UNIVERSITY OF CAMBRIDGE INTERNATIONAL EXAMINATIONS

GCE Advanced Level

MARK SCHEME for the November 2004 question paper

9698 PSYCHOLOGY

9698/03   Paper 3 (The Specialist Choices), maximum raw mark 70

This mark scheme is published as an aid to teachers and students, to indicate the requirements of the examination. It shows the basis on which Examiners were initially instructed to award marks. It does not indicate the details of the discussions that took place at an Examiners' meeting before marking began. Any substantial changes to the mark scheme that arose from these discussions will be recorded in the published *Report on the Examination*.

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*.

- CIE will not enter into discussion or correspondence in connection with these mark schemes.

CIE is publishing the mark schemes for the November 2004 question papers for most IGCSE and GCE Advanced Level syllabuses.

UNIVERSITY *of* CAMBRIDGE
International Examinations

Grade thresholds taken for Syllabus 9698 (Psychology) in the November 2004 examination.

	maximum mark available	minimum mark required for grade:		
		A	B	E
Component 3	70	49	43	29

The thresholds (minimum marks) for Grades C and D are normally set by dividing the mark range between the B and the E thresholds into three. For example, if the difference between the B and the E threshold is 24 marks, the C threshold is set 8 marks below the B threshold and the D threshold is set another 8 marks down. If dividing the interval by three results in a fraction of a mark, then the threshold is normally rounded down.

UNIVERSITY *of* CAMBRIDGE
International Examinations

November 2004

GCE A LEVEL

MARK SCHEME

MAXIMUM MARK: 70

SYLLABUS/COMPONENT: 9698/03

PSYCHOLOGY

The Specialist Choices

UNIVERSITY *of* CAMBRIDGE
International Examinations

SECTION A

Q	Description	Marks
Qa	No answer or incorrect answer	0
	Some understanding, but explanation brief and lacks clarity	1
	Clear, accurate and detailed and explicit explanation of term	2
	max mark 2	
Qb	*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, detailed	3
	max mark 3 or 6	
Qc	*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, detailed	3
	max mark 3 or 6	
	Maximum mark for part (a)	**11**

www.dynamicpapers.com

Page 2	Mark Scheme	Syllabus	Paper
	A LEVEL – NOVEMBER 2004	9698	3

Q	Description	Marks
SECTION B		
Q	**Description**	**Marks**
Qa	**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
Qb	**EVALUATION** [Assessing quality of data]	
	The quality of pertinent evidence is considered against one evaluation issue.	1
	The quality of evidence is considered against a number of issues, but is limited in scope and detail.	2
	The quality of evidence is considered against a number of issues and is reasonably wide ranging and detailed.	3
	The quality of evidence is considered against a number of issues and is wide ranging and detailed.	4
	ANALYSIS [Key points and valid generalisations]	
	Key points are identified for a given study (or number of studies) OR across studies, but no valid generalisations/conclusions are made.	1
	The answer identifies key points across studies and valid generalizations/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 and argument.	1
	Structure sound and argument clear and coherent.	2
	Maximum mark for part (b)	10
Qc	**APPLICATION** [Applying to new situations and relating to theory/method]	
	An attempt has been made to apply the assessment request specifically to the evidence.	1
	Appropriate suggestion. One basic application.	1
	The assessment request has been applied effectively to the evidence.	
	Appropriate suggestion. One or more detailed 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 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 Question	24

PSYCHOLOGY AND EDUCATION

SECTION A

1 (a) Explain, in your own words, what is meant by the term 'motivation in education'. 2

Typically: motivation is 'the force that energises, directs and sustains behaviour'; here it should be applied to education to receive full marks

(b) Describe <u>two</u> ways in which motivation in a classroom can be improved. 3

Most likely answers will involve positive reinforcement, for example praise for good work or reward in some form of desired behaviour will be permitted.

(c) Describe <u>one</u> example of learned helplessness. 6

Any appropriate example that is indicative of learned helplessness e.g. students who do not attempt to calculate statistical tests because 'I can't do maths'.

2 (a) Explain, in your own words, what is meant by the 'cognitive' approach to education 2

Typically: emphasis placed on the individual learners cognitive structure; how information is processed, organised and recalled. How this is best achieved is the problem. Is it best through discovery learning etc.

(b) Describe <u>two</u> ways in which the cognitive approach has been applied in education. 3

Most likely: **Discovery learning:** learning that takes place when students are not presented with subject matter in its final form but are required to organise it themselves [LeFrancois, 7th Ed p92]. Similar is guided discovery. Expository (reception) learning (Ausubel) argued to be preferable.

(c) Describe <u>one</u> weakness of the cognitive approach in education. 6

Most likely: Discovery learning is too time consuming. Expository learning better. Discovery learning affected by **set** (predisposition to learn in a particular way); **need state** (degree of arousal); **mastery of specifics** (amount and detail of learning); **diversity of training** (variety of conditions under which learning takes place).

www.dynamicpapers.com

Page 5	Mark Scheme	Syllabus	Paper
	A LEVEL – NOVEMBER 2004	9698	3

SECTION B

3 **(a)** **Describe ways in which educational performance is assessed in schools. 8**

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 (such as 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 and Wales) SAT's, GCSE's and GCE's or it may be they focus on tests used by psychologists as a diagnostic aid.

(b) **Evaluate ways in which educational performance is assessed in schools. 10**

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

- the ethics of testing;
- reliability and validity;
- the implications of testing for teachers;
- the implications tests have for young children;
- the assumptions tests make about human behaviour.

(c) **Giving reasons for your answer, suggest ways in which the artistic ability of children could be assessed.   6**

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

Here candidates have to apply what they have written about in part **(a)** to a classroom situation in relation to assessing artistic ability - for which they are unlikely to have prepared. This will, therefore, test their knowledge, understanding and application. Any appropriate suggestion to receive credit.

4 **(a)** **Describe what psychologists have learned about the design and layout of educational environments.   8**

1. <u>Focus on building design</u>:

   a. with comparisons between 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. Wheldall (1981) 'on-task' (formal) vs. 'off-task' (informal).

   b. Some studies refer to effect of number of windows (e.g. Ahrentzen, 1982); amount of light.

   c. Some to effects of temperature (e.g Pepler, 1972)

   d. Reynolds et al (1980) found age and physical appearance of school had nothing to do with academic accomplishments.

   e. small versus. large school (Barker & Gump, 1964): small have several advantages e.g. sense of belonging.

Page 6	Mark Scheme	Syllabus	Paper
	A LEVEL – NOVEMBER 2004	**9698**	**3**

www.dynamicpapers.com

2. <u>Focus on classroom layout</u>: (a discovery learning room) with availability of resources; use of wall space: too much versus too little (e.g. Porteus, 1972).

3. <u>Focus on seating arrangements</u>: sociofugal versus sociopetal (rows versus horseshoe versus grouped).

4. <u>'perspectives' approach</u>: architectural [environmental] determinism.

5. a. Staffing theory (Wicker et. al. (1972): understaffed, overstaffed or adequately staffed.

   b. Classroom capacity: how many is room designed for and how many crammed in = lack of privacy, crowding = stress and poor performance.

   c. Skeen (1976) suggests spatial zone affects performance (Hall's personal and intimate zone = optimal).

(b) Evaluate what psychologists have learned 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;
- consider 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) Giving reasons for your answer, suggest a suitable design for a classroom of six year old children. 6

Mark scheme guidelines apply in that any reasonable suggestion is acceptable
For example, any of the features for part **(a)** above could be included.

www.dynamicpapers.com

Page 7	Mark Scheme	Syllabus	Paper
	A LEVEL – NOVEMBER 2004	9698	3

PSYCHOLOGY AND ENVIRONMENT

SECTION A

5   (a)   **Explain, in your own words, what is meant by the term 'noise'.**   **2**

Sound can be positive or negative as determined by individual perceptions.
Negative or unwanted sound is defined as noise.

(b)   **Describe <u>two</u> studies showing the negative effects of noise on performance.**   **6**

Performance: 3 categories to consider:

(a)   **effects during exposure**: Laboratory studies have shown mixed results with a wide range of variables. Effect depends on: volume, predictability and controllability; type of task performed; stress tolerance; individual personality.

(b)   **after-effects**: effect of noise may continue for some time and hinder later performance. e.g. Glass et al (1969); Sherrod et al (1977).

(c)   **effects on children**: (could be in above categories also): Hambrick-Dixon (1986); Cohen et al (1986) compared children from noisy and quiet schools near Los Angeles airport. Found those from noisy environment suffered from learned helplessness, lack of achievement and distractibility. Evans at al (1993) study of those near Munich airport.

(c)   **Describe <u>one</u> way in which the negative effects of noise on performance may be reduced.**   **3**

Any appropriate answer to receive credit. Suggestions should be psychologically based, like all other question part **(c)**'s.

6   (a)   **Explain, in your own words, what is meant by the term 'weather'.**   **2**

Climate is long term/seasonal conditions; weather is short-term, rapidly changing.

(b)   **Describe <u>two</u> studies showing the negative effects of climate and/or weather on performance.**   **6**

Lots of **laboratory studies** show conflicting results mainly due to variations in design.

Also many **field studies** and most likely are those by Pepler (1972) in classrooms with and without air conditioning, and Adam (1967) with soldiers suffering acclimatisation problems.

(c)   **Describe <u>one</u> way in which the effects of seasonal affective disorder (SAD) may be reduced.**   **3**

Answers must be psychological: moving to 'better' climate insufficient. Best treatment is with a light box.

SECTION B

7   (a)   **Describe what psychologists have found out 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 suggests a look at performance, social behaviour and health.

(a)   **animal studies:** Dubos (1965) with lemmings; Christian (1960) deer and Calhoun (1962) rats.

(b)   **human studies:** 1. **performance:** Aiello et al (1975b) found impaired task performance. In laboratory 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 lots of effect when there is interaction.

(c)   **human studies**: 2. **social behaviour**: **helping**: studies by Bickman et. al. (1973) in dormitories and Jorgenson & 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**.

(d)   **human studies**: 3. **health**: Paulus, McCain & Cox (1978) also found increase in density led to increase in blood pressure in prisoners. McCain, Cox & Paulus (1976) increase in density = 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 found out 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;

(a) ethical issues studies may raise.

   (c)   **Using your psychological knowledge suggest what may be done to cope with the effects of crowding when on public transport, such as a bus.   6**

Suggestion must apply to public transport. Suggestions like raise ceiling height not really applicable. To 'look out of window' is fine as long as reference is made to study itself such as Baum (see mark scheme). More likely is to increase cognitive control e.g. Langer & Saegert (1977)

8 **(a)** **Describe what psychologists have found out about natural disaster and/or technological catastrophe.** **8**

Candidates may well begin with a definition (e.g. that of the American president!) and a distinction between **disasters** (natural causes) and **catastrophes** (human causes). Catastrophes mean there is some human error/fault and blame can be attributed. A focus on **methodology** would be pertinent. Lab studies are low in ecological validity or not ethical (e.g. Mintz (1951). Simulations are more true to life (e.g. simulation following Manchester airplane fire) but participants know it is a simulation. Actual events better but not ethical to study injured, stressed, etc. and no comparison or control. Candidates could look at how people **behave during** emergencies. Archea (1990) compares behaviours of people during earthquakes in Japan and America. Alternatively, LeBon (1895) suggests people behave like wild animals with primitive urges and stampede and are crushed (examples of fires where this has happened). Alternatively people may be crushed without stampeding (e.g. Hillsborough). Smelser (1964) suggests people do not panic if in mine or submarine due to escape routes. LaPierre (1938) looks at how panic develops. Alternatively Sime (1985) found in fire people seek companions first and do not behave as individual 'animals'. Candidates may focus on what can be done to **prevent panic** and look at evacuation messages (e.g. Loftus) or the follow me/follow directions dilemma of Sugiman & Misumi (1988).

Another focus may be on **preparation for an event** or whether people think it will happen to them (e.g. Stallen, 1988) and study at Dutch chemical plant. Candidates may also look at **behaviour after an event**, typically post traumatic stress (e.g. source and Herald of Free Enterprise). Some candidates may look at pre traumatic stress.

Candidates can legitimately look at the effects of **toxic exposure**. It is included in this syllabus subsection, and this should be treated as a technological catastrophe. The Three Mile Island accident raised fears about the release of radioactive gases for example. It could be argued that sick building syndrome is caused by toxic exposure. Whilst this may well be true, and even though a recommended text includes SBS in the same chapter as disasters, SBS can hardly be categorised as a catastrophe and so should receive no credit.

(b) **Evaluate what psychologists have found out about natural disaster and/or technological catastrophe.** **10**

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

- defining and categorising disaster and catastrophe;
- cultural differences in disaster/catastrophe behaviour;
- whether theories apply in real life,
- the methods psychologists use to gain their evidence.

(c) **Giving reasons for your answer, suggest ways in which psychologists could help people** <u>after</u> **the occurrence of a natural disaster/technological catastrophe.** **6**

They could look at **attitudes** toward potential danger 'it won't happen to me'; fear of flying, etc; they could look at **evacuation messages** and plans for escape. Relevant evidence referred to above. They could look at **emergency plans** such as those issued by the FEMA for earthquakes. Psychologists could help with counselling and/or treating for PSTD.

www.dynamicpapers.com

Page 10	Mark Scheme	Syllabus	Paper
	A LEVEL – NOVEMBER 2004	9698	3

PSYCHOLOGY AND HEALTH

SECTION A

9 (a) **Explain, in your own words, what is meant by the term 'health promotion'. 2**

Typically: enhancing good health and preventing illness

(b) **Outline <u>two</u> methods that have been used by psychologists to change health behaviours.   6**

Any two from:

[1] **appeals to fear**/fear arousal (Janis & 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 are not the most effective. The Yale model (source of message/message/recipient) underlies so many attempts.

[2] **providing information** via media (e.g Flay, 1987) three approaches:

[1] provide negative information only;
[2] for those who want to be helped provide first steps;
[3] self help via television audience.

[3] **behavioural methods**: provision of instructions, programmes, diaries to use as reinforcers. Also worth credit would be programmes in **schools**, **worksites** (e.g Johnson & Johnson) and communities (e.g three community study)

(c) **Describe <u>one</u> community health promotion campaign.   3**

Most likely possibilities include:

(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

10 (a) **Explain, in your own words, what is meant by the term 'substance abuse'. 2**

Candidates could refer to:

ADDICTION, a condition, produced by repeated consumption of a natural or synthetic substance, in which the person has become physically and psychologically dependent on the substance.

PHYSICAL DEPENDENCE is a state in which the body has adjusted to the presence of a substance and incorporated it into the 'normal' functioning of the bodies tissues. This state has two characteristics: (1) *TOLERANCE* the process in which the body increasingly adapts to a substance and requires larger and larger doses of it to achieve the same effect. (2) *WITHDRAWAL*: the unpleasant physical and psychological symptoms people experience when they stop using a substance.

PSYCHOLOGICAL DEPENDENCE is a state in which people feel a compulsion to use a substance for the pleasant effect it produces (without necessarily being physically dependent e.g. alcohol initially psychological dependence perhaps later leading to physical dependence).

More importantly for full marks, candidates should refer to substance abuse specifically, which is:

SUBSTANCE ABUSE is defined on the basis of three criteria (Rosenhan & Seligman, 1984):

(i) Existence of a clear pathological use e.g. heavy daily use or inability to stop.
(ii) Heightened problems in social or occupational functioning e.g loses job.
(iii) Existence of pathological use for at least a month.

(b) Describe <u>two</u> theories of substance abuse applied to a substance of your choice.   **6**

Any two theories or explanations acceptable.

- 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.

- 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. Lots of explanations to choose from.

(c) Describe <u>one</u> way in which people can be discouraged from abusing a substance.

3

Difficult this - depends on substance. Most likely is use of **health promotion campaign** which could take place in schools, worksites or communities. As usual, any appropriate information to receive credit.

SECTION B

11 (a) Describe what psychologists have discovered about lifestyles and health behaviour. **8**

Candidates are likely to focus on one or more of three areas:

1. **General:**

   Risk Factors: behaviours associated with causes of death:

   HEART DISEASE: smoking, high cholesterol, lack of exercise, high blood pressure, stress.
   CANCER: smoking, high alcohol use, diet, environmental factors.
   STROKE: smoking, high cholesterol, high blood pressure, stress.
   ACCIDENTS: alcohol use, drug abuse.
   INFECTIOUS DISEASES: smoking, failing to get vaccinated.

   What do people do to protect their health?

   Primary Prevention (health behaviour) consists of actions taken to avoid disease or injury.

   Secondary Prevention (illness behaviour) is where actions are taken to identify and treat an illness or injury early with the aim of stopping or reversing the problem.

   Tertiary Prevention (sick role behaviour) ranges from seeing a practitioner and filling a prescription to when a serious injury or a disease progresses beyond the early stages and leads to lasting or irreversible damage.

2. **Studies**:

   Harris & Guten (1979) American study which found the three most common health protective behaviours were eating sensibly, getting enough sleep and keeping emergency numbers by the phone.

   Turk et. al. (1984) studied American nurses, teachers and college students.

   Found three highest in each category:

   Nurses = emergency numbers, destroying old medicines, having first aid kit.

   Teachers = watching weight, seeing dentist regularly, eating sensibly.

   Students = getting exercise, not smoking, spending time outdoors.

   Mechanic (1979) in a longitudinal study found little correlation (.1 or .2) between subjects tested when children and 16 years later.

www.dynamicpapers.com

Page 14	Mark Scheme	Syllabus	Paper
	A LEVEL – NOVEMBER 2004	**9698**	**3**

3. **Models**:

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.

Argues all above merely identify variables. Better is stages people go through in their readiness to adopt a health related behaviour. Similar is

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.

(b) **Evaluate what psychologists have discovered about lifestyles and health behaviour** **10**

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

- the methods used by psychologists;
- comparing and contrasting health belief theories;
- ethical issues involved in research;
- generalisation of results from participants used.

www.dynamicpapers.com

Page 15	Mark Scheme	Syllabus	Paper
	A LEVEL – NOVEMBER 2004	**9698**	**3**

(c) **Using your psychological knowledge, suggest ways in which people can be encouraged to improve their lifestyle and health behaviour.** **6**

Lots of possibilities here and candidates can usefully refer to studies of health promotion. As with all section **(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. For the latter, First Ladies of America went on television to raise awareness of breast cancer.

12 **(a)** **Describe what psychologists have found out about adherence to medical advice.** **8**

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. Also is Non-adherence by medical staff

- **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 do not 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?

www.dynamicpapers.com

Page 17	Mark Scheme	Syllabus	Paper
	A LEVEL – NOVEMBER 2004	**9698**	**3**

(b) **Evaluate what psychologists have found out about adherence to medical advice.** **10**

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:

(f) changing physician behaviour (DiMatteo & DiNicola, 1982); sending doctors on training courses;
(g) changing communication style (Inui et al, 1976);
(h) change information presentation techniques (Ley et al, 1982);
(i) have the person state they will comply (Kulik & Carlino, 1987);
provide social support (Jenkins, 1979) and increase supervision (McKenney et al, 1973).
(k) behavioural methods: tailor the treatment; give prompts and reminders; encourage self monitoring; provide targets and contracts.
introduce educational strategies (Sackett & Hayes, 1976).

www.dynamicpapers.com

Page 18	Mark Scheme	Syllabus	Paper
	A LEVEL – NOVEMBER 2004	9698	3

PSYCHOLOGY AND ABNORMALITY

SECTION A

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

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

(b) **Describe <u>one</u> historical explanation of abnormality. 6**

Most likely: primitive possession and demonology; malleus maleficarium.

(c) **Describe <u>two</u> historical treatments for mental illness which have been shown to be ineffective. 3**

Most likely: leaches!; various religious ceremonies (although some argue these are effective); inducing malaria to treat schizophrenia; wrapping in cold wet towels and 'hydrotherapy' (hosing down).

14 (a) **Explain, in your own words, what is meant by the term 'abnormal affect'. 2**

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

(b) **Briefly describe <u>two</u> symptoms of an abnormal affect. 6**

Most likely: autistic thinking (excessive preoccupation), delusions, disorders of emotion (such as exaggerated moods), disorientation, flight of ideas, hallucinations, motor disturbances, speech disturbances.

(c) **Give <u>one</u> way an abnormal affect of your choice can be treated. 3**

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.

15 (a) **Describe what psychologists have found out about abnormal affect due to trauma. 8**

Most likely focus will be on post traumatic stress disorder, amnesia and fugue.
Psychogenic fugue is leaving one's home, work and life and taking a new identity with loss of memory for the previous identity.
Psychogenic amnesia is losing one's memory because of psychological reasons.
PTSD is a stress response caused by events outside the range of normal human experience.

(b) **Evaluate what psychologists have found out about abnormal affect due to trauma.** **10**

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

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

(c) **Giving reasons for your answer, suggest ways in which abnormal affect due to trauma can be treated.** **6**

Most likely: if it is PTSD, then the most likely treatment is systematic desensitisation. For amnesia/fugue, hypnosis is one possibility. Sometimes this is helped with sodium amytal and sodium pentothal.

16 **(a)** **Describe what psychologists have discovered about abnormal avoidance and/or need.** **8**

Candidates can focus on either **avoidance** or **need** or both.

Need: will include problems such as compulsive gambling and kleptomania but any other need is legitimate.

Avoidance: any phobia appropriate here as would be elective withdrawal.
Candidates may focus on suggested explanations or on typical behaviour /symptoms.

(b) **Evaluate what psychologists have discovered about abnormal avoidance and/or need.** **10**

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

- points about defining and categorising abnormal behaviours:
- cultural and individual differences in need/avoidance;
- comparing and contrasting explanations;
- implications for person with abnormal need/avoidance.

(c) **Giving reasons for your answer, suggest how an abnormal need of your choice 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 'job analysis'.** 2

Typically: the systematic study of the tasks, duties, and responsibilities of a job and the qualities needed to perform it.

(b) **Briefly describe <u>one</u> job analysis technique.** 3

Focus on method acceptable e.g. observation, interview, survey.

More likely: specific job analysis techniques:
FJA [functional job analysis] technique examining sequence of tasks in a job;
PAQ [positional analysis questionnaire] uses structured questionnaire to analyse jobs;
CIT [critical incidents technique] uses examples of successful or unsuccessful job performance.

Ref Riggio p59, 63-66

(c) **Describe <u>two</u> reasons why performance is appraised.** 3

Most likely:

For organisation - assessing productivity - decide on promotions, demotions, bonuses and firing.

Gives information on training needs; validates employee selection; evaluate effectiveness of organisational change.

For individual - basis of career advancement; feedback on improving performance and recognising weaknesses.

Ref Riggio pp73

18 (a) **Explain, in your own words, what is meant by the term 'organisational work conditions'.** 2

Typically: any logical comment referring to the conditions of the working environment.

(b) **Briefly describe <u>one</u> physical and <u>one</u> psychological condition of a work environment** 6

PHYSICAL can include:
Illumination, temperature, noise, motion(vibration), pollution, aesthetic factors (e.g. music and/or colour). Can also include workspace/office layout

PSYCHOLOGICAL can include:
Feelings of privacy or crowding, excessive or absence of social interaction, sense of status or importance/anonymity or unimportance, feelings of job satisfaction or alienation.

Any other appropriate work condition acceptable.

Ref Riggio p404-413

Page 21	Mark Scheme	Syllabus	Paper
	A LEVEL – NOVEMBER 2004	**9698**	**3**

(c) **Describe <u>one</u> way in which the negative effects of physical work conditions can be reduced.** **3**

Any appropriate suggestion acceptable. E.g. noise reduced through ear muffs /headphones,

www.dynamicpapers.com

Page 22	Mark Scheme	Syllabus	Paper
	A LEVEL – NOVEMBER 2004	9698	3

SECTION B

19 (a) **Describe what psychologists have discovered about leadership and management.** **8**

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) whose leader-member exchange model

(b) **Evaluate what psychologists have discovered about leadership and management.** **10**

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

• comparing and contrasting theoretical explanations;
• the implications leadership style have for follower behaviour;
• examining theoretical strengths and weaknesses;
• How psychologists gain their evidence.

(c) **If you owned a company, how would you improve leader-worker satisfaction? Give reasons for your answer.** **6**

Any appropriate answer acceptable that relates to the improvement of leader worker relationships. For example a team-building exercise is a possibility.

20 (a) Describe what psychologists have discovered about motivation to work. 8

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 scoring can be unreliable. Good application: match profiles to jobs; achievement training programmes.

[2] Job design theories: if job well designed and satisfying needs = good motivation.

[a] Herzberg's two factor theory (1966): Job satisfaction and job dissatisfaction are two separate factors. Motivators = responsibility, achievement, recognition, etc. job satisfaction. Hygienes = supervision, salary, conditions, etc. = job dissatisfaction. Some support but led to job enrichment (redesigning jobs to give workers greater role).

[b] Job characteristics model (Hackman & Oldham, 1976): workers must perceive job as meaningful (skill variety, task identity and task significance) responsible (autonomy) and gain knowledge of outcome (feedback). These can be scored. Also JDS (job diagnostic survey) is questionnaire measuring above characteristics.

[3] Rational (cognitive) theories: people weigh costs and rewards of job

[a] Equity theory (Adams, 1965) fair treatment = motivation. Worker brings inputs (skills, etc) and expects outcomes (pay, etc.). Equality determined by comparison with others.

[b] VIE theory (or expectancy) (Vroom, 1964): workers are rational and decision making and guided by potential costs (negative outcomes) and rewards (positive outcomes).

[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.

Ref Riggio Chapter 6

(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 how the management of any company could increase performance through motivation.   6**

This question requires more than mere replication of the above theories and it requires more than common sense answers such as "increase pay".   This question requires candidates to specifically apply motivators to salespeople. 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.