answers constituting reasonable description with minimal focus on the question are likely to be in this band.

3 – 1 marks **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief, perhaps unfinished answer will come into this band.

Total AO1 for Question 5: 10
Total AO2 for Question 5: 10
Total marks for Question 5: 20 marks

6 **Total for this question: *20 marks***

(a) Distinguish between generalised anxiety disorder and phobias. *(3 marks)*

[AO1 = 2, AO2 = 1]

AO1 One mark for knowledge of GAD (form of anxiety that is continuous and unfocused/free-floating, non-specific) and one mark for knowledge of phobia (extreme, irrational fear of object or situation).

AO2 Award 1 mark for distinction, eg phobia is experienced momentarily as a response to a stimulus whilst GAD is long-lasting.

Note - candidate might start by offering the difference and expand by relating this difference to each disorder.

(b) Identify and briefly discuss **one** therapy for post-traumatic stress syndrome (PTSS). *(5 marks)*

[AO1 = 2, AO2 = 3]

AO1 One mark for identification of a therapy for PTSS and one mark for elaboration. Likely answers: sedatives; systematic desensitisation; humanistic therapies such as counselling/ repetitive talking leading to mastery/control; cognitive behaviour therapy as in stress inoculation also acceptable although it is more usually seen as a preventative measure.

AO2 Up to 3 marks for discussion/comment on the given therapy. For example, using drugs works in the short-term but problem may keep recurring. Credit references to other therapies as long as they are linked to the discussion. Credit any reference to research as AO2.

(c) Describe and discuss a behavioural explanation for obsessive-compulsive behaviour. *(12 marks)*

[AO1 = 6, AO2 = 6]

AO1 Up to 6 marks for knowledge and understanding of the behavioural explanation of OCD. Answers should include reference to principles of conditioning. Initial fear might arise out of association of unpleasant event with neutral stimulus, eg dirt. Initial fear is coincidentally relieved by performance of the compulsive behaviour, eg hand-washing. Repeated relief following performance of hand-washing behaviour acts as positive reinforcement. Positive reinforcement serves to establish and maintain the behaviour which becomes OCD.

AO2 Up to 6 marks for discussion and evaluation of the behavioural explanation. Answers are likely to refer to the way in which behavioural explanations, relying on coincidental first performance of the compulsive behaviour, are not really an adequate explanation of how OCD arises, but a better explanation of how they are maintained. Credit reference to other more plausible explanations where linked to the discussion, eg biochemical - low serotonin; cognitive - intrusive thoughts; psychodynamic - childhood fixation, all offer explanations of how OCD arises. Credit evidence showing a reduction in anxiety levels after performance of ritual compulsion, eg Hodgson and rachman 1972, hand-washing and Roper 1973 - checking rituals.

Mark Bands

12 – 10 marks **Excellent answers**

The behavioural explanation for OCD is clearly described showing sound, detailed and accurate knowledge and understanding. There is clear and appropriate reference to theory. Discussion is full and well balanced with appropriate analysis. Evaluative comment/alternative explanations are not simply stated but are presented in the context of the discussion as a whole. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks **Good to average answers**

Answer shows knowledge and understanding of behavioural explanation for OCD and there is an attempt to present a balanced discussion. Reference to theory is apparent. Some analysis is evident and the answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. Points/ alternative explanations are perhaps not linked so clearly to the discussion as for the top band.

6 – 4 marks **Average to poor answers**

Answer shows some knowledge and understanding of the area. Answers in this band are likely to be mostly descriptive and there is likely to be irrelevance and/or inaccuracy. Answers constituting reasonable description with minimal focus on the question are likely to be in this band.

3 – 1 marks **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief, perhaps unfinished answer will come into this band.

Total AO1 marks for Question 6: 10
Total AO2 marks for Question 6: 10
Total marks for Question 6: 20 marks

7 **Total for this question: *20 marks***

(a) From the point of view of patients suffering from schizophrenia, outline **one** advantage and **one** limitation of community care. *(4 marks)*

[AO1 = 4, AO2 = 0]

AO1 Award up to two marks each for advantage and disadvantage of community care depending on detail.

Likely advantages: normalisation - patients have contact with all members of the community leading to exposure to and possible modelling of 'normal' behaviours; development of social skills; access to employment opportunities.

Likely limitation: inadequate supervision leading to disruption of medication; lack of availability of specialist support.

(b) Briefly discuss **one** problem with the psychodynamic approach to schizophrenia. *(4 marks)*

[AO1 = 2, AO2 = 2]

AO1 Problem may relate to the explanation or to therapy. One mark for identification of a problem with the psychodynamic approach to schizophrenia. Second mark for detail/ elaboration. Possible answer: psychodynamic therapy usually not helpful (1) patient has insufficient insight (1).

AO2 Up to 2 marks for discussion/analysis of psychodynamic approach. Focus may be on either explanation or therapy. With an insufficient grasp on reality, as would be the case for patients suffering from delusions and hallucinations, talking therapy is of little use. However, credit references to Sullivan 1929 who showed some success with psychodynamic therapy with schizophrenia.

(c) Outline and evaluate **at least one** cognitive treatment for mood disorders. *(12 marks)*

[AO1 = 4, AO2 = 8]

AO1 Up to 4 marks for knowledge of at least one cognitive treatment, for example, Beck's CBT, Ellis's RET and Meichenbaum's self-instructional training. One or more may be offered. Award marks for knowledge of the general cognitive approach to treating depression (need to change irrational beliefs and substitute them with more positive, rational beliefs, patient as scientist, role of reinforcement) or for detailed knowledge of one type of cognitive therapy, eg Ellis's emphasis on rational confrontation.

AO2 Up to 8 marks for evaluation which may include application. Useful discussion points include: cognitive treatment works best for certain kinds of patients, ie well motivated, intelligent. Not useful for severely depressed patients who will better benefit from a combination of drug therapy and (later) cognitive treatment; active involvement enables patient to control the therapy; credit references to research into effectiveness of cognitive treatment, eg Elkin 1989; based on sound learning principles; advantages over other therapies. Award up to 3 application marks for elaboration of how the principles of cognitive treatment might be applied in a therapy session and might lead to improvement.

Mark Bands

12 – 10 marks **Excellent answers**

At least one cognitive treatment for mood disorders is clearly outlined showing sound, detailed and accurate knowledge and understanding. Evaluation is full and well balanced with appropriate analysis/application. Evaluative comment/ alternative approaches are not simply stated but are presented in the context of the discussion as a whole. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks **Good to average answers**

Answer shows knowledge and understanding of a cognitive treatment and there is an attempt to present a balanced evaluation. Some analysis/application is evident and the answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. Points are perhaps not linked so clearly to the discussion as for the top band.

6 – 4 marks **Average to poor answers**

Answer shows some knowledge and understanding of the area. Answers in this band are likely to be mostly descriptive and there is likely to be irrelevance and/or inaccuracy. Any references to research are lacking in detail. Answers constituting reasonable description with minimal focus on the question are likely to be in this band.

3 – 1 marks **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief, perhaps unfinished answer will come into this band.

Total AO1 for Question 7: 10
Total AO2 for Question 7: 10
Total marks for Question 7: 20 marks

8 **Total for this question: *20 marks***

(a) Outline **two** major components of psychodynamic therapy. *(4 marks)*

[AO1 = 4, AO2 = 0]

AO1 Award up to 2 marks each for each component of psychodynamic therapy.
One mark for giving a component. Second mark for elaboration.
Likely answers: accessing unconscious; uncovering unconscious wishes/fears; use of named techniques, eg free association, analysis of dreams, analysis of resistance, analysis of transference, analysis of slips of the tongue.

(b) Identify and briefly discuss **one** limitation of the biological approach to the treatment of atypical behaviour. *(4 marks)*

[AO1 = 1, AO2 = 3]

AO1 One mark for identification of a limitation of the biological approach to treatment. Likely answers: reductionist; treats behaviour not cause; treatments may have side-effects; limitations associated with ECT, eg unknown mode of action.

AO2 Up to 3 marks for discussion of limitation given. Candidates are expected to provide a brief analysis of the extent of the limitation, possibly referring to the necessity for biological therapy in some instances or the benefits of a biological therapy in relation to other therapies.

(c) Outline circumstances in which society might assume such a right, and discuss ethical dilemmas faced by professionals treating atypical behaviour. *(12 marks)*

[AO1 = 5, AO2 = 7]

AO1 Up to 2 marks for identification of relevant circumstances, ie where patient is either a danger to self (1) or to others (1) or 1 mark for recognition that text refers to compulsory treatment, although not necessarily sectioning.

Up to 3 further marks for knowledge of ethical dilemmas involved in treating atypical behaviour. A wide variety of ethical issues may be considered here including: consent or consent of family/guardian; labelling; stigma associated with sectioning; withdrawal from treatment; confidentiality versus need to communicate with family/guardian; possible stress/harm through treatment. Do not credit general ethical issues in research, eg debrief unless made relevant to therapy.

AO2 Up to 7 marks for discussion, analysis and application. Candidates should present a balanced discussion of the relative rights and responsibilities of individuals and society. Wider discussion might focus on: individual right to self-determination; the role of the police; need for independent second opinion; the role of the Approved Social Worker; needs of the family; reliability of information, eg from family; the Mental Health Act; implications of treating/not treating.

Mark Bands

12 – 10 marks **Excellent answers**

At top of band answer shows a clear awareness of circumstances. Ethical dilemmas are clearly described showing sound, detailed and accurate knowledge and understanding. Discussion is full and well balanced with appropriate analysis/ application. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks **Good to average answers**

Answer shows knowledge and understanding of ethical dilemmas and there is an attempt to present a balanced discussion. Some analysis/application is evident and the answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. Points are perhaps not linked so clearly to the discussion as for the top band.

6 – 4 marks **Average to poor answers**

Answer shows some knowledge and understanding of the area. Answers in this band are likely to be mostly descriptive and there is likely to be irrelevance and/or inaccuracy. Any references to research are lacking in detail. Answers constituting reasonable description with minimal focus on the question are likely to be in this band. For 6 marks there must be at least some discussion.

3 – 1 marks **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief, perhaps unfinished answer will come into this band.

Total AO1 for Question 8: 10
Total AO2 for Question 8: 10
Total marks for Question 8: 20 marks

Health Psychology

9 **Total for this question: *20 marks***

(a) Explain **one** problem in defining health. *(4 marks)*

[AO1 = 2, AO2 = 2]

AO1 Up to 2 marks for knowledge of a problem in defining health: health is subjective; health is culturally/historically/politically relative; health is not purely biological but also psychological and social; biological definition is reductionist; health cannot be reified but should be seen in the context of the health-illness continuum. One mark for a vague answer, 2 marks for a detailed answer.

AO2 Up to 2 marks for expansion/analysis of the problem given above. Candidates will probably offer a definition (or several) and deconstruct it/them to illustrate the problem via example, eg subjectivity is a problem in that what one person perceives to be healthy might not seem healthy to another. One person might find a level of chronic pain, eg from arthritis such that they consider themselves to be ill, whereas another person might accept it as an inevitable and normal part of ageing and still define themselves as healthy.

(b) Explain how visualisation might be used in the treatment of illness. Illustrate your answer with an example. *(4 marks)*

[AO1 = 2, AO2 = 2]

AO1 Up to 2 marks for knowledge of the techniques/procedures involved in visualisation: use of mental imaging/imagery and mental rehearsal of either healing process, physiological process or medical procedure. Answer must go beyond the stem thus do not credit 'visualisation' or 'visualising'.

AO2 One mark for explanation of how visualisation might be used. Examples: patient might visualise healing taking place after an operation thus promoting a positive outlook; patient might visualise a forthcoming medical procedure so that less fear is experienced beforehand (controllability) and less post-operative pain is experienced. Second mark for the example.

(c) Describe and discuss the biomedical model of health. *(12 marks)*

[AO1 = 6, AO2 = 6]

AO1 Up to 6 marks for knowledge and understanding of the biomedical model, eg focus on biological normality as a definition of health; absence of disease; illness as a result of injury, infection, biochemical imbalance etc.; emphasis on diagnosis; focus on cure using biomedical therapies – drugs, surgery, ECT etc.; reductionism.

AO2 Up to 6 marks for discussion of the biomedical model. Likely analytical points would include the need for consideration of social and psychological factors as in a whole person approach, eg personality factors, lifestyle and environment. Limitations of strictly biomedical therapies might also be discussed, eg use of drugs alone to control conditions such as hypertension and the treatment of symptoms rather than cause. Positive evaluative points might include reference to the success of many biomedical treatments. Where evidence is used to support analysis and evaluation it may be credited as AO2.

Mark Bands

12 – 10 marks **Excellent answers**

The biomedical model is thoroughly described, showing sound knowledge and understanding of the area. Discussion is full and well balanced with appropriate analysis. Evaluative comment is not simply stated but is presented in the context of the discussion as a whole. The answer is well focused and mostly relevant with little misunderstanding.

9 – 7 marks **Good to average answers**

Answer shows reasonably accurate knowledge and understanding of the biomedical model. There is an attempt to present a balanced discussion. Some analysis is evident and the answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding.

6 – 4 marks **Average to poor answers**

Answer shows some knowledge and understanding of the biomedical model. Some points are likely to be only vaguely linked to the question. Answers constituting reasonable description with limited focus on the question are likely to be in this band.

3 – 1 marks **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief, perhaps unfinished answer will come into this band.

Total AO1 for Question 9: 10
Total AO2 for Question 9: 10
Total marks for Question 9: 20 marks

10 **Total for this question: *20 marks***

(a) (i) Identify **two** ways in which a patient might show non-compliance with medical advice. *(2 marks)*

[AO1 = 2, AO2 = 0]

AO1 Award 1 mark for each way given. Likely answers: not taking medicine; not finishing a course of medicine; not resting; not changing lifestyle habits, eg by taking exercise or dieting.

Do not credit repetition of stem e.g. 'not following Dr.'s advice'.

(ii) Outline and briefly discuss **one** way in which Dr Evans might increase the level of compliance in her patients. *(6 marks)*

[AO1 = 3, AO2 = 3]

AO1 Up to 3 marks for knowledge of a way in which compliance might be increased. Likely answers:

- improving communication/style of communication with the patient (eg anticipation of unspoken questions, attending to the order of information, increasing the level of explanation, being explicit, eliciting of questions from the patient, checking understanding, giving sufficient information)
- using behavioural methods (eg structured/tailored regime, prompts/reminders, self-monitoring system, contracted behaviour)

AO2 Up to 3 marks for discussion which might focus on the way given above - in this case there should be analysis of reasons why the way would have the desired effect, or indeed, not have an effect. For example, theoretical underpinnings of behavioural methods might be given as support for these methods. Alternatively discussion might refer to reasons why non-compliance might continue regardless of the change in practitioner behaviour, eg relevant points would include the following: non-compliance is sometimes rational for a number of reasons - side-effects, lack of funds, testing to see whether the illness has gone. Compliance may also depend on level of social support from family, etc.

(b) Describe and discuss **at least one** psychological intervention for chronic and/or terminal illness. Refer to empirical evidence in your answer. *(12 marks)*

[AO1 = 5, AO2 = 7]

AO1 Up to 5 marks for description/knowledge of at least one psychological intervention in chronic and/or terminal conditions. Relevant techniques include: cognitive behaviour therapy to help quit smoking in cancer sufferers (Ockene 1992); relaxation training in cardiac patients (Oldenburg 1985); combined programmes for cardiac rehabilitation - including diet, exercise, stress-management (Ornish 1990); relaxation training/imagery and systematic desensitisation for chemotherapy-related nausea in cancer sufferers (Carey & Burish 1988); exercise, relaxation training and self-help for AIDS patients (Antoni 1990). Do not credit biomedical interventions.

Candidates may choose just one intervention and describe it in detail or may refer to more than one in less detail.

AO2 Up to 7 marks for discussion of the intervention method/s described. Most answers will focus on the usefulness/effectiveness of the intervention both for short-term outcomes, eg reducing nausea following a chemotherapy session (Carey & Burish 1988) and for long-term outcomes, eg survival outcomes - Spiegel at al 1989 intervention liked to increased life expectancy in cancer victims; quality of life - lowered anxiety and depression in HIV/AIDS sufferers. Candidates are also likely to refer to the limitations of psychological interventions and the role of biomedical interventions in treatment of chronic/terminal illnesses.

Maximum 6 marks if no evidence given

Mark Bands

12 – 10 marks **Excellent answers**

At least one psychological intervention for chronic/terminal illness is clearly described showing sound, detailed and accurate knowledge and understanding. Evidence is detailed and appropriate. Discussion is full and well balanced with appropriate analysis/application. Evaluative comment/alternative approaches are not simply stated but are presented in the context of the discussion as a whole. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks **Good to average answers**

Answer shows knowledge and understanding of at least one psychological intervention. Evidence is apparent and there is an attempt to present a balanced discussion. Some analysis/application is evident and the answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. Points are perhaps not linked so clearly to the discussion as for the top band.

6 – 4 marks **Average to poor answers**

Answer shows some knowledge and understanding of the area. Answers in this band are likely to be mostly descriptive and there is likely to be irrelevance and/or inaccuracy. Answers constituting reasonable description with minimal focus on the question are likely to be in this band. For 6 marks there must be at least some discussion.

3 – 1 marks **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevan ce. A valid but extremely brief, perhaps unfinished answer will come into this band.

Total AO1 for Question 10: 10
Total AO2 for Question 10: 10
Total marks for Question 10: 20 marks

11 **Total for this question: *20 marks***

(a) Explain what is meant by *primary prevention* in relation to health-related behaviour. Illustrate your answer with an example. *(3 marks)*

[AO1 = 1, AO2 = 2]

AO1 One mark for knowledge that primary prevention is a way of reducing risk aimed at a **whole** population.

AO2 One mark for elaboration/expansion of above through explanation of the meaning of 'whole' population, eg by comparing primary prevention with the alternatives, eg secondary prevention (aimed at high-risk groups) or tertiary prevention (aimed at afflicted individuals).

One mark for a relevant example, eg anti-smoking appeal in a TV advert or anti-drug education for all secondary school children.

(b) Describe **one** study in which the effect of exercise on health was investigated. Indicate why the study was conducted, the method used, results obtained and conclusion drawn. *(5 marks)*

[AO1 = 5, AO2 = 0]

AO1 A whole range of studies would be appropriate here, eg DeVries 1977 - reversing negative effects of ageing; Blumethal 1989 - physiological gains using aerobics; Alpert et al 1990 - self-esteem increases; Raglin & Morgan 1987 - reductions in anxiety.

1 mark for aim (must specify either type of exercise or aspect of health)
1 mark for method
1 mark for results
1 mark for conclusion
1 mark for additional detail

(c) Discuss the role of diet in cardiovascular disorders. Refer to empirical evidence in your answer. *(12 marks)*

[AO1 = 4, AO2 = 8]

AO1 Up to 4 marks for knowledge of the role of diet in cardiovascular disorders. Expect reference to: cholesterol - deposits of fatty plaques in blood vessels; low-density lipoproteins associated with high cholesterol build-up; link between fat intake (eggs, fatty meats, etc.) and cholesterol build-up. Role of caffeine leading to raised blood pressure. Role of sodium in elevated blood pressure. Links between obesity and cardiovascular disorder.

AO2 Up to 8 marks for analysis of the role of diet. Some evidence that lowering blood serum cholesterol reduces cardiovascular disorder, eg Blankenhorn 1987 found reversal of development of arteriosclerosis using combined dietary and drug treatment. Caffeine research has been contradictory, eg LeGrady 1987 found caffeine consumption was related to high mortality rates from heart disease whereas Salvaggio et al 1990 found the opposite. Sound evidence that sodium reduction leads to lower blood pressure - Law et al 1991.

Relevance of other factors such as heredity, Type A behaviour and external stressors.

Maximum 6 marks if no evidence

Mark Bands

12 – 10 marks **Excellent answers**

Role of dietary factors is clearly described showing sound, detailed and accurate knowledge and understanding. Discussion is full and well balanced with appropriate analysis. There are accurate references to research. Evaluative comment is not simply stated but is presented in the context of the discussion as a whole. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks **Good to average answers**

Answer shows knowledge and understanding of the role of diet and there is an attempt to present a balanced discussion. Some analysis is evident and the answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. Evidence is presented. Points are perhaps not linked so clearly to the discussion as for the top band.

6 – 4 marks **Average to poor answers**

Answer shows some knowledge and understanding of the area although answers in this band are likely to be mostly descriptive and there is likely to be irrelevance and/or inaccuracy. Answers constituting reasonable description with minimal focus on the question are likely to be in this band. Must be some discussion for 5/6 marks.

3 – 1 marks **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief, perhaps unfinished answer will come into this band.

Total AO1 for Question 11: 10
Total AO2 for Question 11: 10
Total marks for Question 11: 20 marks

12 **Total for this question: *20 marks***

(a) Outline what is meant by *hardiness*, and explain how hardiness might affect an individual's response to stress. *(4 marks)*

[AO1 = 2, AO2 = 2]

AO1 Up to 2 marks for knowledge of elements of hardiness (Kobasa 1979). Likely answers: involves perceived control; involves commitment and a sense of purpose (in life and to others); involves seeing change as challenge and opportunity. Credit any two elements of hardiness presented. One mark for general answers, eg resilience or ability to cope.

AO2 Up to 2 marks for explanation of link between hardiness and health/illness, ie hardy individuals are less likely to suffer illness under stress; they are better able to deal with stressors; they are less likely to become anxious and aroused by these stressors. One mark may be awarded for an example although not explicitly required.

(b) Outline **two** components of rational emotive behaviour therapy (REBT) as used in the management of stress. *(4 marks)*

[AO1 = 4, AO4 = 0]

AO1 Up to 2 marks each for components outlined. Likely answers:

Identifying irrational beliefs likely to cause/exacerbate stress, eg I am worthless.
Discriminating between sensible ideas and totally irrational ones, eg I am worthless v I have made a bit of a mess of this one job.
Challenging irrational beliefs through rational confrontation or dispute. Replacing stressful and irrational thoughts/beliefs - with more realistic and positive ones.
Use of homework assignments - practising substituting irrational ideas with rational ones/desensitisation exercises.

(c) Discuss **at least two** ways of measuring stress. *(12 marks)*

[AO1 = 4, AO2 = 8]

AO1 Up to 4 marks for description of at least two ways of measuring stress, usually award up to two marks for each way. Possible answers include

- physiological measures e.g. hormone analysis via blood or urine samples, polygraph (GSR) measure of arousal
- self-report e.g. SRRS (Holmes and Rahe 1967), Life Events Scale or Daily Hassles and Uplifts Scale (Kanner 1981), Life Events and Difficulties Schedule (Harris 1967)
    - behavioural measures usually recorded as a diary e.g. insomnia, forgetfulness, making mistakes, avoidance of stressful situations, eg absenteeism.

AO2 Up to 8 marks for discussion and analysis of stress measures described. Candidates are expected to identify strength and limitations of the methods. For example, physiological measures are objective, reliable, easy to analyse, can be taken under controlled conditions but are not always valid in that they measure physiological arousal but do not distinguish between negative arousal (stress) and positive arousal (excitement). Self report measures might be quick to administer but may be unreliable, subjective. Also credit comment specific to named measures, eg vagueness of certain SRRS items/ failure of SRRS to consider meaning of events for individuals/ failure of SRRS to distinguish between desirable and undesirable events, low correlation .30 between SRRS scores and illness (Dohrenwend 1981). AO2 marks may also be gained through comparison with other methods of stress measurement or for application through use of examples.

Maximum 7 marks if only one way presented

Mark Bands

12 – 10 marks **Excellent answers**

Two ways of measuring stress are clearly described showing sound, detailed and accurate knowledge and understanding. Discussion is full and well balanced with appropriate analysis. Evaluative comment is not simply stated but is presented in the context of the discussion as a whole. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks **Good to average answers**

Answer shows knowledge and understanding of ways of measuring stress and there is an attempt to present a balanced discussion. Some analysis is evident and the answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. Points are perhaps not linked so clearly to the discussion as for the top band. Exceptionally award 7 marks for an answer referring to just one way of measuring stress.

6 – 4 marks **Average to poor answers**

Answer shows some knowledge and understanding of the area although answers in this band are likely to be mostly descriptive and there is likely to be irrelevance and/or inaccuracy. Answers constituting reasonable description with minimal focus on the question are likely to be in this band. Must be some discussion for 5/6 marks.

3 – 1 marks **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief, perhaps unfinished answer will come into this band.

Total AO1 for Question 12: 10
Total AO2 for Question 12: 10
Total marks for Question 12: 20 marks

Contemporary topics in Psychology

13 **Total for this question: *20 marks***

(a) With reference to the triangular theory of love, distinguish between **two** types of love. *(3 marks)*

[AO1 = 2, AO2 = 1]

AO1 Award 1 mark each for identifying two types of love within the Sternberg model, eg consummate, romantic, fatuous, companionate or empty.

AO2 One mark for making distinction between the two types of love given under AO1. For example, in romantic love there is an absence of commitment and in companionate love there is an absence of passion.

(b) Outline and briefly discuss the role of similarity in interpersonal attraction. *(5 marks)*

[AO1 = 2, AO2 = 3]

AO1 Up to 2 marks for knowledge of the role of similarity in attraction.
- knowing that similar types are attracted to each other - 1 mark
- identifying aspects of similarity, eg social background, interests, looks, etc. - 1 mark

AO2 Up to 3 marks for discussion of similarity as a factor. Likely points include: evidence, eg Murstein; conflict with theory of complementarity - opposites attract; conflicting evidence; comparative influence of other factors such as proximity, physical attractiveness, reciprocal liking etc; link between the similarity hypothesis and broad theories of attraction, eg social exchange or balance theory.

(c) With reference to the nature-nurture debate, describe and discuss the role of nature in relation to sexual orientation. *(12 marks)*

[AO1 = 6, AO2 = 6]

AO1 Up to 6 marks for knowledge of the nature explanation of sexual orientation and associated evidence. Credit accurate references to genes and heritability - linkage research LeVay (Xq28 region or x chromosome) and Hamer 1994, hormones (levels of androgens) and brain structure (LeVay - enlarged hypothalamus). Whilst most answers will focus primarily on homosexuality accept answers relating to any type of sexual orientation.

AO2 Up to 6 marks for discussion and analysis of the nature hypothesis. Candidates are likely to explore alternative explanations. Possible issues: Freudian theory of universal bisexuality with differentiation occurring at the Phallic stage; social learning theory and upbringing; more general environment, eg hedonism and eroticism condoned (Blumstein and Schwartz). Discussion could also focus on flaws in the nature hypothesis, eg lack of evidence for the androgen hypothesis. Credit also implications of accepting the nature argument.

Mark Bands

12 – 10 marks **Excellent answers**

The nature explanation is clearly described showing sound, detailed and accurate knowledge and understanding. Discussion is full and well balanced with appropriate analysis. Any references to research are accurate. Evaluative comment is not simply stated but is presented in the context of the discussion as a whole. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks **Good to average answers**

Answer shows knowledge and understanding of the nature argument and there is an attempt to present a balanced discussion. Psychological knowledge is apparent. Some analysis is evident and the answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. Points are perhaps not linked so clearly to the discussion as for the top band.

6 – 4 marks **Average to poor answers**

Answer shows some knowledge and understanding of the area. Answers in this band are likely to be mostly descriptive and there is likely to be irrelevance and/or inaccuracy. Any references to research are lacking in detail. Answers constituting reasonable description with minimal focus on the question are likely to be in this band.

3 – 1 marks **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief, perhaps unfinished answer will come into this band.

Total AO1 for Question 13: 10
Total AO2 for Question 13: 10
Total marks for Question 13: 20 marks

14 **Total for this question: *20 marks***

(a) For **each** of the statements below, write down in your answer book whether it is an example of

- psychokinesis;
- clairvoyance;
- telepathy;
- precognition.

Label your answers clearly.

(i) Rick is able to send information about shapes on a card to another person using his mind alone, and without using any of the five senses.

(ii) Bianca knows about an item that will feature in next week's newspapers, before the event has even taken place.

(iii) Adil is able to gain information about the layout of buildings he has never visited, without using any of his five senses.

(iv) Kerri sees objects fall off the kitchen shelf for no apparent reason. *(4 marks)*

[AO1 = 0, AO2 = 4]

AO2 (i) telepathy
(ii) precognition
(iii) clairvoyance
(iv) psychokinesis

(b) Describe the relationship between extra-sensory perception (ESP) and **two** personality traits. *(4 marks)*

[AO1 = 4, AO2 = 0]

AO1 One mark each for identifying any two of neuroticism, extraversion and introversion.

Further mark each for stating direction of correlation:
Neuroticism - high levels are negatively correlated with ESP performance
Either
Extraversion - high levels are positively correlated with ESP performance
Or
Introversion – high levels are negatively correlated with ESP performance

(c) Describe and discuss **one** type of free-response test and **one** type of restricted-choice test used in the investigation of extra-sensory perception (ESP). *(12 marks)*

[AO1 = 6, AO2 = 6]

AO1 Up to 3 marks for description of an example of each test. For free-response - credit a relevant test (dream studies, remote viewing) plus description, eg test where participant must describe the target material either visually or verbally without any cues or prompts, ie no limit to number of possible answers. For restricted choice - credit a relevant test (Zener cards or similar) plus description, eg test where participant must identify the target material from a number of fixed choices, eg dice rolling.

Ganzfield technique to be credited as part of description of **either** free-response study **or** restricted-choice study.

AO2 Up to 3 marks for discussion, analysis and evaluation of each method.

Free-response - difficult to determine a correct answer in relation to forced choice testing; dependent on independent observer's analysis of similarity between target and description, thus subjective; analysis of results is time consuming; more spontaneous measure than forced choice.

Restricted choice - data is more easily quantifiable; results can be compared with probability of chance occurrence; does not involve subjective analysis; inherent bias towards certain cards in conventional packs; less spontaneous than free-response.

Maximum 7 marks if candidate refers to only one type of test

Mark Bands

12 – 10 marks **Excellent answers**

Both types of test are clearly described showing sound, detailed and accurate knowledge and understanding. Discussion is full and well balanced with appropriate analysis. Any references to research are accurate. Evaluative comment is not simply stated but is presented in the context of the discussion as a whole - answers should demonstrate psychological knowledge in the understanding of key terms. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks **Good to average answers**

Answer shows knowledge and understanding of both types of test and there is an attempt to present a balanced discussion. Psychological knowledge is apparent in the explanation and understanding of terms. Some analysis is evident and the answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. Points are perhaps not linked so clearly to the discussion as for the top band. Maximum 7 marks for an exceptional answer relating to just one type of test.

6 – 4 marks **Average to poor answers**

Answer shows some knowledge and understanding of either/both types of test. Answers in this band are likely to be mostly descriptive and there is likely to be irrelevance and/or inaccuracy. Any references to research are lacking in detail. Answers constituting reasonable description with minimal focus on the question are likely to be in this band.

3 – 1 marks **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief, perhaps unfinished answer will come into this band.

Total AO1 for Question 14: 10
Total AO2 for Question 14: 10
Total marks for Question 14: 20 marks

15 **Total for this question: *20 marks***

(a) Explain **one** way in which social 'inoculation' might be used in these circumstances. *(3 marks)*

[AO1 = 1, AO2 = 2]

AO1 One mark for knowledge of any aspect of social inoculation, eg communication of consequences; group discussion of social influences on abuse behaviour; role playing - how to say 'No'; decision and public pronouncement of intention.

AO2 Award up to 2 marks for applying knowledge of the given element/aspect of social inoculation to the situation in the text. One mark for a vague answer, two for explicit application.

(b) Describe **one** study in which the treatment of substance abuse was investigated. Indicate why the study was conducted, the method used, results obtained and conclusion drawn. *(5 marks)*

[AO1 = 5, AO2 = 0]

AO1 Any study in which treatment of substance abuse was investigated is acceptable. A wide variety of studies covering alcoholism, nicotine addiction and drug abuse can be expected. Examples of acceptable treatments from the specification are aversion therapy (Elkins 91 for alcohol) and self-management (Budney & Higgins 98 for cocaine), but other relevant therapies should also be accepted e.g. stress management, social/problem-solving skills training and insight-oriented psychotherapy.

1 mark for aim (must go beyond stem)
1 mark for method
1 mark for results
1 mark for conclusion
1 mark for additional detail (credit evaluation if adds to description)

(c) Discuss the role of social influence **and/or** social norms in substance abuse. Refer to empirical evidence in your answer. *(12 marks)*

[AO1 = 4, AO2 = 8]

AO1 Up to 4 marks for knowledge of social influence and/or social norms (acceptable/expected behaviour within a group) relevant to substance abuse. Candidates should explain the terms and describe appropriate influences/norms, eg media, peer, parental influences and the influence of role models. Award marks also for recognition of the social setting (presence of friends) as a key factor. Broader psychological theory might also be made relevant, eg references to operant conditioning and social learning.

AO2 Up to 8 marks for analysis and discussion. For example, candidates might refer to how different influences are more applicable for certain types of abuse (alcohol - parents are prime role models; smoking & drugs - peers are prime role models). Credit reference to 'social selection', ie how at risk adolescents will seek out people similar to themselves and associate with others at risk, thus exposure to the social influence is an active choice. Other key points might include: the difference between perceived norms (what we think our peers are doing) and actual norms which might be quite different; cross-cultural differences in abusing as evidence for social influences. Credit references to evidence as AO2. Evidence may be specific to substance abuse literature (Kandel 74 peer influences on marijuana use; Brook et al 1983 parental/peer modelling - marijuana) or may be general social psychological evidence e.g. conformity studies (Asch 51) or social learning studies (Bandura 63).

Credit references to other possible influences e.g. heredity where they form part of the discussion.

Maximum 6 marks if no evidence given

Mark Bands

12 – 10 marks **Excellent answers**

The role of social influences/norms in substance abuse is clearly described showing sound, detailed and accurate knowledge and understanding. There is clear and appropriate reference to evidence. Discussion is full and well balanced with appropriate analysis. References to research are accurate. Evaluative comment is not simply stated but is presented in the context of the discussion as a whole. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks **Good to average answers**

Answer shows knowledge and understanding of the role of social influences/norms in substance abuse and there is an attempt to present a balanced discussion. Reference to evidence is apparent. Some analysis is evident and the answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. Points are perhaps not linked so clearly to the discussion as for the top band.

6 – 4 marks **Average to poor answers**

Answer shows some knowledge and understanding of the area. There must be some discussion for 5/6 marks. Answers in this band are likely to be mostly descriptive and there is likely to be irrelevance and/or inaccuracy. Answers constituting reasonable description with minimal focus on the question are likely to be in this band.

3 – 1 marks **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief, perhaps unfinished answer will come into this band. Common-sense answers will deserve little, if any, credit.

Total AO1 for Question 15: 10
Total AO2 for Question 15: 10
Total marks for Question 15: 20 marks

16 **Total for this question: *20 marks***

(a) Using an example, explain how social skills training might be used in the treatment of offenders. *(3 marks)*

[AO1 = 1, AO2 = 2]

AO1 AO1 mark for knowledge of social skills training as a way of improving communication (non-verbal or verbal), or for knowledge of any aspect of social skills training, eg role play.

AO2 One mark for applying knowledge of SST to offending, eg by explaining how training benefits offenders, eg

- enables the offender to use appropriate non-verbal messages less likely to lead to confrontational situations
- improves the offender's non-verbal perceptiveness of other people's actions, gestures, expressions etc.

Plus one mark for example.

(b) Outline **one** way in which crime has been measured, and briefly discuss **one** limitation of this method. *(5 marks)*

[AO1 = 3, AO2 = 2]

AO1 One mark for naming a relevant way, two marks for outline with some detail. Examples - official statistics, crime surveys or victimisation surveys, self-report studies.

Third AO1 mark for identifying limitation of given method. Likely answers:

- Official statistics: reflect police recording techniques; lead to underestimation (dark figure); depend on whether crime is reported.
- Victim surveys: accuracy depends on reliability of memory; exclude crimes not against the person, eg company fraud, shoplifting etc.
- Self-report: some samples, eg young males may exaggerate; social desirability may lead to under-reporting.

AO2 Up to 2 marks for expansion/explanation of the limitation identified. Award marks according to detail. Marks may also be gained here by comparison with other ways of measuring crime.

(c) With reference to Dave, describe and discuss the psychoanalytic **and** social learning theories of offending. *(12 marks)*

[AO1 = 6, AO2 = 6]

AO1 Up to 6 marks for description of the psychoanalytic and social learning theories of offending.
Psychoanalytic: the uncontrolled id and inadequacy of the superego - perhaps in the context of unsatisfactory identification in the Phallic stage; sublimation - criminal activity as a means of re-directing primitive impulses; Bowlby's theory of affectionless psychopathy; overcontrolled individuals.
Social learning theory: observation, imitation, modelling, role models, vicarious reinforcement and cognitive mediators.

AO2 Up to 6 marks for discussion of the theories. Given the demands of the question candidates are not expected to provide extensive discussion but should show an awareness of relevant issues.

Psychoanalytic - general lack of evidence, inconsistency between Freud's suggestion that females are less moral than males and the evidence; criticisms of Bowlby's theory/evidence; implications and alternatives

Social learning - evidence from studies such as Bandura; intuitive plausibility; evidence that offending seems to run in families although this could be consistent with genetic theory.

Reserve 2 AO2 marks for reference to text e.g. psychoanalytic explanation - Dave offends because of identification with father and acquisition of father's moral code/ SLT - Dave models father's behaviour and has had vicarious reinforcement through observation of how father benefits from crime.

Maximum 7 marks if only one theory presented

Mark Bands

12 – 10 marks **Excellent answers**

Both theories clearly described showing sound, detailed and accurate knowledge and understanding. Top band answers need not show equal consideration of each theory. Discussion shows appropriate analysis and application to the text. Evaluative comment is not simply stated but is presented in the context of the discussion as a whole. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks **Good to average answers**

Knowledge/understanding of both theories and some analysis is evident. Answer is mostly focused on the question though there may be some irrelevance and/or misunderstanding. Points are perhaps not linked so clearly to the discussion as for the top band. Exceptional answers referring to just one theory may gain up to 7 marks.

6 – 4 marks **Average to poor answers**

Answer shows some knowledge and understanding of the area although answers in this band are likely to be mostly descriptive and there is likely to be irrelevance and/or inaccuracy. Answers constituting reasonable description with minimal focus on the question are likely to be in this band.

3 – 1 marks **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief, perhaps unfinished answer will come into this band.

Total AO1 for Question 16: 10
Total AO2 for Question 16: 10
Total marks for Question 16: 20 marks

ASSESSMENT OBJECTIVE GRIDS - UNIT 4: CHILD DEVELOPMENT AND OPTIONS

SECTION A: CHILD DEVELOPMENT

Question	Marks AO1	Percentage	Marks AO2	Percentage	Total Marks
Q1 (a)	1		2		
(b)	5		0		
(c)	4	50	8	50	20
Q2 (a)	4		0		
(b)	2		2		
(c)	4	50	8	50	20
Q3 (a)	4		0		
(b)	2		2		
(c)	4	50	8	50	20
Q4 (a)	1		2		
(b)	5		0		
(c)	4	50	8	50	20

SECTION B: OPTIONS
PSYCHOLOGY OF ATYPICAL BEHAVIOUR

Question	Marks AO1	Percentage	Marks AO2	Percentage	Total Marks
Q5 (a)	1		2		
(b)	5		0		
(c)	4	50	8	50	20
Q6 (a)	2		1		
(b)	2		3		
(c)	6	50	6	50	20
Q7 (a)	4		0		
(b)	2		2		
(c)	4	50	8	50	20
Q8 (a)	4		0		
(b)	1		3		
(b)	5	50	7	50	20

SECTION B: OPTIONS
HEALTH PSYCHOLOGY

Question	Marks AO1	Percentage	Marks AO2	Percentage	Total Marks
Q9 (a)	2		2		
(b)	2		2		
(c)	6	50	6	50	20
Q10 (a) (i)	2		0		
(ii)	3		3		
(b)	5	50	7	50	20
Q11 (a)	1		2		
(b)	5		0		
(c)	4	50	8	50	20
Q12 (a)	2		2		
(b)	4		0		
(c)	4	50	8	50	20

SECTION B: OPTIONS
CONTEMPORARY TOPICS IN PYSCHOLOGY

Question		Marks AO1	Percentage	Marks AO2	Percentage	Total Marks
Q13	(a)	2		1		
	(b)	2		3		
	(c)	6	50	6	50	20
Q14	(a)	0		4		
	(b)	4		0		
	(c)	6	50	6	50	20
Q15	(a)	1		2		
	(b)	5		0		
	(c)	4	50	8	50	20
Q16	(a)	1		2		
	(b)	3		2		
	(c)	6	50	6	50	20