UNIVERSITY OF CAMBRIDGE INTERNATIONAL EXAMINATIONS

GCE Advanced Level

MARK SCHEME for the October/November 2008 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 Specialist Choices

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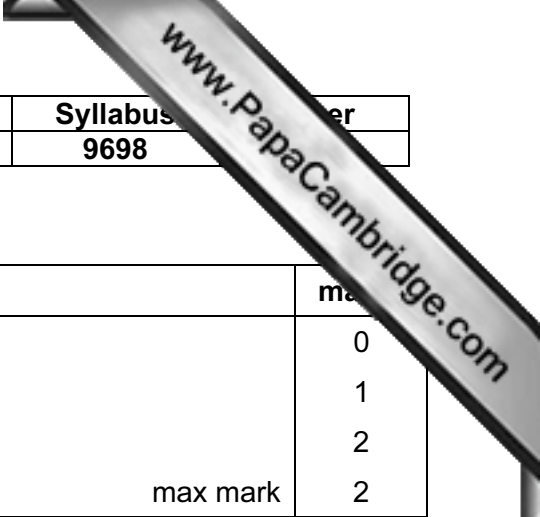
Section B

Q	Description	m~~
(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 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

(c)	**APPLICATION** [Applying to new situations and relating to theory/method]	
	A suggestion (to apply psychological knowledge to the assessment request) has been attempted.	
	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 for Question	24

PSYCHOLOGY AND EDUCATION

Section A

1 (a) **Explain, in your own words, what is meant by 'assessment and categorisation'.** [2]

Typically: standardised assessment (via testing or not) of some educational ability.

(b) **Describe *one* way in which children can be categorised.** [3]

This is difficult because assessment may vary according to different countries. What is required is any form of assessment that may be used in schools. This could be at a simple level such as a written piece of work (an essay) or a project or anything that teachers do as part of their work. It may be that candidates can focus on national examinations (such as (in England & Wales, GCSEs and GCEs) or it may be they focus on tests used by psychologists as a diagnostic aid (such as IQ tests).

(c) **Suggest *two* implications of assessment and categorisation.** [6]

Flexibility required here: could be two implications of assessment (e.g. labelling) two of categorisation or one of each. Are the two separable? Credit with flexibility.

2 (a) **Explain, in your own words, what is meant by the term 'layout of educational environments'.** [2]

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

(b) **Describe *two* effects of physical features on performance.** [6]

Many possible features to include here. Any two from:
a. **open plan** schools versus **'traditional'** designs. Traditional = formal; open plan = individualistic. Rivlin & Rothenberg (1976): open plan imply freedom, but no different from traditional. Open plan offer too little privacy and too much noise. Conclusion: some children do better with traditional, others better with open plan.
b. Some studies refer to effect of number of **windows/light** (e.g. Ahrentzen, 1982).
c. Some to effects of **temperature** (e.g. Pepler, 1972).
d. **classroom layout**: (a discovery learning room) with availability of resources; use of wall space: too much v too little (e.g. Porteus, 1972).
e. **seating arrangements**: sociofugal v sociopetal (rows v horseshoe v grouped).
f. **Classroom capacity**: how many is room designed for and how many occupy = lack of privacy, crowding = stress and poor performance.

(c) **Describe *one* way in which physical features can affect the feelings of children.** [3]

Mark scheme guidelines apply in that any reasonable suggestion is acceptable.
Interesting question. First time this has been asked; interesting to see how it is distinguished from (b) above.

SECTION B

3 (a) **Describe how** *one* **psychological perspective has been applied to learning.**

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 a 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.

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

NOTE: any evaluative point can receive credit; the hints are for guidance only.
- the strengths and weaknesses of psychological perspectives;
- the implications the perspectives have for teachers;
- whether theory applies in practice;
- contrasting alternative perspectives.

(c) **Giving reasons for your answer, suggest how** *one* **perspective could be used to teach a child a different language.** [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 disruptive behaviour in schools.

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

Candidates may then provide an explanation for any of these behaviours which may be behavioural, cognitive or social. Specific causes can include ADHD, for example.

(b) Evaluate what psychologists have found out about disruptive behaviour in schools.

[10]

NOTE: any evaluative point can receive credit; the hints are for guidance only.
- definitions and types of problems;
- the methods used by psychologists to assess problem behaviour;
- ethical issues;
- the challenges a problem child presents for teachers and educators. methodology used to study problem behaviours.

(c) Giving reasons for your answer, suggest how a teacher may correct a disruptive behaviour. [6]

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

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

1) **Reasoning** – this is presenting to the child reasons for not engaging in deviant behaviour and/or reasons for engaging in alternative behaviour. Parke (1974) found reference to actual object more successful in younger children for example. Preferable to punishment?

(2) **Behaviour modification techniques**:

(a) **Positive reinforcement**. Can be intrinsic (internal) and so not directly under teacher control (but teacher could create situation leading to satisfaction, etc.) and Extrinsic (external): attention, praise, stars, etc.

Bijou and Sturges (1959) classify extrinsic reinforcers into five categories: consumables, manipulatables, visual and auditory stimuli, social stimuli and tokens.

O'Leary & Becker (1967) used tokens to eliminate deviant responses with much success, although others (Kazdin & Bootzin, 1972) did not.

Premack (1965) outlines the 'Premack Principle' where children behaving appropriately engage in a reinforcing activity – one that the child enjoys.

Michael (1967) describes 7 principles one should be wary of when attempting to control behaviour through consequences.

(b) **Modelling**. Punishing one student may inhibit the same behaviour in another; rewarding one student may lead to copying behaviour by another.

(c) **Punishment**. Can be (1) presentation of unpleasant stimulus such as facial gestures, reprimands, detention, time-out, physical punishment, etc. (2) removal of pleasant stimulus. Many studies illustrate all these variations. For example Bratner & Doherty (1983) distinguish three types of time out: isolation, exclusion and non-exclusion.

PSYCHOLOGY AND ENVIRONMENT

Section A

5 (a) **Explain, in your own words, what is meant by 'controlling crowds'.** [2]
Typically where crowds behave appropriately to the situation, which could be peacefully rather than aggressively or acquisitively, they may behave calmly rather than panicky.

(b) **Describe *two* types of crowd.** [6]
Brown (1965) classifies crowds according to their behaviours:
1. acquisitive crowd
2. apathetic crowd
3. expressive/peaceful crowd
4. baiting crowd
5. aggressive crowd [often referred to as 'mob psychology']
6. escaping crowd [panicky and non-panicky]
Description of any **two** of the above.

(c) **Describe *one* way in which crowds in emergency situations can be controlled.** [3]
Most likely is 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:
1. Let the crowd self-police wherever possible;
2. Effective liaison should take place between police and organisers;
3. If police are involved they should use minimum force so are not perceived by crowd as causing trouble;
4. Those involved in managing crowds should be trained in effective interpersonal communication;
5. The police should be perceived as accountable and not able to do what they like.
However, in emergency situations escaping crowds can be controlled by follow me/follow directions e.g. Sugiman and Mitsumi. Evacuation messages worded appropriately can reduce panic, e.g. Loftus.

6 (a) **Explain, in your own words, what is meant by the term 'housing design'.** [2]
Typically: fairly obvious again. Must be design and not construction.

(b) **Describe *one* type of urban housing design.** [3]
Several possibilities here depending on what prevails in the Country in which candidates live. One type is to build high-rise blocks of flats. (e.g. Pruitt-Igoe in USA). Alternative is to build houses with 'parks and open gardens' and increase defensible space. An alternative (called urban homesteading in USA) is where occupants agree to 'code of conduct' in return for a house. Gentrification is the growth of middle class housing in areas that were previously deteriorated.

(c) **Describe *two* weaknesses urban housing design may have.** [6]
Most likely: if gentrification, then this has caused an increase in violent crime (in USA). People who once lived in these areas have to move elsewhere! If high-rise then all problems associated with Pruitt-Igoe apply.

SECTION B

7   (a) **Describe what psychologists have learned about territory.**
Focus must be on, territory.
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 and 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.
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.
Defence of primary territory (e.g. home): Newman (1976): **defensible space**: physical space that is characterised by a high level of social responsibility and personal safety. Certain buildings are more likely to be vandalised/burglarised because of their design. Evidence from Pruitt-Igoe building: 33 high-rise blocks each with 80 apartments. After 3 years = very high crime rate and 70% were empty. Why? Newman: (1) **zone of territorial influence** – an area which appears to belong to someone. (2) **opportunities for surveillance** – if it can be seen by occupants, then no vandalism. High-rise have many semi-public areas: entrance-halls, lifts = not belong to anyone so no markers so vandalism. Also no opportunities for surveillance so vandalism. Pruitt-Igoe – one had a chain fence around it. Vandalism 80% lower than other buildings and vacancy rate 5%.

   (b) **Evaluate what psychologists have learned about 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 what a person can do to defend secondary territory in a classroom.**   **[6]**
Suggestion will usually be to put books on desk, or bag or coat on seat.

8 (a) **Describe what psychologists have learned about environmental cognition.**

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

Methods: main ones are sketch maps, recognition tasks and multidimensional scaling.

Candidates are likely to mention the work of **Lynch** who found five common elements: 1. *Paths*: roads, walkways, rivers (i.e. routes for travel); 2. *Edges*: non-travelled lines e.g. fences, walls; 3. *Districts*: larger spaces; 4. *Nodes*: places, junctions, crossroads, intersections where people meet; 5. *Landmarks*: distinctive places people use for reference points e.g. tallest building, statue, etc.

Acquisition of maps: main reference is likely to be Piaget and his work on Swiss mountains. Piaget has support (e.g. Acredolo, 1977) but critics too such as DeLoache (1987) who says 3 yo's have spatial cognition. Children acquiring maps could be the same for adults in a new situation: 1] landmarks are noticed and remembered; 2] paths between landmarks are constructed; 3] landmarks and paths organised into clusters; 4] clusters and features co-ordinated into overall framework.

Errors in maps: a] Euclidean bias: people assume roads etc. are grid-like: they are not. Sadalla & Montello (1989). b] superordinate-scale bias: areas (e.g. counties) grouped together and judgement made on area rather than specific place, e.g. Stevens & Coupe (1978); c] segmentation bias: Allen & Kirasic (1985) we estimate distances incorrectly when we break a journey into segments compared to estimate as a whole. Also: 1. maps are often incomplete: we leave out minor details. 2. We distort by having things too close together, too far apart or mis-aligning, e.g. people over-estimate the size of familiar areas. 3. We augment: add non-existent features.

Gender differences: 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) men 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.

Candidates could also legitimately look at 'animals and cognitive maps'.

Candidates could also legitimately look at 'the scenic environment'.

(b) **Evaluate what psychologists have learned about environmental cognition.** [10]

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

- the methods psychologists use to study cognitive maps;
- laboratory versus real-life studies;
- errors made in cognitive maps;
- competing theoretical explanations.

(c) You are required to design a booklet for tourists. Giving reasons for your answer what features of the scenic environment your booklet would include.

Most likely: the **descriptive approach** (Litton, 1972) emphasising the importance of form, colour and texture. In psychology we refer to this as the **physical-perceptual approach**. Studies here (e.g. Zube et al, 1974; Vining et al, 1984 and Im, 1984) look at specifically measurable characteristics such as heights, distances, edges, etc. Generally natural scenes are preferred to those created by humans. But there is no individuality or *psychology* here. Brunswick's lens model (1956) is also appropriate. Berlyne (1974) has developed a **model of aesthetics**. Important are **collative stimulus properties** which stimulate us (can be **novelty**, **incongruity**, **complexity** or **surprisingness**) to investigate further and compare with an existing image and **types of exploration**. Specific exploration is when we examine a stimulus closely and diverse exploration is when we seek out a stimulus to examine. Berlyne also outlines two dimensions: **uncertainty-arousal** and **hedonic tone**. The former suggests that an unknown stimulus arouses specific exploration and the latter, related to diverse exploration is a curvilinear relationship where a stimulus first increases hedonic tone (degree of pleasantness) then decreases it. Aesthetic judgements are a combination of these factors. Alternatively Kaplan and Kaplan (1975) outline a **preference model**. They believe we prefer landscapes that are useful and are survivable. Further, that we like to process information and prefer scenes which are understandable and make sense. They outline a **preference matrix** with **coherence**, **legibility**, **mystery** and **complexity** (e.g. we prefer complex scenes). But there are **individual differences in preference**: age, sex, place of residence and familiarity. Many studies and many examples are available for students to use. A phenomenological approach is also a possibility (e.g. Seamon, 1982) which also considers individual preference.

PSYCHOLOGY AND HEALTH

Section A

9 (a) **Explain, in your own words, what is meant by the term 'health belief model'.** [2]
Typically: models which take into account a range of factors that help predict whether people are more or less likely to engage in health protective behaviour to improve their lifestyle.

(b) **Describe *two* ways in which lifestyles can be measured.** [6]
Most likely:
Harris and Guten is very common – lists what people do to aid their lifestyle.
Weinstein also common – questions about lifestyle attitudes. Found optimistic bias.
Mechanic did correlational study.
Measures of physiology (cholesterol) over time.

(c) **Describe *one* health belief model.** [3]
Several models to choose from:
Becker & Rosenstock (1984) **The health belief model**. Related studies: Champion (1994) used HBM to inform women about benefits of mammography. Hyman et al (1994) perceived susceptibility not good predictor. Barriers and benefits better but ethnicity best. Aiken et al (1994) regular place to go and practitioner recommendation much better predictor than HBM.
Ajzen & Fishbein (1975) **Theory of reasoned action**. Related studies: Montano et al (1997) low income women questioned regarding attitude, subjective norm and intentions toward mammography. Found all significantly related to use. O'Callaghan et al (1997) better predictor is past experience/behaviour.
Ajzen (1985) Theory of planned behaviour. As above model but adds **perceived behavioural control**.
Weinstein et al (1998) **The precaution-adoption process model**. Above merely identify variables. Stages people go through in their readiness to adopt a health related behaviour.
Prochaska et al (1992) **The transtheoretical model**. Five stages of behaviour change: Precontemplation – no intention of changing. Isn't a problem. Contemplation– awareness of problem. Thoughts about changing but no action. Preparation – plans made to change behaviour. Action – plans put into action. Maintenance – attempt to sustain changes and resistance to relapse.

10 (a) Explain, in your own words, what is meant by 'health promotion'.
Typically: enhancing good health and preventing illness.

(b) Outline *two* methods for promoting health. [6]
Any two from:
1] **Appeals to fear**/fear arousal (Janis & Feshbach, 1953; Leventhal, 1967) is the traditional starting point. The Yale model (source of message/message/recipient) underlies many attempts.
2] **Providing information** via media (e.g. Flay, 1987) 3 approaches: 1] provide negative info only; 2] for those who want to be helped provide first steps; 3] self help via tv audience.
3] **Behavioural methods**: provision of instructions, programmes, diaries to use as reinforcers.
Also worth credit would be programmes in **schools**, (e.g. Tapper) **worksites** (e.g. Johnson & Johnson) and **communities** (e.g. three community study).

(c) Describe *one* community-wide health promotion study. [3]
Most likely <u>possibilities include</u> (e.g.'s from USA):
(a) The three community study (Farquhar et al, 1977) 14,000 people.
(b) Minnesota heart health programme (Blackburn et al, 1984) 350,000 people.
(c) Pawtuckett heart health project (Lasater et al, 1984) 170,000 people.
(d) Pennsylvania county health improvement program (Stunkard et al, 1985), 220,000.
(e) Stanford five city project (Farquhar et al, 1984) 359,000 people.

Section B

11 (a) Describe what psychologists have found out about adherence to medical advice.
Lots of possibilities here from a vast area. Candidates could focus on one or more of the following:

Types of non-adherence
[1] failure to take medication;
[2] failure to arrive for recommended appointment;
[3] any other non-adherence.

Measuring non-adherence
[1] **Subjective** [a] ask practitioner to estimate: [b] ask patient to estimate (self report): [c] estimate of family member/medical personnel.
[2] **Objective** [a] Quantity accounting (pill count) where number of pills remaining is measured. [b] Medication dispensers which record and count times when used. [c] Biochemical tests such as blood or urine sample. [d] Tracer/marker method add tracer to medication e.g. riboflavin (vitamin B2) fluoresces under ultraviolet light. [e] Recording number of appointments kept.

Why patients do and don't adhere to advice
[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] Practitioners 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?

(b) Evaluate what psychologists have found out about adherence to medical adv

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

- how psychologists gained their evidence;
- individual differences;
- cultural differences;
- implications for patient's health and/or practitioner satisfaction.

(c) Using psychological evidence, suggest what can be done to improve adherence to medical advice. **[6]**

By no means exhaustive list of possibilities include:

(a) changing physician behaviour (DiMatteo & DiNicola, 1982); sending Dr's on training courses;

(b) changing communication style (Inui et al, 1976);

(c) changing information presentation techniques (Ley et al, (1982);

(d) have the person state they will comply (Kulik & Carlino, 1987);

(e) provide social support (Jenkins, 1979) and increase supervision (McKenney et al, (1973);

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

(k) Introduce educational strategies (Sackett & Hayes, 1976).

12 (a) Describe what psychologists have discovered about substance use and abuse.

Candidates could offer definitions, distinguishing between use and abuse (e.g. Rose Seligman, 1984); dependence (physical and/or psychological), tolerance, addiction withdrawal. They could also consider who uses/abuses and why they use/abuse. Possib causes:

Smoking: 1. **genetic** (e.g. Eysenck, 1980) 2. **nicotine addiction/regulation model** (e.g. Schachter, 1980) 3. **Biobehavioural model** (e.g. Pomerleau, 1989) 4. **opponent process model** (e.g. Solomon, 1980) cough=nasty so smoke=nice. 5. **social learning**/modelling. 6. Tomkins (1966): positive affect; negative affect; habitual; addictive. 7. Leventhal & Cleary (1980): why start: tension control; rebelliousness; social pressure. Lots of evidence to support; some good some iffy.

Drinking: 1. **tension reduction hypothesis** (e.g. Conger, 1956) 2. **disease model** (a) Jellineks (1960) gamma and delta; (b) **alcohol dependency syndrome** (e.g. Edwards et al, 1977) =7 elements of dependency. 3. **social learning/modelling**. Whereas 2. = genetic, 3. = learning so good for section (b).

Drugs: similar reasons to above. Note that types of drugs and their effects are not relevant and should receive no credit.

Food: (obesity) 1. **age and metabolism** 2. **'gland problems'** 3. **heredity**: lots of twin studies and correlations with parents. 4. The **set-point theory**: set-point determined by fat consumed as a child determining need for fat later. 5. **restrained** versus **unrestrained** eaters. **Food**: (anorexia/bulimia) biological, cultural and psychological revolving around body image in females.

(b) Evaluate what psychologists have discovered about substance use and abuse. **[10]**

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

- the methods psychologists use to gain their evidence;
- comparing and contrasting theories;
- ethical issues involved in the research;
- generalisation of the results from the use of research participants.

(c) Using your psychological knowledge, suggest ways in which people using a substance can be encouraged to quit. **[6]**

Most likely:

going it alone – must people just give up (but don't succeed!);

drug therapy – nicotine replacement if smoker; use of emetic for alcoholics, etc.;

behaviour therapies: aversion therapy most common but also many self management strategies;

Many candidates will write about **social support** from friends and family.

PSYCHOLOGY AND ABNORMALITY

Section A

13 (a) **Explain, in your own words, what is meant by the term 'amnesia'.** [2]
   Typically: a loss of memory, most often personal information.

   (b) **Describe *one* cause of amnesia.** [3]
   Often the type of amnesia is determined by the cause, which could be alcoholism, brain damage or ageing, or can be caused by some traumatic event.

   (c) **Describe *two* types of amnesia.** [6]
   psychogenic amnesia which is memory loss due to psychological factors. Amnesia can be **localised** (e.g. loss for 3 days after accident);
   selective (e.g. some but not all events);
   continuous (e.g. permanent) or
   generalised (loss of all memory of one's life).

14 (a) **Explain, in your own words, what is meant by the term 'schizophrenia'.** [2]
   Typically: Term from Greek schzein (split) and phren (mind).

   (b) **Describe *two* types of schizophrenia.** [6]
   Are 5 main 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 all the others who do not fit the above!

   (c) **Give *one* way in which schizophrenia may be treated.** [3]
   Most likely:
   psychosurgery – once popular! But now highly unlikely;
   ECT – very common and still used today;
   chemotherapy – very popular;
   behaviour therapy – less likely, but some token economy used.

SECTION B

15 (a) Describe psychological models of abnormality.

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

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

Psychodynamic: disorders caused by unresolved unconscious conflicts usually 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.

Abnormality must be identified and treatments must be appropriate to it.

(b) Evaluate psychological models of abnormality. **[10]**

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

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

(c) Giving reasons for your answer, suggest treatments for an abnormality. **[6]**

Most likely: **ECT** (electroconvulsive therapy)/electroplexy is very common.

Chemotherapy also common. Tranquilizers (e.g. chlorpromazine) for manic episodes and lithium for both manic and depressive episodes.

Psychotherapy also a possibility but less common and less successful.

Behavioural: behavioural or cognitive-behavioural therapy such as systematic desensitisation.

16 (a) Describe what psychologists have found out about anxiety disorders.

A general feeling of dread or apprehensiveness accompanied by various physical reactions such as increased heart rate, sweating, muscle tension, rapid and short breathing.

Three main types: **phobias**, **obsessive-compulsive** and **PTSD** (Post traumatic stress disorder).

Phobias – agoraphobia, social phobia and specific phobia (many types). Explanations provided by behavioural and psychodynamic approaches.

Obsessive-compulsive: obsessions – recurring thoughts that interfere with normal behaviour; compulsions – recurring actions which the individual is forced to enact. Obsessive-compulsive = irresistible thoughts or actions that must be acted on.

Explanations:

Psychoanalytic: traced to anal stage.

Behavioural: hypercritical, demanding parents reward similar behaviour in children.

Superstition – must go through rituals (O'leary & Wilson).

Chemical: OCD's have increased activity in frontal lobe of left hemisphere.

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

(b) Evaluate what psychologists have found out about anxiety disorders. [10]

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

- points about defining and categorising anxiety disorders;
- neuroses, so comparing and contrasting with psychoses;
- comparing and contrasting explanations;
- implications for person with anxiety disorder.

(c) Giving reasons for your answer, suggest how an anxiety disorder may be treated. [6]

Most likely treatment will be behaviourally or cognitive-behavioural such as systematic desensitisation. Psychotherapy is also a possibility.

PSYCHOLOGY AND ORGANISATIONS

Section A

17 (a) **Explain, in your own words, what is meant by the term 'personnel selection'.** [2]
Typically: the choosing from a sample of job applicants the individuals best suited to the jobs available.

(b) **Describe *two* ways in which personnel selection decisions are made.** [6]
Many theories to choose from:
1. **selection interview**: formal, informal and many aspects that could be included.
2. **work sample tests**: applicant required to perform a task to judge ability.
3. **Assessment centres**: make use of a range of methods that could last several days.
4. **biographical information**: cv, references, etc.
5. **Others**: peer assessment, self assessment, graphology, Polygraph.

(c) **Outline *one* pitfall or weakness with personnel selection decisions.** [3]
Most likely:
One aspect of the methods above may be flawed, (e.g. not reliable or valid) but main weakness is lack of fairness and/or bias.

18 (a) **Explain, in your own words, what is meant by the term 'leadership'.** [2]
Typically: easy marks here; just need to state the obvious.

(b) **Describe *two* theories of leadership.** [6]
Many theories to choose from:
Universalist theories of leadership: [1] The *great man theory* (Wood, 1913) [2] McGregor (1960) *Theory X and Theory Y.*
Behavioural theories of leadership [1] Researchers at Ohio State University Halpin and Winer (1957) suggested *initiating structure and consideration.* [2] 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: [1] Fiedler's contingency model (Fiedler, 1967). [2] House's (1971) *path-goal theory.* [3] Vroom and Yetton (1973) propose a *decision-making theory.* [4] Dansereau et. al. (1975) *leader-member exchange model.*

(c) **Describe *one* management style.** [3]
Most likely: **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. Could be McGreaor's (1960) effective and ineffective groups.

Section B

19 (a) Describe what psychologists have discovered about motivation to work.

A number of theories to choose from. Can do a range with less detail or few in more detail.
[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] McClellands **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 so 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. Hygiene's = 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).
[4] **Goal setting theory** (Locke, 1968): for motivation goals must be specific, clear and challenging. [5] **Reinforcement theory** (traditional): positive and negative reinforcers and punishment.

(b) Evaluate what psychologists have discovered about motivation to work. **[10]**

NOTE: any evaluative point can receive credit; the hints are for guidance only.
- Comparing and contrasting theoretical explanations;
- the measures used to gain data;
- the assumptions made about human behaviour;
- individual differences in motivation to work.

(c) Using your psychological knowledge, suggest what the management of a company could do to motivate its employees. **[6]**

This question requires more than mere replication of the above theories and it requires more than common sense answers such as "increase pay". What is required is the combination of suggestions with an appropriate theory e.g. an increase in pay is one of Herzberg's hygiene factors. This, of course is only one approach. Possible motivators include:
a] responsibility for decisions such as negotiating prices, planning journeys and times, etc.
b] material reward: salary, commission, bonuses, promotions and competitions/incentive schemes could be used against sales objectives such as volume, profitability, new account development.
c] material reward: merchandise incentives, company car etc.

20 (a) **Describe what psychologists have discovered about organisational work co...**

Riggio (1990) divides work conditions into **physical conditions** such as illumin... temperature, noise, motion, pollution and aesthetic factors such as music and colour; a... **psychological conditions** such as privacy or crowding, status/anonymity and importance/unimportance. Vibration, body movement and posture (e.g. seating or lifting) can be added to the list of physical conditions. The amount of evidence available for each of these, particularly physical conditions, is vast. However, it should not be too difficult to judge whether the evidence has psychological foundation rather than being largely anecdotal.

Another distinction is between a **mechanistic design** (chip making at McDonalds has 19 distinct steps and so has distinct rules to follow but little satisfaction) and an **organic structure** where a broad knowledge of many different jobs, with increased satisfaction, is required. Mintzberg (1983) has gone a step further and he outlines **five organisational types**: simple, machine, professional, divisional and adhocracy which involve five elements (operating core e.g. teachers; strategic apex e.g. management; support staff, etc.).

Work schedules are somewhat more specific but can include *compressed work weeks* and *flexitime* in addition to *shift work*. Pheasant outlines primary chronic fatigue, extremely karoshi (Japanese for sudden death due to overload). Minor effects = sleep disturbance, physical and mental.

(b) **Evaluate what psychologists have discovered about organisational work conditions.**

[10]

NOTE: any evaluative point can receive credit; the hints are for guidance only.
- individual differences in responses to work conditions;
- the assumptions made about human behaviour;
- the methods used by psychologists to gain their evidence;
- implications for the design of work conditions.

(c) **Giving reasons for your answer, suggest how negative effects of work environments can be reduced.** **[6]**

Work conditions (above) can be counteracted by, for example wearing headphones to reduce noise, etc. Change/improvement of any of above features fine. Also all agree shift-work bad. How counteract? Two schools of thought: *rapid rotation theory*: based on frequent change and preferred by workers who only do same shift for short time. Two options: 1] *metropolitan rota*: 2 early, 2 late, 2 night, 2 rest. 2] *continental rota*: 2 early, 2 late, 3 night, 2 rest, then 2 early, 3 late, 2 night, 3 rest. etc. *Slow rotation theory* – should change as infrequently as possible to minimise effects but not popular (night shift for 1 month).