UNIVERSITY OF CAMBRIDGE INTERNATIONAL EXAMINATIONS

GCE Advanced Level

MARK SCHEME for the October/November 2006 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 students, 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.

The grade thresholds for various grades are published in the report on the examination for most IGCSE, GCE Advanced Level and Advanced Subsidiary Level syllabuses.

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UNIVERSITY of CAMBRIDGE
International Examinations

Section A

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 some peripheral relevance only	**1**
	Answer appropriate, some accuracy, brief	**2**
	Answer appropriate, accurate, detailed	**3**
	max mark	**3 or 6**
	Maximum mark for Section A	**11**

Section B

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 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 (compare or contrast) is explicit.	**2**
	ANALYSIS [Structure of an 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. Appropriate suggestion. One basic application.	**1**
	The assessment request has been applied effectively to the evidence. Appropriate suggestions. 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

Q1a	Explain, in your own words, what is meant by the term 'teaching style'.	**2**
	Typically: way in which teacher teaches.	
Q1b	Describe **one** way in which learning styles have been measured.	**3**
	Most likely: Kolb's 'kite' model. Myers-Briggs type indicators also a possibility.	
Q1c	Describe **two** ways in which learning effectiveness can be improved.	**6**
	Any appropriate answer based on student study skills. Can be based on revision programmes or memory techniques e.g. PQRST. Could be McCarthy's 4-mat system or the SPELT approach.	

Q2a	Explain, in your own words, what is meant by 'physical features of educational environments'.	**2**
	Typically: features of the architecture and contents of any area where education takes place.	
Q2b	Describe **two** physical features of learning environments that may affect learning.	**6**
	Many possible features to include here. Any two from: NB any physical feature fine. 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 & 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 horseshoes v grouped). f. classroom privacy: how many is room designed for & how many crammed in = lack of privacy, crowding = stress & poor performance.	
Q2c	Describe how **one** physical feature could be changed to improve learning.	**3**
	Wide range of answers possible here. Could be a change to any one of the features above or could be a study such as that by Bronzaft.	

Section B

Q3a	Describe what psychologists have discovered about special educational needs.	**8**
	Special needs can include giftedness and specific learning and behavioural disabilities. A definition of giftedness might be a good place to start but right away there are problems. Some believe it is **exceptional performance** on an intelligence test. But where is the borderline between gifted and others set? Terman (1925) claimed IQ of 140 (approx 1 in 200); Ogilvie (1973) suggests IQ of 130 (1 in 40) and DeHaan and Havighurst (1960) suggest 120 (approx 1 in 10). Others believe giftedness is a more **specific ability** such as in sport or music. Bridges (1969) and Tempest (1974) outline **signs of giftedness**, Bridges with seven (read at 3 years of age; enormous energy) and Tempest with nine (likely to be highly competitive; able to deal with abstract problems.) Hitchfield (1973) found teachers were not good at identifying giftedness and Torrance (1970) claims 'society is savage toward creative thinkers' and Ogilvie (Schools Council Report on gifted children in primary schools 1973) suggested provision was inadequate. 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 & withdrawal; immaturity and verbal and physical aggression; bullying. School refusers disrupt themselves. Persistently disruptive children are often labelled as having emotional and behavioural difficulties (EBD).	

Q3b	Evaluate what psychologists have discovered about special educational needs.	**10**
	NOTE: any evaluative point can receive credit; the hints are for guidance only. • The methods used to gather data • Competing explanations • The implications for children • The implications for teachers	
Q3c	You are the parent of a child with a specific learning difficulty. Giving reasons for your answer, suggest what strategies you would expect teachers to use to educate your child successfully.	**6**
	Mark scheme guidelines apply in that any reasonable suggestion is acceptable. How does an education system deal with children with learning difficulties? Two main approaches are segregation or integration. If children are segregated they could be taught on a one-to-one basis or be part of some small group. If they are integrated the teacher will need to show clear differentiation.	

Q4a	Describe what psychologists have found out about disruptive behaviour in schools.	**8**
	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 & withdrawal; immaturity and verbal and physical aggression; bullying. School refusers disrupt themselves. Persistently disruptive children are often labelled as EBD. Candidates may then provide an explanation for these behaviours which may be behavioural, cognitive or social. Specific causes include ADHD.	
Q4b	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.	
Q4c	Suggest how a teacher may prevent disruptive behaviour from happening.	**6**
	Mark scheme guidelines apply in that any reasonable suggestion is acceptable There are a number of **preventative** (NOT corrective) strategies: (1) Care for children: know their names and other relevant information. (2) Give legitimate praise (Marland, 1975). (3) Use humour.	

PSYCHOLOGY AND ENVIRONMENT
Section A

Q5a	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.	
Q5b	Describe **two** studies showing the negative effects of noise on health.	**6**
	Can be specific such as work of Grandjean and Eggersten or can be part of wider study e.g. Cohen et al & Evans studied schools mean airports. Found performance and health were affected.	
Q5c	Describe **one** positive use of sound.	**3**
	Any appropriate answer to receive credit. Suggestions should be psychologically based, like all other question part (c)s. Candidates could focus on music played in doctor/dental waiting rooms to distract patents from worrying about what may lie ahead. They could focus on Muzak, used in shops, supermarkets, etc. to encourage people to buy certain products or attract a certain type of client. Candidates could focus on the use of music in studying (Mozart effect), or any other aspect of behaviour.	

Q6a	Explain, in your own words, what is meant by 'urban renewal'.	**2**
	A cognitive map is a pictorial and semantic image in our head of how places are arranged (Kitchin, 1994).	
Q6b	Describe **two** studies showing the effects of urban living on social behaviour.	**6**
	Social behaviour can include: anti-social behaviour and pro-social behaviour. Pro-social behaviour: **Altman** (1969) had participants knock on a door explaining that they were visiting a friend and they had lost the address. They still had the number and could you possibly use their phone to call your friend. Do you think that people would let you in? Altman found that a woman was admitted to about 94% of the small-town homes but only to 40% of the city homes: a man was admitted to about 40% of the small town homes but only 14% of the city homes. **Amato** (1983) study in 55 different Australian communities. A man limped down a street and then screamed, fell over and clutched his leg which began bleeding profusely. Small town (under 1,000 inhabitants) 50% stopped to help. In a city of 20,000-30,000 this dropped to 25%, down to 15% in major cities with over 1 million inhabitants. These findings have been confirmed in studies carried out in countries such as Israel, Turkey, Sudan, Australia and Britain. **Anti-social behaviour**: study by Zimbardo – car left for few days. In city car totally vandalised; in rural area car left untouched.	
Q6c	Describe **one** urban housing design that has been successful.	**3**
	Most likely: Newman put ideas into practice and designed low-cost housing project – Clason Point in New York City. Clason Point consists of cluster housing of 12-40 families per cluster. Increased defensible space. 1. Assigned public space to be controlled by specific families by using fencing. 2. Reduced number of pedestrian routes though the project and improved lighting along the paths. 3. Improved the image and encouraged a sense of personal ownership by giving different colours to individual dwellings. Residents took pride in their dwellings, planting grass, adding own new modifications and even sweeping the public sidewalks. Serious crimes dropped by 62%. Number of residents who said they felt they had the right to question a stranger in the project doubled. Also Five Oaks, Dayton, Ohio (1994) streets closed, speed bumps introduced and divided into 'mini-neighbourhoods'.	

Section B

Q7a	Describe what psychologists have learned about environmental cognition.	**8**
	Definitions: environmental cognition is the way we acquire, store, organise and recall information about locations, distances and arrangements of the great outdoors (Gifford, 1997). A cognitive map is a pictorial and semantic image in our head of how places are arranged (Kitchin, 1994). Wayfinding is successful navigation. 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. Methods: main ones are sketch maps, recognition tasks and multidimensional scaling. **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 year olds 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: we group areas (e.g. counties) together and make judgement 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'.	
Q7b	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;* • *Errors made in cognitive maps;* • *Competing theoretical explanations.*	
Q7c	To improve wayfinding you are required to design a tourist map. Giving reasons for your answer, suggest what important features your map would include.	**6**
	Several possibilities here. Most likely is work of Levine: Levine (1982) looked at you-are-here maps. Suggests two aspects which significantly improve map: 1) structure mapping – the map should reflect the layout and appearance of the setting it represents. 3 subsections: a) the map should be placed near an asymmetrical feature so more than one building is visible. b) the map should include a landmark which is visible in reality (then person can match the two and plan a route). c) the map has the map itself drawn on it. 2) orientation – the map should be aligned the same way as the setting (building on right of map is on right in reality) and it should have forward equivalence (the top of the map should be straight ahead). Could also involve use of colour such as on London Underground.	

Q8a	Describe what psychologists have discovered about natural disaster and/or technological catastrophe.	**8**
	Candidates may well begin with a definition 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 aeroplane 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 don't 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.	
Q8b	Evaluate what psychologists have discovered 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.	
Q8c	Giving reasons for your answer, suggest ways in which psychologists could help people **before** the occurrence of a disaster or 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.	

PSYCHOLOGY AND HEALTH
Section A

Q9a	Explain, in your own words, what is meant by the term 'pain'.	**2**
	Most likely: involves sensation, emotional reaction, and the evaluative/cognitive component.	
Q9b	Outline **two** theories of pain.	**6**
	Specificity theory **Descartes** (1644) captured idea of pain in his analogy of bell ringing: 'pull the rope at the bottom and the bell will ring in the belfry'. This theory proposes that there are pain receptors in bodily tissue which connect to a pain centre in the brain. The view was that there were four types of sensory receptor: warmth, cold, pressure and pain. **Gate control theory – Melzack** (1965) At the heart of the gate-control theory is a neural 'gate' that can be opened and closed in varying degrees.	
Q9c	Describe **one** type of pain.	**3**
	Acute pain: following tissue damage the individual adopts behaviour involving protection and care of the damaged area. After a relatively brief time period the pain subsides, the damage heals and the individual returns to a pre-damage state. **Chronic pain**: following tissue damage the pain does not subside even though the damage is apparently healed, and may continue for many months or years.	

Q10a	Explain, in your own words, what is meant by 'health promotion'.	**2**
	Typically: enhancing good health and preventing illness.	
Q10b	Outline **one** school health promotion study and **one** worksite study.	**6**
	Most likely: **Walter** (1985) In 22 American elementary schools a special curriculum was designed with the emphasis on nutrition and physical fitness. The schools were randomly assigned so that students would either participate in the programme or act as a control group. After 2 years the two groups were compared. Most likely: **Johnson & Johnson Company**: They began their '***live for life***' program in 1978, and it is one of the largest, best funded, and most effective worksite programmes yet developed. All employees are now a part of this programme. The goal is to help as many employees as possible live healthier lives by making improvements in their health knowledge, stress management, and efforts to exercise, stop smoking and control their weight.	
Q10c	Describe **one** campaign to promote the health of a specific problem.	**3**
	Answers could focus on several things: smoking, drinking, food/nutrition, self examination. Too many options to give detail.	

Section B

Q11a	Describe what psychologists have discovered about the patient-practitioner relationship.	**8**
	Question stresses practitioners and patients and so should answers. Answers could focus on: Lorber (1975) distinguishes between 'good' and 'bad' patients; Diagnosis & information processing (Elstein & Bordage, 1979) type 1 & type 2 errors; Interpersonal skills: non-verbal communications Communication skills: accent, native language Provision of information a. about illness; b. about diagnosis & treatment; Organisation of setting e.g. seating positions Attitudes of doctor (practitioner style) and attitudes of patients (patient style) Health beliefs	
Q11b	Evaluate what psychologists have discovered about the patient-practitioner relationship.	**10**
	NOTE: any evaluative point can receive credit; the hints are for guidance only • How psychologists gained their evidence; • Reasons why proposal of theories/models is difficult in this area; • Implications the evidence has for health care; • Psychological perspectives related to counselling situations.	
Q11c	Using your psychological knowledge, suggest ways in which the patient-practitioner relationship can be improved.	**6**
	Candidates could focus either on improving the patient 'end' or that of the practitioner. Practitioner more logical as they could attend training courses (e.g. Inui) or they could be more patient-centred rather than doctor-centred. Any appropriate suggestion based on psychological evidence is acceptable.	

Q12a	Describe what psychologists have learned 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 cause 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 in 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. 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: *PRECOMTEMPLATION* – 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.	
Q12b	Evaluate what psychologists have learned 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.	
Q12c	Using psychological evidence, outline the main features of a health promotion campaign aimed at improving lifestyles.	**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.	

PSYCHOLOGY AND ABNORMALITY

Section A

Q13a	Explain, in your own words, what is meant by 'classifying abnormality'.	**2**
	Typically: placing an abnormality into a category on DSM or ICD. 1 mark if no ref to ICD or DSM.	
Q13b	Describe **one** way in which abnormality is classified.	**3**
	Most likely: can be major categories e.g. neuroses or psychoses or can be more precise e.g. agoraphobia is an abnormal avoidance, depression is affect, etc.	
Q13c	Describe **two** types of abnormality.	**6**
	Depends on choice, but most likely: depression, phobia, really anything from syllabus.	

Q14a	Explain, in your own words, what is meant by the term 'abnormal avoidance'.	**2**
	Typically: an abnormal response to an object or 'thing' leading a person to take steps to avoid contact with the object or 'thing'. Most typically in the form of a phobia, such as agoraphobia.	
Q14b	Describe **two** types of abnormal avoidance.	**6**
	Any phobia appropriate here e.g. agoraphobia (the most common) and people can have fears of a variety of things e.g. heights – it becomes a 'clinical phobia' when treatment is sought. Elective withdrawal also a form of abnormal avoidance.	
Q14c	Give **one** way in which an abnormal avoidance of your choice may be treated.	**3**
	Most likely treatment will be behaviourally or cognitive-behavioural such as systematic desensitisation (main treatment for phobias).	

Section B

Q15a	Describe what psychologists have found out about cultural, societal and individual differences in abnormality.	**8**
	Abnormality does vary from culture to culture. For example, Russia has 51 per 10,000 cases of schizophrenia, Denmark has only 15 per 10,000. Not only are there different abnormalities, but there are very different treatment methods too. There are gender differences and relationship differences. For example, divorced people are much more likely to be admitted to a US mental hospital (1183 per 100,000) than those who are married (136 per 100,000). The family also has a bearing.	
Q15b	Evaluate what psychologists have found out about cultural, societal and individual differences in 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 if individual and society.	
Q15c	Giving reasons for your answer, suggest how treatments for an abnormality of your choice have differed according to culture, society or individual differences.	**6**
	Most likely: depending on abnormality chosen, treatments will either be medical (drugs) or psychological (cognitive-behavioural or psychodynamic) or alternatives (hypnosis, etc)	

Q16a	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.	

Q16b	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 disorder.	
Q16c	Giving reasons for your answer, suggest ways of coping with and reducing effects of trauma.	**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.	

PSYCHOLOGY AND ORGANISATIONS
Section A

Q17a	Explain, in your own words, what is meant by the term 'performance appraisal'.	**2**
	Nothing complex here – just what its name suggests. Or 'the formalised means of assessing worker performance in comparison with established organisational standards'.	
Q17b	Describe **two** reasons why performance is appraised.	**6**
	Most likely: For organisation – assessing productivity – decide on promotions, demotions, bonuses & firing. Gives info on training needs; validates employee selection; evaluate effectiveness of organisational change. For individual – basis of career advancement; feedback on improving performance and recognising weaknesses.	
Q17c	Outline **one** weakness of a performance appraisal technique	**3**
	Any appropriate comment acceptable. Could focus on methods of rating, e.g. comparisons, checklists or rating scales. Weakness could be with assessor being too lenient/severe; halo or recency effect.	

Q18a	Explain, in your own words, what is meant by 'job satisfaction'.	**2**
	Typically: job satisfaction: the positive feelings and attitudes about one's job.	
Q18b	Describe **two** ways in which job satisfaction can be measured.	**6**
	There are many approaches (interviews, scales, surveys). More popular (in America) are the Minnesota Satisfaction Questionnaire (MSQ) and the Job Description Index (JDI). In Britain Cooper et al's (1987) Occupation Stress Indicator is often used.	
Q18c	Give **one** way in which the quality of working life can be improved.	**3**
	Any suggestion based on psychological theory acceptable. Can be done through changes in job itself such as rotation or promotion. Could be material reward such as money. Could be through better conditions (physical or psychological).	

Section B

Q19a	Describe what psychologists have discovered about organisational work conditions.	**8**
	Riggio (1990) divides work conditions into **physical conditions** such as illumination, temperature, noise, motion, pollution and aesthetic factors such as music and colour; and **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 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.	
Q19b	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.	
Q19c	Giving reasons for your answer, suggest how negative effects of work environments can be reduced for individuals.	**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 to counteract? Two schools of thought: *rapid rotation theory*: based on frequent change & 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).	

Q20a	Describe what psychologists have found out about the selection of people for work.	**8**
	Main requirement is a consideration of the procedures involved in (a) *personnel recruitment* (the means by which companies attract job applicants), (b) *personnel screening* (the process of reviewing information about job applicants to select workers) and (c) *personnel selection* (via interviewing). The process could include: (1) Production of **job analysis** and **job description**. (2) Advertising job via appropriate source(s). (3) Production of an **application form**. This could be: (a) standard, (b) weighted, or (c) a Biographical Information Blank. (4) **Screening tests**. These could test: (a) cognitive ability, (b) mechanical ability, (c) motor/sensory ability, (d) job skills/knowledge, (e) personality, (f) test specific to job/organisation. (5) Many methods exist for analysis of screening tests and/or applications. Any method should be (a) reliable: via test re-test or internal consistency (how items correlate) and (b) valid: via content validity or criterion-related validity.	

	(6) **Interviews**: many studies and many aspects. (a) Use structured interviews (b) Make sure that interview questions are job related (c) Provide for some rating or scoring of applicant responses (d) Use trained interviewers (e) Consider using panel interviews (f) Use the interview time efficiently (7) Follow up methods: references & letters of recommendation. (8) Consideration throughout of equal opportunities.	
Q20b	Evaluate what psychologists have found out about the selection of people for work.	**10**
	NOTE: any evaluative point can receive credit; the hints are for guidance only • Issues concerning reliability and validity; • Assumptions made by psychometric testing and appraisal techniques; • Individual differences in test performance; • The usefulness of tests to select people.	
Q20c	Giving reasons for your answer, suggest what personnel selection decisions you would need to make when appointing a new teacher.	**6**
	Should really focus on aspects mentioned for (a) above. Anecdotal = 3 marks max.	