

MARK SCHEME for the May/June 2007 question paper

9698 PSYCHOLOGY

9698/03

Paper 3 (Specialist Choices), maximum raw mark 70

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.

All Examiners are instructed that alternative correct answers and unexpected approaches in candidates' scripts must be given marks that fairly reflect the relevant knowledge and skills demonstrated.

Mark schemes must be read in conjunction with the question papers and the report on the examination.

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Section A

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

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Section B

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

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

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PSYCHOLOGY AND EDUCATION

Section A

- 1 (a) Explain, in your own words, what is meant by the term 'learning difficulty or disability'. [2]

Typically: where a child has a significantly greater difficulty in learning than most children of the same age. OR a child has a disability that needs different educational facilities from those that schools generally provide. Only one needed for 2 marks.

- (b) Describe *one* cause and *one* effect of a learning difficulty or disability. [6]

Dyslexia accounts for 80% of all learning difficulties. Approx 3-5% of the population suffer from dyslexia. It affects boys more than girls. Can be auditory (dysphonetic dyslexia); visual (dyseidetic dyslexia) or mixed/classic. **Features:** Letter reversal or rotation – the letter 'd' may be shown as 'b' or 'p'; Missing syllables – 'famel' for 'family'; Transposition of letters – 'brid' for 'bird'; Problems keeping place when reading; Problems pronouncing unfamiliar words.

Causes of dyslexia: Family research indicates that individuals have a greater likelihood of suffering from dyslexia if one or both parents have the disorder and **Owen (1978)** reported a concordance rate for monozygotic (identical) twins of 100%. Most other twin studies have reported lower rates of concordance, for example, **Plomin et al. (1994)** found monozygotic twins to be 70% concordant, whereas dizygotic twins were 40% concordant. Attempts to specify the mechanism for inheritance of dyslexia using genome scanning to identify the precise location of a dyslexia gene have led to the suggestion that a gene located on chromosome 18 is 'probably a general risk factor in dyslexia, influencing several reading-related processes' (**Fisher et al. 2002**).

Is there a link between testosterone and dyslexia?

Geschwind and **Galaburda (1985)** hypothesised that "several behavioural and medical conditions, including dyslexia, are more prevalent in males due to increased levels of testosterone which inhibits development of the left side of the brain.

Carlson (1994) reports a number of studies showing that brain abnormalities may be responsible for cases of dyslexia. Postmortems of people with a history of dyslexia show that they have abnormalities in the planum temporale, part of Wernicke's area. In comparison to non-dyslexics whose cells are arranged in regular columns, the cells of people with autism show irregular arrangement. Scanning techniques have also confirmed that the planum temporale on the left side of the brain is much smaller in people with dyslexia than in non-sufferers.

Dyscalculia affects mathematical performance affecting around 1% of the population. Sufferers frequently have normal or advanced language skills but experience problems with mathematical processes such as addition, subtraction, and dealing with money. Also poor sense of direction, poor map reading skills and problems with abstract concepts like time. Specific mathematical deficits include substitutions, reversals and omissions. **Overcoming** recommendations include making maths relevant, for example, giving the child responsibility for counting out the right number of question sheets for the class. Maths problems should be written on large squared paper to keep numbers properly aligned and the pupil should be encouraged to write down the rules for a new theory or process.

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Dyspraxia involves problems with fine and/or gross motor co-ordination leading to problems with physical activities in subjects like science and physical education. Many people with dyspraxia have poor understanding of mathematical concepts and experience problems understanding symbols. **Overcoming:** Pupils are encouraged to write on alternate lines and benefit from a multi-sensory approach to teaching.

Dysgraphia is a disorder of writing which can involve the physical aspects of writing, e.g. pencil grip and angle. It might also involve poor spelling and difficulties transferring thoughts to paper. **Overcoming:** Use of computers has helped people with dyspraxia considerably but other useful strategies include use of a tape recorder to record ideas and the option of oral reporting in examinations.

(c) Describe one way in which a learning difficulty or disability may be overcome. [3]

Most likely:

- 1 Focus on different types of schooling: mainstream (integration) or specialist (segregation). Advantages and disadvantages of both.
- 2 Focus on what is done in class.
 - (a) Powell (2000) lists a number of strategies for children with autism.
 - (b) Selikowitz (1998) lists strategies for overcoming dyslexia, see 'overcoming' above.

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

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

Typically: preventing a disruptive behaviour from happening before the event rather than correcting it after the event.

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

This depends on the disruptive behaviour chosen. A definition of disruptive behaviour might be a good place to start but right away there are problems. Who does the defining? Major types are:

- conduct (e.g. distracting, attention-seeking, calling out, out-of-seat);
- anxiety and withdrawal;
- immaturity and verbal and physical aggression;
- bullying;
- School refusers disrupt themselves and is legitimate;
- Persistently disruptive children are often labelled as EBD.

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(c) Describe *two* ways of preventing one type of disruptive behaviour. [6]

There are a number of **Preventative** (NOT corrective) strategies:

- 1 Care for children: know their names and other relevant information.
- 2 Give legitimate praise. (Marland, 1975)
- 3 Use humour.
- 4 Establish 'with-it-ness'. (Kounin, 1970)
- 5 Shape the learning environment.
- 6 Maintain classroom activity. (Stodolsky, 1984 lists 17 activities)
- 7 Maintain democratic procedures (e.g. Webster, 1968).
- 8 Set rules.

Fontana (1981) lists 16 common-sense aspects of classroom management which lend themselves for consideration and non-exclusion.

Section B

3 (a) Describe how *one* psychological perspective has been applied to education. [8]

Generally behaviourists focus on behaviour, cognitivists on thinking and humanists on the person.

Candidates will be tempted to provide details of early **behaviourist approach** (e.g. Pavlov & Skinner). Although this is legitimate in that it aids *understanding*, the question specifically requires **applications**, and so this should not be credited under *knowledge*.

Any application of learning theory is legitimate. Possibilities include: Direct application of **positive and negative reinforcement** to shape behaviour; possible use of schedules. **Programmed learning** as an approach to teaching and learning E.g. Bloom's **mastery learning** and Keller's **personalised system of instruction**. Rote learning versus discovery learning. Use of computers. **Behaviour modification** applied to (a) children who misbehave and (b) children who are disadvantaged. **Social learning** (e.g. Bandura) using teachers or other children as role models.

For the **cognitive approach** typically candidates will include the work of Piaget. His contribution is significant and covers a wide range of aspects such as readiness for teaching mathematics and the type of book a child should read at a particular age. More typically will be the **readiness approach**, a central component of **discovery learning**. If candidates focus on his theory of cognitive development without explicitly linking it to education, this strategy should receive no credit. Piaget is not the only relevant psychologist. Gagne (1977) outlines a number of **cognitive strategies**; Bruner (1966) has looked at **discovery learning**; Ausubel (1977) proposes a **theory of meaningful verbal learning (subsumption)**.

For the **humanistic approach** (e.g. Rogers, 1951) every individual is the centre of a continually changing world of experience. Four features are at the heart: **affect** (emphasis on thinking and feeling, not just information acquisition); **self concept** (children to be positive about themselves); **communication** (attention to positive human relationships) and **personal values** (recognition and development of positive values). Maslow (1970) advocates **student-centred teaching** where teachers are learning facilitators rather than didactic instructors. Dennison (1969) advocates the **open classroom**. Dunn & Griggs (1988) propose that each child has a **personal and unique learning style** and so traditional education should change radically providing a 'staggering range of options'. Johnson et al (1984) believe students see education to be competitive when it should be **co-operative**, involving circles of knowledge, learning together and student team learning.

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(b) Evaluate how *one* psychological perspective has been applied to education. [10]

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

- the strengths and weaknesses of psychological perspectives;
- the implications the perspectives have for teachers;
- whether theory applies in practice;
- contrasting alternative perspectives.

(c) Giving reasons for your answer, suggest how your chosen perspective could be used to teach science. [6]

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

The answer depends on the chosen perspective. See details above about each perspective.

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

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

Most likely answers:

Behaviourist: emphasise extrinsic praise and reward. Brophy (1981) list guidelines for effective and ineffective praise.

Humanistic: emphasise intrinsic motivation. The theories of Maslow (1970) self actualisation, White (1959) competence motivation and Bandura (1981) self efficacy is relevant.

Cognitive: Attribution theory of Weiner (1974) is relevant as is Rotter's Locus of control.

Other: McClelland (1953) achievement motivation and Birney (1969) motivated due to fear of failure.

(b) Evaluate what psychologists have found out about motivation and educational performance. [10]

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

- the strengths and weaknesses of psychological perspectives;
- the implications for teachers;
- whether theory applies in practice;
- comparing/contrasting differing approaches.

(c) Giving reasons for your answer, suggest how a teacher may motivate children. [6]

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

Reference to any of the above approaches is acceptable.

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PSYCHOLOGY AND ENVIRONMENT

Section A

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

Typically: weather, relatively rapidly changing conditions and **climate**, average weather conditions over a period of time.

- (b) Describe *one* study showing the effects of climate and/or weather on performance and describe *one* study showing the effects of climate and/or weather on social behaviour. [6]

Candidates could consider any aspect such as temperature, wind, storms (hurricanes, tornadoes), altitude and anything else that pertains. Note that the syllabus refers to performance, health and social behaviour so that should at least limit coverage a little.

Effects of heat is likely to be most common. **Performance**: Lots of lab studies show conflicting results mainly due to variations in design. Also many field studies e.g. Pepler (1972) in classrooms and Adam (1967) with soldiers.

Social behaviour: aggression: the long hot summer effect: heat causes riots (Goranson & King (1970) and US riot commission (1968) but only in 1967 and only in US!). Baron & Bell (1976) propose negative affect-escape model to explain it and lab studies in support. Many other studies on heat and aggression.

Heat also may or may not affect **helping** (e.g. Page, 1978) and attraction (e.g. Griffit, 1970). Cold temperature can also be covered. Causes hypothermia, frostbite, etc. Cold also affects **performance** and **social behaviour** (too cold to help or be aggressive). Not a lot on wind. Causes fear due to potential destruction. Increases helping in summer and decreases in winter (Cunningham, 1979). Cohn (1993): wind decreases domestic violence.

- (c) Describe *one* study showing the effects of climate and/or weather on health. [3]

Health: heat may cause heat exhaustion (sweating) or heat stroke (no sweating) or heart attacks.

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

Important to make a distinction between **disasters** (natural causes) and **catastrophes** (human causes). Catastrophes mean there is some human error/fault and blame can be attributed.

- (b) Describe *one* natural disaster and *one* technological catastrophe. [6]

Any **one natural** disaster and any **one technological** catastrophe – see definitions above. Could be a published event e.g. three mile island or it could be a more recent event written about anecdotally. Marks allocated according to detail.

- (c) Describe *one* way in which psychologists can help people suffering from post-traumatic stress disorder. [3]

Main solution is systematic desensitisation or some form of counselling. Social support may also be suggested, but this is often a weak alternative.

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Section B

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

Focus could be on space, territory, or both.

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

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

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

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

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

Territory differs from personal space in relation to size, boundaries, location and constancy. Altman (1975): types of territory 1. Primary territory: "a private area owned by an individual"; 2. Secondary territory: "an area that is used regularly but is shared with others"; 3. Public territory: "can only be occupied temporarily on a first come first served basis".

Gender differences: Males claim larger territories than females e.g. Smith et al (1981) beach study; Jason et al (1981) study of women on a beach. Sundstrom & Sundstrom (1977) similar study but on bench.

Cultural differences: Smith et al (1981): French & German beaches; Edney et al (1974) US beaches found: French less territorial; Germans much more marking. Worchel & Lollis (1982) compared Greek with American responses to dropped bags of litter.

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

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

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

(c) Giving reasons for your answer, suggest ways in which territory could be defended on public transport, such as a bus. [6]

Candidates likely to give typical book/bag on seat. Must refer to actual evidence as per general mark scheme. Defence of public territory: Ruback & Snow (1993) person drinking at water fountain invaded. Found non-conscious racism: White invaded by white left quickly. African-Americans stayed longer when invaded by white. Ruback et al (1989) those on phone spent longer on phone when someone else was waiting than in a no-one waiting control.

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

Candidates could look at:

- 1 Theories and effects of urban living on health and social behaviour:
Social behaviour – helping Altman (1969) use of phone; Amato (1983) bleeding leg; Newman & McCauley (1977) urban vs rural friendliness; Milgram (1977) city handshake; Milgram (1970) stimulus overload; Franck et al (1974) students in city.
Social behaviour – crime Zimbardo (1969) deindividuation.
Health: Soderberg (1977) HIV; Torrey & Bowler (1990) urbanisation and schizophrenia; Fisher et al (1994) perception of weight.
- 2 Urban renewal and building design:
Porteus: Definitions of urban renewal; Pruitt-Igoe project; Newman (1976) zone of TI and opps for surveillance; Van Dyke estate; Brownsville; Clason Point.
- 3 Community environmental design: Whyte (1980); Brower (1983).

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

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

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

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

Any appropriate suggestion to receive credit – most likely a reversal to what happened to Pruitt-Igoe (see part (a) above). Could increase opportunities for surveillance (Newman). Can block off streets: control and identity of both people and cars (so recognise anything different and less access for burglars); can build houses so more opportunities for surveillance. Shumaker et al (1982) residents of cul-de-sac felt safer than residents of 'through streets'.

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PSYCHOLOGY AND HEALTH

Section A

9 (a) Explain, in your own words, what is meant by the term ‘adherence to medical advice’.[2]

Typically: the extent to which people carry out the instructions given to them by a medical practitioner. 1 mark basic, 2 marks elaboration.

(b) Outline *one* reason why people may not adhere to medical advice. [3]

Lots of possibilities here from a vast area. Candidates could focus on one or more of the following:

[1] Disease/Medical treatment programmes [a] Severity of illness; [b] Side effects of treatment; [c] Duration of treatment; [d] Complexity of treatment; [e] people are less likely to adhere if the treatment requires a change in long standing habits and behaviours; [f] expense or cost.

[2] Personal Characteristics [a] Cognitive and emotional factors; [b] Social support: adherence is increased if there is appropriate support from family and friends and whether or not the supporters are stable. However, family and friends can have a negative effect, particularly if the patient's family is large; [c] personal beliefs/models:

- 1 Fear of treatments: Leventhal's (1970) parallel response model. People have two beliefs 'danger control' (seek help because their health is in danger) or 'fear control' (seek ways to reduce fear = avoid treatment, get drunk, etc.).
- 2 common sense: Leventhal (1982) model where patients' own views about their illness can contradict doctor instructions and treatment.
- 3 Becker & Rosenstock's (1984) health belief model is relevant. Patients weigh up the pros or benefits of taking action against the cons or barriers of taking action and make a decision based on their assessment of these factors.
- 4 Fishbein & Ajzen's theory of reasoned action is appropriate.
- 5 Stanton's (1987) model of adherence behaviour is pertinent.

[3] Cultural factors

[4] Relationship between person and medical service [a] Speed of service; [b] Practitioner's personality: Byrne & Long (1976) distinguish between: doctor-centred and patient-centred personality. Savage and Armstrong (1990) study on this; [c] Male/female practitioner: Hall et al (1994) found female doctors asked more questions of patients and made more positive statements to patients. Patients talked more to female doctor. Law & Britten (1995) Is a woman doctor better than a man.

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(c) Outline *two ways* in which adherence to medical advice can be improved. [6]

Most likely possibilities include:

- 1 changing physician behaviour (DiMatteo & DiNicola, 1982); sending doctors on training courses;
- 2 changing communication style (Inui et al, 1976);
- 3 change information presentation techniques (Ley et al, 1982);
- 4 have the person state they will comply (Kulik & Carlino, 1987);
- 5 provide social support (Jenkins, 1979) and increase supervision (McKenney et al, 1973).

Behavioural methods: tailor the treatment; give prompts and reminders; encourage self monitoring; provide targets and contracts.

10 (a) Explain, in your own words, what is meant by the term ‘safety behaviour’. [2]

Typically: maintaining healthy existence through safe practices at work and in the home.

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

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

Or specific. Lots of possibilities:

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

Any appropriate suggestion can receive credit.

(c) Describe *two ways* in which safety behaviour can be promoted. [6]

Under global heading of **health promotion campaigns** come many individual approaches which could take place in schools, worksites or communities. Campaigns could also be specific such as that concerning chip pan fires. Answers must be psychological.

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Section B

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

Question stresses practitioners and patients and so should answers. Answers could focus on:

Lorber (1975) distinguishes between 'good' and 'bad' patients

Diagnosis and information processing (Elstein & Bordage 1979) type 1 and type 2 errors

Interpersonal skills: non-verbal communications

Communication skills: accent, native language

Provision of information (a.) about illness; (b.) about diagnosis and treatment

Organisation of setting e.g. seating positions

Attitudes of doctor (practitioner style) and attitudes of patients (patient style)

health beliefs

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

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

- how psychologists gained their evidence;
- reasons why proposal of theories/models is difficult in this area;
- implications the evidence has for health care;
- psychological perspectives related to counselling situations.

- (c) Using your psychological knowledge, suggest ways in which practitioner style can be improved. [6]**

Candidates must focus on improving the practitioner, not the patient. Practitioner could attend training courses (e.g. Inui) or they could be more patient-centred rather than doctor-centred. Any appropriate suggestion based on psychological evidence is acceptable.

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12 (a) Describe what psychologists have learned about stress [8]

So much that could be included here. Most likely candidates will focus on measures of stress or ways of controlling (see syllabus). Also legitimate would be GAS model.

There are two main measures: physiologically and psychologically:

- Physiologically by recording devices; sample tests;
- Psychologically by Questionnaire based on life events (life events a cause); daily hassles (hassles a cause); personality (personality a cause); other causal factors (such as work) e.g. Professional Life Stress Scale.

Controlling or managing stress: see (c) below

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

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

- Comparing and contrasting different approaches;
- the relationship between theory and practice;
- the assumptions made about human nature;
- how psychologists gain their evidence in this area.

(c) Using psychological evidence, suggest how the stress of a teacher may be managed.[6]

Candidates may well have mentioned aspects of managing stress in question part (a), so indicative content included here also applies above.

Here answers must be related to teachers

Candidates may focus on **coping** with stress which is the process by which people try to manage the perceived discrepancy between the demands and resources they appraise in a stressful situation (Sarafino, 1991). Lazarus et. al. (1979) coping serves two functions: (1) **Problem-focused coping** involves attempts to change the situation causing the problem: changing job; new study strategy; time management course, etc. Used when people feel they can control the situation. (2) **Emotion-focused coping** aims to control the emotional response and can consist of (a) behavioural approaches e.g. taking alcohol or drugs; (b) cognitive approaches (intrapsychic processes) involving how people think about a situation/event such as cognitive redefinition. Can also include Freud's defence mechanisms (denial, intellectualisation, suppression).

Candidates may focus on stress management and consider:

- 1 **Medical/pharmacological solutions.** This perspective believes that stress can be relieved medically by use of drugs. Main types prescribed are: [a] benzodiazepines (trade names valium, librium, etc.) reduce physiological arousal and feelings of anxiety by activating a neurotransmitter that decreases neural transmission; [b] beta-blockers (inderal) reduce physiological arousal and feelings of anxiety by blocking neurones stimulated by adrenaline.
- 2 **Psychological solutions 1:** (behavioural/cognitive strategies) can include **progressive relaxation** (Jacobsen, 1938); **systematic desensitisation** (Wolpe, 1958); **biofeedback**; and **modelling**. **Psychological solutions 2:** (cognitive/behavioural) can include **cognitive restructuring** (Lazarus, 1981); **rational-emotive therapy** (Ellis, 1962) and **multi-modal therapy** (Lazarus, 1981); **imagery** (Bridge et al, 1988).
- 3 **Alternative strategies** involving meditation, hypnosis or yoga.
- 4 Providing **social support** may also help (e.g. Cohen & Willis, 1985).

Some candidates may consider ways of reducing post-traumatic stress which is legitimate.

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PSYCHOLOGY AND ABNORMALITY

Section A

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

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

(b) Describe *one* model of abnormality. [3]

Medical: abnormality due to chemical imbalance or physical abnormality. Treatments are chemotherapy, ECT and psychosurgery.

Psychodynamic: disorders caused by unresolved unconscious conflicts, usually in childhood. Treatment is psychoanalysis, possibly therapeutic regression.

Behavioural: disorders are maladaptive (faulty) learning. Usually classical or operant conditioning. Treatments can be systematic desensitisation or a reversal of reinforcers.

Humanistic: disorders caused by external factors preventing personal growth. Lack of unconditional positive regard may lead to distorted self concept. Treatment is client-centred therapy which reasserts free will and self actualisation.

(c) Describe how *two* abnormalities may be explained by one model of abnormality. [6]

Most likely: Too many possibilities here as most models claim to explain ALL disorders. Identifying problem worth 1 mark, how it relates to model scores remaining marks, e.g. behavioural explains phobias and obsessive/compulsive.

14 (a) Explain, in your own words, what is meant by the term ‘abnormal learning’. [2]

Abnormal learning includes any type of learning abnormality a child may have in a classroom. Most typically this would include **autism**, **dyslexia** (and related difficulties e.g. **dyscalculia**), **ADHD** (attention deficit with/without hyperactivity).

(b) Describe *two* types of abnormal learning. [3]

Abnormal learning includes any type of learning abnormality and most typically this would include **autism**, **dyslexia** (and related difficulties e.g. **dyscalculia**) – *see question 1*, **ADHD** (attention deficit with/without hyperactivity) or any other learning abnormality. The focus could be on the suggested causes of such abnormalities or could be on the problems a typical child may have in a classroom.

(c) Describe *one* way in which abnormal learning may be overcome. [6]

Most likely:

1 Focus on different types of schooling: mainstream (integration) or specialist (segregation). Advantages and disadvantages of both.

2 Focus on what is done in class.

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

(b) Selikowitz (1998) lists strategies for overcoming dyslexia, with specific strategies depending on whether the problem is a reading, spelling or writing error.

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Section B

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

Most likely focus will be on post traumatic stress disorder, amnesia and fugue.

Psychogenic fugue is leaving one's home, work and life and taking a new identity with loss of memory for the previous identity.

Psychogenic amnesia is losing one's memory because of psychological reasons.

PTSD is a stress response caused by events outside the range of normal human experience.

(b) Evaluate what psychologists have learned about abnormal affect due to trauma. [10]

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

- points about defining and categorising abnormal affect disorders;
- cultural and individual differences in abnormal affect disorders;
- comparing and contrasting explanations;
- implications for person with abnormal affect disorders.

(c) Giving reasons for your answer, suggest how a trauma response could be treated. [6]

Most likely: if it is PTSD, then the most likely treatment is systematic desensitisation.

For amnesia/fugue, hypnosis is one possibility. Sometimes this is helped with sodium amytal and sodium pentothal.

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

Typically: abnormal affect concerns disorders of mood and emotion, most typically depression and mania or manic-depression. Most likely: mania – person displays spontaneity, activity, has outbursts of exuberance, has heightened good humour and talkative and entertaining. They are often full of good ideas, plans and have grand visions. They are full of energy; appear to be physically inexhaustible.

Depression: are extremely despondent, melancholic and self deprecating. They may be physically lethargic; struggle to think out simple problems. They believe they are utterly worthless and have hopeless guilt.

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

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

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

(c) Giving reasons for your answer, suggest ways of overcoming seasonal affective disorder. [6]

Most likely effect on health will be seasonal affective disorder (SAD) as this is referred to specifically in the specification. SAD treated using a lightbox (Watkins, 1977). Studies looking at acclimatisation may be a possibility and telling people about the negative effects gives perceived control.

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PSYCHOLOGY AND ORGANISATIONS

Section A

17 (a) Explain, in your own words, what is meant by the term 'leader-worker interaction'. [2]

Typically: two or more individuals engaged in a social interaction in the workplace where one is the leader and the other is the worker. Effective leadership said to be determined by this relationship.

(b) Describe *one* study of leader-worker interaction. [3]

Most likely: **Dansereau** et. al. (1975) whose *leader-member exchange model* suggests that it is the quality of interaction between leaders and group members that is important. This model has received much acclaim due to the success it has achieved when applied to real life situations. E.g. **Scandura and Graen** (1984) found that following a training programme, where the aim was to improve the quality of leader-member relationships, both group productivity and satisfaction increased significantly.

(c) Outline *two* leadership styles. [6]

Most likely: **Tuckman** (1965) 4 stages: forming, storming, norming and performing.

Also **Woodcock's** (1979) 4 stages of team development. **Zander's** (1982) achievement-orientated and help-orientated people is pertinent as could be **McGregor's** (1960) effective and ineffective groups.

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18 (a) Explain, in your own words, what is meant by ‘motivation to work’. [2]

Typically: the force that energises, directs and sustains behaviour.

(b) Describe *one* theory of motivation to work. [3]

Many to choose from. Only 3 marks, so answers should be brief.

- 1 **Need theories** of motivation: individual needs [a] Maslow's **need-hierarchy** (1965): five tier hierarchy: physiological, safety, social, esteem and self actualisation. Starting with physiological each must be satisfied in order. Lots of attention received, but not much support; not a good predictor of behaviour and no useful application; [b] Alderfer's **ERG theory** (1972). Three levels: existence, relatedness and growth. Little support; [c] McClelland's **achievement-motivation theory** (1961): three work related needs: need for achievement (get job done, success, etc.); need for power (direct and control others; be influential); need for affiliation (desire to be liked and accepted; friendship). Methodology used: TAT (thematic apperception test): look at picture then relate story it suggests. Is a projective test and scoring can be unreliable. Good application: match profiles to jobs; achievement training programmes.
- 2 **Job design theories**: if job well designed and satisfying needs = good motivation. [a] Herzberg's **two factor theory** (1966): Job satisfaction and job dissatisfaction are two separate factors. Motivators = responsibility, achievement, recognition, etc. = job satisfaction. Hygienes = supervision, salary, conditions, etc. = job dissatisfaction. Some support but led to Job enrichment (redesigning jobs to give workers greater role); [b] **Job characteristics model** (Hackman & Oldham, 1976): workers must perceive job as meaningful (skill variety, task identity and task significance), responsible (autonomy) and gain knowledge of outcome (feedback). These can be scored. Also JDS (job diagnostic survey) is questionnaire measuring above characteristics.
- 3 **Rational (cognitive) theories**: people weigh costs and rewards of job [a] **Equity theory** (Adams, 1965) fair treatment = motivation. Worker brings inputs (skills, etc.) and expects outcomes (pay, etc.). Equality determined by comparison with others; [b] **VIE theory** (or expectancy) (Vroom, 1964): workers are rational and decision making and guided by potential costs (negative outcomes) and rewards (positive outcomes); [c] **Goal setting theory** (Locke, 1968): for motivation goals must be specific, clear and challenging; [d] **Reinforcement theory** (traditional): positive and negative reinforcers and punishment.

(c) Describe *two* ways in which motivation to work can be improved. [6]

Most likely: through rewards which could be financial or in the form of benefits and or bonuses/incentive schemes; improvement in work hours; physical conditions, equipment.

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Section B

- 19 (a) Describe what psychologists have discovered about group behaviour in organisations. [8]

Wide question in that candidates can legitimately focus on one or more of:

Group processes such as cohesiveness, co-operation, competition;

Group decision-making;

Group error such as groupthink and group polarisation.

- (b) Evaluate what psychologists have discovered about group behaviour in organisations. [10]

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

- issues concerning generalisability;
- the measures used to gain data;
- individual differences in types of groups;
- the usefulness of studying group processes.

- (c) Giving reasons for your answer, suggest ways in which team roles and team building can be improved. [6]

Any suggestion based on psychological theory acceptable. Most likely: **Tuckman's** (1965) model [forming, storming, norming, performing]; The **Belbin** approach (1985, 1993) or **Margerison & McCann's** (1991) team management wheel.

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20 (a) Describe what psychologists have found out about interpersonal communication systems. [8]

This is the passage of information between one person or group to another person or group. Candidates may well begin with a definition of communication and what it involves: sender, message and receiver (e.g. Hurier model for effective listening); encoding, channel and decoding.

Candidates may consider the varieties of communication: 'telephone, face-to-face, meeting, memo, newsletter, employee handbooks, reports, e-mail, voice-mail, teleconference, etc.). Each has advantages and disadvantages. Another set of factors are:

- Organisational structures: downward, upward and horizontal/lateral;
- Barriers: filtering, censoring, exaggeration (knowledge is power);
- Breakdown: impression management, self confidence, competence; mistrust; defensiveness; undercommunication.

Candidates can base their answers on communication networks (e.g. Leavitt's (1951) centralised and de-centralised).

(b) Evaluate what psychologists have found out about interpersonal communication systems. [10]

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

- the implications of various communications for speed;
- individual preference and/or satisfaction;
- comparing and contrasting alternative communication techniques;
- how psychologists gather evidence in this area.

(c) Giving reasons for your answer, suggest how the communication flow could be improved. [6]

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