UNIVERSITY OF CAMBRIDGE INTERNATIONAL EXAMINATIONS

GCE Advanced Level

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

9698 PSYCHOLOGY

9698/32 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, which would have considered the acceptability of alternative answers.

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

- Cambridge will not enter into discussions or correspondence in connection with these mark schemes.

Cambridge is publishing the mark schemes for the October/November 2011 question papers for most IGCSE, GCE Advanced Level and Advanced Subsidiary Level syllabuses and some Ordinary Level syllabuses.

UNIVERSITY of CAMBRIDGE
International Examinations

SECTION A

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

SECTION B

Q	Description	Marks
(a)	**KNOWLEDGE (1)** [Terminology and concepts]	
	Some appropriate concepts and theories are considered. An attempt is made to use psychological terminology appropriately.	1
	Range of appropriate concepts and theories are considered. The answer shows a confident use of psychological terminology.	2
	KNOWLEDGE (2) [Evidence]	
	Some basic evidence is described and/or it is of peripheral relevance only and/or it is predominantly anecdotal.	1
	Appropriate psychological evidence is accurately described but is limited in scope and detail.	2
	Appropriate psychological evidence is accurately described and is reasonably wide-ranging and detailed.	3
	Appropriate psychological evidence is accurately described and is wide-ranging and detailed.	4
	UNDERSTANDING [What the knowledge means]	
	Some understanding of appropriate concepts and/or evidence is discernible in the answer.	1
	The answer clearly identifies the meaning of the theory/evidence presented.	2
	Maximum mark for part **(a)**	8

(b)	**EVALUATION ISSUES** [Assessing quality of data]	
	General evaluative comment OR issue identified OR evidence (max 2 marks if no analysis/cross-reference).	1
	Any two from: general evaluative comment/issue/evidence (max 3 marks if no analysis/cross-reference).	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

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

PSYCHOLOGY AND EDUCATION

Section A

1 (a) Explain, in your own words, what is meant by 'individual differences in educational performance'. [2]

Typically: any difference in the performance of an individual which differs from the norm.

(b) Describe <u>one</u> cultural difference and <u>one</u> gender difference in educational performance. [6]

Any **cultural** difference is acceptable. Candidates may well compare their own culture with that of others; flexibility required here. Demie (2001) looked at cultural differences in Lambeth (London) with regard to achievement at key stages 1, 2 and GCSE but this is only based in London.
Gender: most likely: males have better visuo-spatial ability, females better verbal ability; males better spatial ability. This would tend to suggest that males are better at mathematics and related subjects (90% of air traffic controllers are male), girls at languages and related subjects. UK data shows that except for level 3 maths, girls outperform boys in everything else.

(c) Give <u>one</u> explanation for <u>either</u> a cultural difference <u>or</u> a gender difference in educational performance. [3]

Cultural: Wide range of answers possible here. Any two factors from a long list including social class, type of family, position in family, expectation of family, gender, time-orientation, competitiveness and individualism, racism, etc.
Gender: Wide range of answers possible here.
Biological: Are the male brain and female brain different?
Social: Socio-economic class (attitudes), type of family, position in family, expectation of family, time-orientation, competitiveness and self-fulfilling prophecy.

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 <u>one</u> type of disruptive behaviour and <u>one</u> cause for this type of disruptive behaviour. [6]

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

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

Main **causes**: genetic, maladaptive learning, diet, etc. This could include a cause of disruptive behaviour as in someone standing up in class and the effect is to distract others. It could include a cause such as ADHD, or the cause of ADHD being diet. Similarly the cause could be due to medication, such as Ritalin.

(c) Describe <u>one</u> way in which a disruptive behaviour may be prevented. [3]

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

Section B

3 (a) Describe what psychologists have found out about teaching and learning styles. [8]

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

- Lefrancois outlines a **'teaching model'**, pointing out what is desired before, during and after teaching. He also outlines 28 recommended behaviours for effective teaching.
- Fontana suggests the debate is between **formal** (subject emphasis and to initiate children in essentials) and **informal** (emphasis on child; teacher identifying child's needs) styles. A study on this was carried out by Bennett (1976) and followed up by Aitken et al. (1981). Similarly Flanders (1970) suggests **direct** (lectures, etc.) versus **indirect** (accepts that children have ideas and feelings) styles. Evidence exists for each approach.
- Bennett (1976) found progress in three 'Rs' better in primary school using formal approach.
- Haddon and Lytton (1968) found creativity better when informal approach used.
- Based on the work of Lewin et al., Baumrind (1972) outlines three styles: authoritarian, authoritative (i.e. democratic) and laissez-faire. Baumrind believes the authoritative style is most effective.
- It could be argued that learning styles are determined by approach to, or perspective on, learning and so candidates could consider styles adopted if following a **behaviourist** or **cognitivist** or **humanist** approach.
- Learning styles have direct implications for teaching styles. Possible styles include lecturing, discussing, reciting, dictating, questioning, guided discovery, peer tutoring, etc. Advantages and disadvantages of each are relevant.
- An alternative is to consider Kolb's (1976) learning styles whereby a preferred learning style can be identified through a learning 'kite'. Four styles are possible: dynamic, imaginative, analytical and common-sense.
- Curry's onion model (1983): instructional preference, informational processing style and cognitive personality style.
- Grasha's (1996) six categories for learning: independent, dependent, competitive, collaborative, avoidant and participant.

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

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

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

(c) Giving reasons for your answer, suggest how a teacher can improve the learning effectiveness of psychology students by using study skills. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Any appropriate answer based on student study skills. Most likely:

- McCarthy's (1990) **4-MAT** system. Includes: motivation, concept development, practice and application. The teacher matches teaching styles with learning styles.
- **PQRST**: preview, question, read, self-recitation, test. Intended to improve ability to study and remember material in a textbook.
- **SPELT** (Mulcahy, 1986) Strategies for Effective Learning, Thinking. This is concerned with learning how to learn.
- Memory techniques are also worth credit. Answers must be linked to use by psychology students.

4 (a) Describe what psychologists have found out about the design and layout of educational environments. [8]

Building design:

- With comparisons between open plan schools versus 'traditional' designs. Traditional is formal; open plan is individualistic. Rivlin and Rothenberg (1976): open plan implies freedom, but no different from traditional. Open plan offers too little privacy and too much noise. Conclusion: some children do better with traditional, others better with open plan. Wheldall (1981) 'on-task' (formal) vs 'off-task' (informal).
- Some studies refer to effect of number of windows (e.g. Ahrentzen, 1982); amount of light.
- Some studies refer to effects of temperature (e.g. Pepler, 1972).
- Reynolds et al. (1980) found age and physical appearance of school had nothing to do with academic accomplishments.
- Small vs large school (Barker and Gump, 1964): small have several advantages e.g. sense of belonging.

Classroom layout: (a discovery learning room) with availability of resources; use of wall space: too much vs too little (e.g. Porteus, 1972).
Seating arrangements: sociofugal vs sociopetal (rows vs horseshoe vs grouped).
'Perspectives' approach: architectural (environmental) determinism.
Staffing theory (Wicker et al. (1972): understaffed, overstaffed or adequately staffed; **classroom capacity**: how many is room designed for and how many crammed in – lack of privacy, crowding leads to stress and poor performance; Skeen (1976) suggests **spatial zone** affects performance (Hall's personal and intimate zone = optimal).

(b) Evaluate what psychologists have found out about the design and layout of educational environments. [10]

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

- the implications of classroom design for teachers and for pupils;
- the relationship between educational design and performance;
- laboratory versus real-life studies;
- the usefulness of the evidence;
- assumptions about human nature;
- methodology used to study problem behaviours.

(c) A team of designers is about to make changes to a classroom for young children. Giving reasons for your answer, suggest what changes the team could make to the classroom to create a better learning environment. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Most likely: candidates will pick on one or more aspects included in question part **(a)**

PSYCHOLOGY AND ENVIRONMENT

Section A

5 (a) Explain, in your own words, what is meant by 'controlling crowds'. [2]

Sears et al. (1991) define a crowd as people in physical proximity to a common situation or stimulus.
Additionally crowds must involve a number of interacting people; need not be face-to-face; need not be assembled in one place; members must influence one another. For 2 marks mention must be made of how crowds can be controlled.

(b) Describe <u>one</u> type of crowd. [3]

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

(c) Describe <u>one</u> way in which problems may be prevented in emergency situations and describe <u>one</u> way in which crowds can be controlled in emergency situations. [6]

Prevention and control: most likely answers will be based on study by Waddington et al. (1987) who argue that public disorder is predictable (not the outcome of mob psychology) and problems can be avoidable. Crowds should be perceived as collections of individuals who share a social purpose and who are interpreting what is going on around them.
Five recommendations for successful crowd control:
- Let the crowd self-police wherever possible;
- Effective liaison should take place between police and organisers;
- If police are involved they should use minimum force so are not perceived by crowd as causing trouble;
- Those involved in managing crowds should be trained in effective interpersonal communication;
- The police should be perceived as accountable and not able to do what they like.

6 (a) Explain, in your own words, what is meant by 'environmental cognition'. [2]

Definitions: environmental cognition is the way we acquire, store, organise and recall information about locations, distances and arrangements of the great outdoors (Gifford, 1997). A cognitive map is a pictorial and semantic image in our head of how places are arranged (Kitchin, 1994). Way-finding is successful navigation.

(b) Describe <u>one</u> way in which cognitive maps can be measured and describe <u>one</u> type of error commonly made when drawing cognitive maps. [6]

Methods: main ones are sketch maps, recognition tasks and multidimensional scaling. Sketch maps: Lynch identified five **common elements**: *Paths:* roads, walkways, rivers (i.e. routes for travel); *Edges:* non-travelled lines e.g. fences, walls; *Districts:* larger spaces; *Nodes:* places, junctions, crossroads, intersections where people meet; *Landmarks:* distinctive places people use for reference points e.g. tallest building, statue, etc.
Errors in maps: (a) Euclidean bias: people assume roads etc. are grid-like: they are not. Sadalla and Montello (1989); (b) superordinate-scale bias: we group areas (e.g. counties) together and make judgement on area rather than specific place, e.g. Stevens and Coupe (1978); (c) segmentation bias: Allen and Kirasic (1985); we estimate distances incorrectly when we break a journey into segments compared with estimate as a whole. Also: maps are often incomplete: we leave out minor details; we distort by having things too close together, too far apart or misaligning, e.g. people over-estimate the size of familiar areas; we augment – add non-existent features.

(c) Describe <u>one</u> individual difference in environmental cognition. [3]

Most likely:
Bryant et al. (1991) men are much better than women in the acquisition, accuracy and organisation of spatial information. This could be due to experience. Studies by Garling et al. (1981) in Sweden; Kirisic et al. (1974) suggest men are better than women at locating places difficult to locate. Appleyard (1976) found overall accuracy was equal, but women emphasised districts and landmarks whereas men emphasised path structure. Holding (1992) found men began with paths and nodes followed by landmarks; women began with landmarks. Overall conclusion is that there is a difference in style (not that one is better than the other). However in reading a road map, based on paths and nodes and not landmarks, men will have an advantage because of their preferred style.

Section B

7 (a) Describe what psychologists have learned about density and crowding. [8]

Candidates may look at distinctions between density (physical) and crowding (psychological). They may look at methods (laboratory and naturalistic) and both human and animal studies. The syllabus guidance notes suggest a look at performance, social behaviour and health. NB work on crowds (e.g. LeBon (contagion), Zimbardo (deindividuation) or Turner (emergent norm), to receive **no** credit.

- **animal studies**: Dubos (1965) and lemmings; Christian (1960) deer and Calhoun (1962) rats.
- **human studies**:
  performance: Aiello et al. (1975b) found impaired task performance. In lab studies both Bergman (1971) and Freedman et al. (1971) report that density variations do not affect task performance. But task is crucial: no effect if task is simple; effect if task is complex. Saegert et al. (1975) in high social density supermarket and railway station found impairment of higher level cognitive skills (e.g. cognitive maps). Heller et al. (1977) suggests there is no effect on task performance when there is high social or spatial density and there is no interaction, but an effect when there is interaction.
  social behaviour: **helping**: studies by Bickman et al. (1973) in dormitories and Jorgenson and Dukes (1976) in a cafeteria requesting trays be returned. **aggression**: studies involving children. Price (1971); Loo et al. (1972); Aiello et al. (1979) all found different things. Crucial variable is toys given to children. Studies on male-female differences too. Candidates could look at crowding and **attraction**.
  health: Paulus, McCain and Cox (1978) also found increase in density led to increase in blood pressure in prisoners. McCain, Cox and Paulus (1976) found increase in density led to more complaints of illness in prisoners. Di Atri et al. (1981) study in prisons showed higher blood pressure and pulse than when in more spacious conditions. Baron et al. (1976) found students in high density dormitories visit health centre more.

(b) Evaluate what psychologists have learned about density and crowding. [10]

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

- the usefulness of studying animals;
- differing methodologies used to gather evidence;
- individual differences in the experience of crowding;
- ethical issues studies may raise.

(c) Giving reasons for your answer, suggest what may be done to cope with the effects of crowding. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Most likely is to increase cognitive control e.g. Langer and Saegert (1977) or use a technique such as attention diversion e.g. Karlin et al. (1979).

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

Candidates could look at:
Theories and effects of urban living on health and social behaviour:

Social behaviour – helping

- Amato (1983) study in 55 different Australian communities. A man limped down a street then screamed, fell over and clutched his leg which began bleeding profusely. Small town (under 1000 inhabitants), 50% stopped to help. In a city of 20 000–30 000 this dropped to 25%. Down to 15% in major cities with over 1 million inhabitants.
- Milgram (1977) city handshake: undergraduate students approached a stranger and extended their hand in a friendly gesture (as if to initiate a handshake). Only 38.5% of city-dwellers reciprocated compared with 66% in rural areas.

Social behaviour – crime

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

Health:

- Soderberg (1977) measured rates of HIV infection, comparing urban, semi-urban and rural blood donors. Sample: 3474 males and 1287 females in Tanzania. Between March 1988 and April 1991, all blood was tested for HIV infection. The highest rate of infection was seen in urban areas and Soderberg suggested that city people exhibit riskier behaviours.

Urban renewal and building design

- **Pruitt-Igoe project**: public housing project in which 12 000 persons were relocated into 43 buildings, 11 storeys high, containing 2762 apartments, and covering 57 acres. After 3 years there was a very high crime rate. Accounts exist of gangs forming and that rape, vandalism and robbery were common as crime frequently took place in elevators and stairwells; the upper floors were abandoned. By 1970, 27 of the 43 buildings were empty. Whole estate demolished in 1972.
- Newman (1976), certain buildings are likely to be vandalised/burgled because of their design. Crucial aspects include zone of territorial influence and opportunities for surveillance.

Community environmental design: Whyte (1980); Brower (1983).

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

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

- comparison of 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) Using your psychological knowledge, suggest what features would contribute to a successful urban renewal and housing design project. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Newman (1976): certain buildings are likely to be vandalised/burgled because of their design. Crucial aspects include:
Zone of territorial influence: an area which appears to belong to someone. If no apparent owner (i.e. is semi-public), more vandalism.
Opportunities for surveillance: vandalism more likely if vandals cannot be seen.
Newman put ideas into practice and designed low-cost housing project – Clason Point in New York City. Clason Point consists of cluster housing of 12–40 families per cluster. Increased defensible space:

- assigned public space to be controlled by specific families by using fencing;
- reduced number of pedestrian routes through the project and improved lighting along the paths;
- improved the image and encouraged a sense of personal ownership by giving different colours to individual dwellings.

Residents took pride in their dwellings, planting grass, adding own new modifications and even sweeping the public sidewalks. Serious crimes dropped by 62%. Number of residents who said they felt they had the right to question a stranger in the project doubled.
Also Five Oaks, Dayton, Ohio (1994), streets closed, speed bumps introduced and divided into 'mini-neighbourhoods'.

PSYCHOLOGY AND HEALTH

Section A

9 (a) Explain, in your own words, what is meant by 'improving adherence to medical advice'. [2]

Typically: adherence is the extent to which people carry out the instructions given to them by a medical practitioner.
This question also concerns improving this process, so 2 marks only if improvement is acknowledged. See **(c)** for examples.

(b) Outline <u>two</u> reasons why people may not adhere to medical advice. [6]

Several possibilities:
Disease/medical treatment programmes: severity of illness; side effects of treatment; duration of treatment; complexity of treatment; people are less likely to adhere if the treatment requires a change in long-standing habits and behaviours; expense or cost.
Personal characteristics: cognitive and emotional factors; 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; personal beliefs/models:

- 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 so avoid treatment, get drunk, etc.).
- Common sense: Leventhal (1982) model where patients' own views about their illness can contradict doctors' instructions and treatment.
- Becker and Rosenstock's (1984) health belief model is relevant. Patients weigh up the pros or benefits of taking action against the cons or barriers to taking action and make a decision based on their assessment of these factors.
- Fishbein and Ajzen's theory of reasoned action is appropriate.
- Stanton's (1987) model of adherence behaviour is pertinent.

Cultural factors
Relationship between person and medical service: speed of service; practitioner personality: Byrne and Long (1976) distinguish between doctor-centred and patient-centred personality and Savage and Armstrong's (1990) study on this; 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.

(c) Outline <u>one</u> way in which adherence to medical advice can be improved. [3]

Most likely possibilities include:

- changing physician behaviour (DiMatteo and DiNicola, 1982); sending a doctor on a training course;
- changing communication style (Inui et al., 1976);
- change information presentation techniques (Ley et al., 1982);
- have the person state they will comply (Kulik and Carlino, 1987);
- 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.

Candidates could focus either on improving the patient 'end' or that of the practitioner. Practitioner more logical as they 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.

In addition, there are specific suggestions to change physician behaviour. Tapper-Jones (1988) suggests using visual material such as diagrams. Emphasising key information and having the patient repeat what has been said (Kulik and Carlino, 1987) all improve patient satisfaction.

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

Two aspects required here: a comment on measures and a comment on stress.

There are two main measures of stress: physiological and psychological – see details below.

(b) Describe <u>two</u> studies where stress was measured psychologically. [6]

Any two from:

There are two main **measures**: physiological and psychological.

- Psychologically by questionnaire based on life events: e.g. Holmes and Rahe (1967).
- Psychologically by questionnaire based on daily hassles: e.g. Kanner/Lazarus (1967).
- Psychologically by questionnaire based on personality: e.g. Friedman and Rosenman (1974).
- Psychologically by questionnaire based on other causal factors (such as work) e.g. Professional Life Stress Scale.

(c) Describe <u>one</u> study where stress was measured physiologically. [3]

- Physiologically by recording devices: e.g. Goldstein et al. (1992) measured blood pressure in paramedics.
- Physiologically by sample tests.
- Geer and Meisel (1972) measured GSR in participants exposed to photographs of dead bodies.
- Lundberg (1976) measured corticosteroids in urine in crowded train conditions.
- Johansson (1978) measured stress levels in a Swedish sawmill.

Section B

11 (a) Describe what psychologists have found out about health promotion. [8]

Answers are likely to include:

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

Also worth credit would be programmes in:

- **Schools** e.g. Walter (1985) in US and Tapper et al. (2003) in UK with food dudes.
- **Worksites** e.g. Johnson and Johnson in US and Gomel (1985) in Australia.
- **Communities** e.g. Farquhar's (1977) three community study.
- The three community study (Farquhar et al., 1977) 42 000 people.
- Minnesota heart health programme (Blackburn et al., 1984) 350 000 people.
- Pawtuckett heart health project (Lasater et al., 1984) 170 000 people.
- Pennsylvania county health improvement program (Stunkard et al., 1985), 220 000.
- Stanford five city project (Farquhar et al., 1984) 359 000 people.

(b) Evaluate what psychologists have found out about health promotion. [10]

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

- the effectiveness of promotions;
- the assumptions about human nature;
- the ethics of some strategies;
- the methodology used by psychologists.

(c) Using psychological evidence, suggest a health promotion campaign to overcome a health problem of your choice. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Answers must focus on a specific health problem. The target could be schools, worksites and communities.
Lots of possibilities here and candidates will refer to studies of health promotion. As with all part **(c)** questions candidates should refer to a technique which is based on psychological knowledge rather than a common-sense, anecdotal suggestion. For example, it would be legitimate to refer to a fear-arousal approach, or 'providing information', or through mass communication.

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

Two types of answer:
General:

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

Specific (lots of possibilities):

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

Any appropriate suggestion can receive credit.

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

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

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

(c) Giving reasons for your answer, suggest how safety behaviours could be promoted in schools. [6]

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

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

PSYCHOLOGY AND ABNORMALITY

Section A

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

Typically: a collection of assumptions concerning the way abnormality is caused and treated.

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

Most likely:
- The biomedical model is based on the assumption that dysfunctional behaviour has a biological cause.
- Mental disorders are the same as physical illnesses, just located in a different part of the body.
- Mental illnesses can be diagnosed and treated in the same ways as physical illnesses: mainly with drugs, but with the options of surgery or electro-convulsive therapy.

(c) Describe <u>two</u> medical treatments for abnormalities. [6]

- There are a number of **medical treatments**:
- The catecholamine hypothesis of **affective disorders,** where the chemical imbalance hypothesis for mental health disorders, especially for depression, was outlined. There are four main types of drug that relieve the symptoms of depression: Tricyclics; MAOIs (Monoamine Oxidase Inhibitors); SSRIs (Selective Serotonin Reuptake Inhibitors); SNRIs (Serotonin and Noradrenaline Reuptake Inhibitors).
- The first generation of **anti-psychotics** (or neuroleptics) began in the 1950s e.g. chlorpromazine. Then came **atypical anti-psychotics** which acted mainly by blocking dopamine receptors. The third generation of drugs, such as Aripiprazole, are thought to reduce susceptibility to metabolic symptoms present in the second generation atypical anti-psychotics.
- Medications for **anxiety** commonly prescribed include benzodiazepines, such as alprazolam and diazepam; anti-depressants, including SSRI; and possibly atypical anti-psychotics such as quetiapine.
- **ECT** (electroconvulsive therapy)/electroplexy is very common.

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

Typically: kleptomania is an impulse control disorder characterised by a recurrent failure to resist stealing. Most kleptomaniacs have money to pay and do not need the item(s) stolen. It is an impulse control disorder.

(b) Outline the characteristics of <u>one</u> abnormal need. [3]

Typically: people *need* various things to stay alive (food) and they also have a psychological dependence on various things but usually these are desires rather than essentials. Where people cannot cope without something, where the need takes over 'normal' psychological functioning and often where that thing is illegal (such as kleptomania and pyromania), the need is abnormal.
What follows may then be a description of the characteristics of kleptomania, e.g. people with this disorder are compelled to steal things, generally objects of little or no significant value.

(c) Give <u>one</u> explanation for, and <u>one</u> way of overcoming, kleptomania. [6]

Explanations:
Behavioural: due to conditioning – the kleptomaniac is rewarded by not getting caught;
Psychodynamic: inability by ego and superego to suppress the urges of the id: 'I want';
Physiological: thrill-seeking to achieve positive emotions;
Families: also blamed for kleptomania; various studies argue for a genetic component;
Cognitive: thrill-seeking; faulty thought patterns. Impulse control disorder.
Overcoming:
Kleptomania has several different treatments. Cognitive behaviour therapy is recommended as a helpful addition to medication. Other treatments include seeing the patient's actions as an unconscious process and analysing it to help the patient get rid of the behaviour. Often, this treatment is followed by a more psychodynamic approach that addresses the underlying problems that generated the negative emotions causing the mania. Some medications that are used for people diagnosed with kleptomania are selective serotonin reuptake inhibitors, mood stabilisers and opioid antagonists.

Section B

15 (a) Describe what psychologists have discovered about schizophrenia. [8]

Term from Greek schzein (split) and phren (mind).
Candidates could focus on **symptoms**:
'Positive' symptoms (very common) include:
- Hallucinations – hearing, smelling, feeling or seeing something that isn't there.
- Delusions – believing something completely even though others don't believe it.
- Difficulty thinking – finding it hard to concentrate and drifting from one idea to another.
- Feeling controlled – thoughts are vanishing, or that they are not your own, being taken over by someone else.

'Negative' symptoms (not very common) include:
- Loss of interest, energy and emotions; feeling uncomfortable with other people.

Candidates could focus on **types**:
- **Hebephrenic**: incoherence, disorganised behaviour, disorganised delusions and vivid hallucinations.
- **Simple**: gradual withdrawal from reality.
- **Catatonic**: impairment of motor activity, often holding same position for hours/days.
- **Paranoid**: well organised, delusional thoughts (and hallucinations), but high level of awareness.
- **Undifferentiated/untypical**: for those who do not fit the above.

Candidates could focus on **explanations**:
- **Behavioural**: due to conditioning and observational learning.
- **Psychodynamic**: regression to oral stage.
- **Families** also blamed for schizophrenia; as are twins.
- **Cognitive**: breakdown in ability to attend selectively to stimuli in language, etc.
- **Genetics** also may play a role.

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

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

NOTE: any evaluative point can receive credit; the hints are for guidance only.
- points about defining and categorising abnormality;
- cultural and individual differences;
- comparing and contrasting explanations of cause;
- usefulness of therapies;
- implications for individual and society.

(c) You are a behaviourist. Giving reasons for your answer, suggest how the behaviour of a person with schizophrenia may be modified. [6]

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

- Sensky (2000) has used cognitive behaviour therapy in the treatment of schizophrenia.
- Paul and Lentz (1977) found that the use of tokens was successful in reducing bizarre motor behaviours and in improving social interactions with staff and other patients.

No credit for any non-behaviourist treatment.

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

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

Types:

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

Causes:

- The **biopsychosocial model** proposes that biological, psychological and social factors all play a role to varying degrees in causing depression.
- The **diathesis–stress model** suggests that depression results when a pre-existing vulnerability, or diathesis, is activated by stressful life events.
- The **monoamine hypothesis**: depression arises when low serotonin levels promote low levels of norepinephrine.
- Depression also runs in families and the closer the **genetic relationship**, the more likely people are to be diagnosed with the disorder. Oruc et al. (1998): first degree relatives of people diagnosed with depression are two or three times more likely to be diagnosed with depression than those who are not first degree relatives.

Psychological: Beck proposed the **cognitive model of depression** with a triad of negative thoughts comprising cognitive errors about oneself, one's world, and one's future; recurrent patterns of depressive thinking, or *schemas*; and distorted information processing.

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

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

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

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

Most likely:

- Beck et al. (1979) believe in **cognitive restructuring.** Ellis (1962) outlined rational emotive therapy which was developed into **rational emotive behaviour therapy (REBT).**
- Seasonal Affective Disorder treated using a light box (Watkins, 1977). Studies looking at acclimatisation may be a possibility and telling people about the negative effects gives perceived control.

Any appropriate treatment to receive credit.

PSYCHOLOGY AND ORGANISATIONS

Section A

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

Typically: Chemers (2002) defines leadership as the 'process of social influence in which one person can enlist the aid and support of others in the accomplishment of a common task'. However, a formal definition is not required. More simply it is 'the ability to guide a group to achieve a goal'. Also needed is acknowledgement of theory, an analytic structure designed to explain a set of empirical observations.

(b) Describe one theory of leadership. [3]

Any **one** from:

- **Universalist theories** of leadership: The *Great Man Theory* (Wood, 1913); McGregor (1960) *Theory X and Theory Y.*
- **Behavioural theories** of leadership: researchers at Ohio State University, Halpin and Winer (1957), suggested *initiating structure* and *consideration*; researchers at the University of Michigan identified *task-oriented behaviours* and *relationship-oriented behaviours.* This extended into Blake and Moulton's (1985) *Managerial Grid*.
- **Charismatic** (or transformational) leaders have the determination, energy, confidence and ability to inspire followers.
- **Contingency theories** of leadership: Fiedler's contingency model (Fiedler, 1967); House's (1971) *path-goal theory*; Vroom and Yetton (1973) propose a *decision-making theory*; Dansereau et al. (1975) has a *leader-member exchange model*.

(c) Describe <u>one</u> management style and <u>one</u> leadership style. [6]

Most likely management style:
Tuckman (1965) 4 stages: forming, storming, norming and performing. Also **Woodcock** (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.
Most likely leadership style:
Lewin's: autocratic, democratic and laissez-faire styles.

18 (a) Explain, in your own words, what is meant by the term 'theory of motivation'. [2]

Typically: a theory is an analytic structure designed to explain a set of empirical observations, and in this case to explain the force that energises, directs and sustains behaviour.

(b) Briefly describe <u>one</u> theory of motivation and suggest <u>one</u> way in which motivation at work can be improved. [6]

A number of theories to choose from.

- **Need theories** of motivation: individual needs.
- Maslow's **need-hierarchy** (1965); Alderfer's **ERG theory** (1972). McClelland's **achievement-motivation theory** (1961).
- **Job design theories**: a job well designed and satisfying needs will lead to good motivation.
- Herzberg's **two factor theory** (1966); **job characteristics model** (Hackman and Oldham, 1976).
- **Rational (cognitive) theories**: people weigh costs and rewards of job; **equity theory** (Adams, 1965); **VIE theory** (or expectancy) (Vroom, 1964).
- **Goal setting theory** (Locke, 1968): for motivation goals must be specific, clear and challenging.
- **Reinforcement theory** (traditional): positive and negative reinforcers and punishment.

Motivation can be improved through:

- responsibility for decisions such as negotiating prices, planning journeys and times, etc;
- material reward: salary, commission, bonuses, promotions and competitions/incentive schemes could be used against sales objectives such as volume, profitability, new account development;
- material reward: merchandise incentives, company car etc.

(c) Give <u>one</u> reason why motivation and performance are not always related. [3]

Most likely:

- systems and technology variables: inadequate systems, sub-standard tools and equipment, etc.;
- individual difference variables: workers without basic skills and talents. New employees may be most motivated but least productive;
- group dynamics variables: performance can be hindered by poor team workers even if rest of team are motivated. Group dynamics may hinder a motivated individual;
- organisational variables: does each department work equally efficiently? Organisational politics may affect motivation and performance too.

Section B

19 (a) Describe what psychologists have found out 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; e.g. SWOT Analysis – evaluation by the decision-making individual or organisation of Strengths, Weaknesses, Opportunities and Threats with respect to desired end state or objective.
- **Group decision-making** deciding what action a group should take. Could be more precise and involve types such as democratic or autocratic decisions.
- **Group error** such as groupthink and group polarisation.
  Groupthink: syndrome characterised by a concurrence-seeking tendency that overrides the ability of a cohesive group to make critical decisions (Janis, 1965).
  Group polarisation: groups who make decisions that are more extreme than those made by individuals.

(b) Evaluate what psychologists have found out 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]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Any suggestion based on psychological theory is acceptable. Most likely: **Tuckman's** (1965) model (forming, storming, norming, performing); the **Belbin** approach (1985, 1993) or **Margerison and McCann's** (1991) team management wheel.

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. the Hurier model for effective listening); encoding, channel and decoding.
Candidates may consider the varieties of communication: phone, face-to-face, meeting, memo, newsletter, employee handbooks, reports, email, voicemail, teleconference, etc. Each has advantages and disadvantages. Another set of factors is:

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

Candidates can base their answers on communication networks e.g. Leavitt's (1951) centralised and decentralised networks involving various formations such as circle and wheel – which they may well draw.

(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 strategies that can improve communication flow from workers to management. [6]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
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 and Rosen's** (1985) the MUM effect, the reluctance to tell superiors something bad.