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GCE Advanced Level

MARK SCHEME for the October/November 2009 question paper for the guidance of teachers

9698 PSYCHOLOGY

9698/32 Paper 32 (Specialist Choices), maximum raw mark 70

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PSYCHOLOGY AND EDUCATION

Section A

1 (a) Explain, in your own words, what is meant by the term 'gender issues' in education. [2]
Definition is as term suggests, any gender difference or 'issue' pertinent to education.

(b) Describe *one* gender difference in educational performance. [3]
Most likely: males have better visuo-spatial ability, females better verbal ability; males better spatial ability. This would tend to suggest that males are better at mathematics and related subjects (90% of air traffic controllers are male), girls at languages and related subjects.
UK data shows that except for level 3 maths, girls outperform boys in everything else.

(c) Give *two* explanations for gender differences in educational performance. [6]
Wide range of answers possible here. Any two factors from a long list including:
Biological: are the male brain and female brain different?
Social: socio-economic class (attitudes), type of family, position in family, expectation of family, time-orientation, competitiveness and self-fulfilling prophecy.

2 (a) Explain, in your own words, what is meant by the term 'learning difficulty or disability'. [2]
Typically: where a child has a significantly greater difficulty in learning than most children of the same age OR a child has a disability that needs different educational facilities from those that schools generally provide. Only one needed for 2 marks.

(b) Describe *two* types of 'learning difficulties or disabilities'. [6]
Most likely:
Dyslexia accounts for 80% of all learning difficulties. Approx 3–5% of the population suffer from dyslexia. It affects boys more than girls. Can be auditory (dysphonetic dyslexia); visual (dyseidetic dyslexia) or mixed/classic. **Features**: letter reversal or rotation – the letter 'd' may be shown as 'b' or 'p'; missing syllables – 'famel' for 'family'; transposition of letters – 'brid' for 'bird'; problems keeping place when reading; problems pronouncing unfamiliar words.
Dyscalculia affects mathematical performance affecting around 1% of the population. Sufferers frequently have normal or advanced language skills but experience problems with mathematical processes such as addition, subtraction, and dealing with money. Also poor sense of direction, poor map reading skills and problems with abstract concepts like time. Specific mathematical deficits include substitutions, reversals and omissions.
Dyspraxia involves problems with fine and/or gross motor co-ordination leading to problems with physical activities in subjects like science and physical education. Many people with dyspraxia have poor understanding of mathematical concepts and experience problems understanding symbols.
Dysgraphia is a disorder of writing which can involve the physical aspects of writing, e.g. pencil grip and angle. It might also involve poor spelling and difficulties transferring thoughts to paper.
Also acceptable: deafness, partial sight or any other physical disability.

(c) Describe *one* way in which a learning difficulty or disability can be assessed. [3]
Most likely answers will describe a type of test e.g. intelligence, aptitude or diagnostic or name a test such as the Wechsler.

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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) SATs, GCSEs and GCEs or it may be they focus on tests used by psychologists such 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) Imagine you are the parent of a mentally gifted child. Giving reasons for your answer, suggest ways in which you expect the educational performance of your child to be assessed. [6]

Many types of giftedness so many 'measures'.

Exceptional performance on an intelligence test. So give an intelligence test.

Marland (1972) states that 'gifted and talented children are those identified by professionally qualified persons who by virtue of outstanding abilities are capable of high performance'.

Sternberg and Wagner (1982) however, suggest that giftedness is characterised by insight skills that allow a person to separate relevant from irrelevant material, combine isolated pieces of information into a coherent whole and relate newly acquired information to that already in their possession.

Renzulli (1986) argues that giftedness is shown by those who display:

1. Above average general or specific ability (which may be evidenced from achievement and/or an IQ score);
2. High levels of task commitment (or persistence and motivation);
3. High levels of creativity (which may be seen in the generation of novel ideas and/or problem solving).

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.

Mathematical giftedness is usually determined by a checklist such as **Straker's (1983)** *Mathematics for Gifted Pupils*.

Musical giftedness; one measure of musical intelligence is the Bentley Test for Music (1966) which involves assessment of four areas: pitch discrimination, tonal memory, rhythmic memory and chord analysis.

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4 (a) Describe how the Behaviourist approach has been applied to human learning. [8]

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

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

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

(b) Evaluate how the Behaviourist approach has been applied to human learning. [10]

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

- The strengths and weaknesses of the Behaviourist approach
- The implications the Behaviourist approach has for teachers
- Whether theory applies in practice
- Contrasting alternative perspectives

(c) Giving reasons for your answer, suggest how a teacher could use the Behaviourist approach when teaching mathematics. [6]

Most likely:

1. **Direct application** of positive and negative reinforcement (such as in the source) to shape behaviour. Use of schedules.
2. **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.

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PSYCHOLOGY AND ENVIRONMENT

Section A

5 (a) Explain, in your own words, what is meant by the term 'defending territory and space'. [2]

Most likely: use of territorial markers such as bag on desk or item of clothing on seat.

(b) Briefly describe *two* ways in which personal space can be measured. [6]

Most likely:

1. Simulation method: uses fuzzy felt or drawing and distance between two figures measured.
2. Stop-distance method: person stops at others feet and distance is measured.
3. Naturalistic observation.
4. Invasion of space: maybe best, but is unethical.
5. CIDS: comfortable interpersonal distance scale: drawings of how close people can come. Drawings of CIDS acceptable.

(c) Using an example, briefly describe *one* type of territory. [3]

Most likely: Altman (1975): outlines three types of territory

1. Primary territory: 'a private area owned by an individual' (e.g. house)
2. Secondary territory: 'an area that is used regularly but is shared with others' (e.g. desk in a classroom)
3. Public territory: 'can only be occupied temporarily on a first come first served basis' (e.g. seat on bus)

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

Definition is as term suggests – living (having a place of residence) in a relatively densely populated area.

(b) Briefly describe *two* 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 that they had lost the address. They still had the number and could they 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 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, the 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.

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(c) Briefly describe *one* effect of urban living on health. [3]

Health: Soderberg (1977) HIV; Torrey & Bowler (1990) urbanisation and schizophrenia; Fisher et al. (1994) perception of weight.

Franck et al. (1974) Interviews with students who were newcomers to either or small town or a large City. Urban newcomers experienced significantly more tension in the city. Reverse true of those moving to rural area. Urbanites affected far more by physical stressors (pollution, crowding, and noise). Rural newcomers complained of lack of cultural diversity.

Section B

7 (a) Describe what psychologists have learned about crowds. [8]

Sears et al. (1991) define a crowd as people in physical proximity to a common situation or stimulus.

Additionally crowds: must involve a number of interacting people; need not be face-to-face; need not be assembled in one place; members must influence one another.

Brown (1965) classifies crowds according to their behaviours:

1. Acquisitive crowd: Mrs Vaught (1928) where banks closed
2. Apathetic crowd: study of Kitty Genovese
3. Expressive/peaceful crowd: Benewick & Holton (1987) interviewed people attending the visit of the Pope to Britain in 1982
4. Baiting crowd: in 1964 there was the case of a man, standing on the ledge of a building ten storeys high. The crowd below of some 500 people shouted to him to jump off the ledge
5. Aggressive crowd (often referred to as 'mob psychology')
6. Escaping crowd (panicky and non-panicky)

Explanations of aggressive crowd behaviour: **Mob Psychology** of **Le Bon** (1895): otherwise normally civilised people become 'barbarians' – wild and irrational, giving vent to irrational impulses. **Turner** (1974) proposed the **emergent norm theory**. **Zimbardo** (1969) **deindividuation**: each person is nameless, faceless, anonymous and has diminished fear of retribution.

Laboratory studies of deindividuation

Zimbardo (1969) participants wore laboratory coats and hoods that masked their faces. Similarly, **Prentice-Dunn** and **Rogers** 1983, gave participants' the opportunity to give a 'victim' an electric shock. Milgram (1963) found that people were more willing to administer shocks when the participants could not see the victim and when the victim could not see them.

Deindividuation in children: Diener et al. (1976) looked at deindividuation in children, using Hallowe'en and Trick or Treat as the scenario.

Social constructionism and aggressive crowds: **Reicher** (1984b) who cites violent incidents involving aggressive crowds. His classic example is the riot that happened in the St. Paul's district of Bristol in 1980.

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

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

- Comparing and contrasting explanations
- How psychologists gather their data
- The ethics of various studies
- Generalisability from studies: sample ethnocentrism; method

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(c) Giving reasons for your answer, suggest what may be done to prevent crowd problems when free products are offered to the public. [6]

Most likely answers will be based on study by Waddington et al. (1987) who argue that public disorder is predictable (not the outcome of mob psychology) and problems can be avoidable. Crowds should be perceived as collections of individuals who share a social purpose and who are interpreting what is going on around them.

Five recommendations for successful crowd control:

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 Sugiman and Mitsumi follow me/follow directions. Evacuation messages worded appropriately can reduce panic, e.g. Loftus.

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8 (a) Describe what psychologists have found out 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:

1. Euclidean bias: people assume roads etc. are grid-like: they are not. Sadalla & Montello (1989).
2. Super ordinate-scale bias: we group areas (e.g. counties) together and make judgement on area rather than specific place e.g. Stevens & Coupe (1978)
3. Segmentation bias: Allen & Kirasic (1985) we estimate distances incorrectly when we break a journey into segments compared to estimate as a whole.

Also:

- Maps are often incomplete: we leave out minor details.
- We distort by having things too close together, too far apart or misaligning e.g. people over-estimate the size of familiar areas.
- We augment – add non-existent features.

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 found out 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

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(c) You are required to design a 'you are here' map to help new students at your school. Giving reasons for your answer suggest what important features your map would include. [6]

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).

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PSYCHOLOGY AND HEALTH

Section A

9 (a) Explain, in your own words, what is meant by the term 'misuse of health services'. [2]

Typically: the extent to which people do not use health services in a usual way. Can be over-use or under-use.

(b) Outline *two* reasons why people may misuse health services. [6]

Lots of possibilities here. Candidates could focus on one of the following:

1. **Over-use of services**: Munchausen's Syndrome. People seek out excessive medical attention, often going from city to city to get new diagnosis and new surgical intervention. In very exceptional circumstances, individuals seek excessive and inappropriate medical contact through the 'illness' of a relative such as a child. This can be seen as a form of child abuse, where the parent (usually a mother) exaggerates, fabricates or induces illness in their child. This condition is known as Munchausen's Syndrome by Proxy.
   Hypochondriacs interpret real but benign bodily sensations as symptoms of illness. Hypochondriasis refers to the tendency of individuals to worry excessively about:
   - Their own health.
   - Monitor their bodily sensations closely.
   - Make frequent unfounded medical complaints.
   - Believe they are ill despite reassurances by physicians they are not.

2. **Under-use of services**:
   Pitts (1991a) suggests the following:
   - Persistence of symptoms; we are likely to take a 'wait and see' approach if we get ill and only seek advice if the symptoms last longer than expected.
   - Expectation of treatment; we are only likely to seek medical advice if we think it will do some good. If we have had the same symptoms before and not received any useful treatment then we are unlikely to bother making an appointment.

   People do not go to the doctors unless they feel it is important because we do not think we 'should waste their valuable time'. This perception means that many people do not seek advice even when they have developed serious symptoms. **Safer (1979)** found people delayed seeking treatment for up to two months.

(c) Describe *one* way in which the patient-practitioner relationship can be improved. [3]

Most likely possibilities include:

- Changing physician behaviour (DiMatteo & DiNicola, 1982); sending Dr's on training courses.
- Changing communication style (Inui et al., 1976).
- Change information presentation techniques (Ley et al., (1982).
- Have the person state they will comply (Kulik & Carlino, 1987).
- Provide social support (Jenkins, 1979) and increase supervision (McKenney et al., (1973).

Behavioural methods: tailor the treatment; give prompts and reminders; encourage self monitoring; provide targets and contracts.
Candidates could focus either on improving the patient 'end' or that of the practitioner. Practitioner more logical as they could attend training courses (e.g. Inui) or they could be more patient-centred rather than doctor-centred. Any appropriate suggestion based on psychological evidence is acceptable.

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10 (a) Explain, in your own words, what is meant by 'lifestyles'. [2]

Typically: the ways in which people live which may be harmful to their health or maintaining healthy existence through health protective behaviours.

(b) Describe *two* ways in which lifestyles can be measured. [6]

Most likely:

- **Harris & Guten** (1979) lists what people do to aid their lifestyle. 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.
- Measures of physiology (cholesterol) over time

(c) Describe *one* behaviour that would improve health. [3]

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. Alternatively:

(1) basic such as eating healthily; not smoking, etc. and going to doctor.

(2) those which are a little more psychologically informed and use psychological evidence e.g. **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. Similarly **Turk et al.** (1984) studied American nurses, teachers and college students. Found: 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.

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Section B

11 (a) Describe what psychologists have discovered 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 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:
      - (i) 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.).
      - (ii) Common sense: Leventhal (1982) model where patients own views about their illness can contradict doctors instructions and treatment.
      - (iii) 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.
      - (iv) Fishbein & Ajzen's theory of reasoned action is appropriate.
      - (v) 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?

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(b) Evaluate what psychologists have discovered 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) Giving reasons for your answer, suggest ways in which a medical practitioner can measure adherence to medical advice. [6]

(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.

12 (a) Describe what psychologists have found out about stress. [8]

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

There are two main measures: physiologically and psychologically:

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

Controlling stress:

(1) Coping.
  (a) Problem-focused coping
  (b) Emotion-focused coping

(2) Medical/pharmacological solutions.
  (a) benzodiazepines (trade names valium, librium, etc.)
  (b) beta-blockers (inderal) reduce physiological arousal and feelings of anxiety by blocking neurones stimulated by adrenaline.

(3) Psychological solutions.
  (a) (behavioural/cognitive strategies) can include progressive relaxation (Jacobsen, 1938); systematic desensitisation (Wolpe, 1958); biofeedback; and modelling. Psychological solutions
  (b) (cognitive/behavioural) can include cognitive restructuring (Lazarus, 1981); rational-emotive therapy (Ellis, 1962) and multi-modal therapy (Lazarus, 1981); imagery (Bridge et al., 1988)

(4) Alternative strategies involving meditation, hypnosis or yoga.

(5) Providing social support may also help (e.g. Cohen & Willis, 1985).

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

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(b) Evaluate what psychologists have found out about stress. **[10]**

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

- Comparing and contrasting different approaches
- The relationship between theory and practice
- The assumptions made about human nature
- How psychologists gain their evidence in this area

(c) Using psychological evidence, suggest how the stress of a student can be managed. **[6]**

Most likely: progressive muscle relaxation, stress inoculation training, imagery.
Any appropriate psychological suggestion acceptable.

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PSYCHOLOGY AND ABNORMALITY

Section A

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

Typically: placing an abnormality into a category on DSM or ICD. 1 mark if no ref to ICD or DSM.

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.

(b) Describe *two* definitions of abnormality. [6]

There are a number of definitions:

Deviation from statistical norms: anything that is not statistically frequent is abnormal.

Deviation from ideal mental health: normal people possess certain characteristics; those abnormal do not.

Failure to function adequately: an individual who 'fails to function adequately' is abnormal.

Deviation from social norms: all societies have norms for acceptable behaviour. Abnormality is breaking such norms.

(c) Describe *one* type of abnormality. [3]

Could be general such as psychoses and neuroses or could be specific such as mania or depression or manic depression. Can be any abnormality as appears on DSM or ICD.

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

Typically: abnormal affect concerns disorders of mood and emotion, most typically depression and mania or manic-depression. Overcoming refers to treatments or ways of managing. Both components needed for 2 marks. Could be reference to treatments e.g. SAD treated using a light box (Watkins, 1977).

(b) Describe *one* type and *one* characteristic of abnormal affect. [6]

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

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

Seasonal affective disorder: summer and winter versions also a legitimate possibility.

(c) Describe *one* explanation for abnormal affect. [3]

Most likely: chemical imbalance (possibly hormonal); genetic/familial; life events. Any appropriate explanation acceptable.

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Section B

15 (a) Describe models of abnormality. [8]

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.

(b) Evaluate 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
- Usefulness of therapies
- Implications of individual and society

(c) Giving reasons for your answer, suggest treatments for an abnormality based on *one* model of 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.

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16 (a) Describe what psychologists have found out about somatoform disorders. [8]

Typically: disorders in which physical symptoms are prominent but no cause can be found. Similarly: physical symptoms that mimic disease or injury for which there is no identifiable physical cause.

E.g. hypochondriasis, pain where there is no physical cause, complaints about headaches, etc.

Types:

Hypochondriasis: preoccupation and exaggerated concerns about health, or having a serious illness.

Conversion: where patients present with neurological symptoms such as numbness, paralysis, or fits, but where no neurological explanation can be found.

Somatisation: (Briquet's syndrome) patients who chronically and persistently complain of varied physical symptoms that have no identifiable physical origin.

Psychogenic pain: reports of pain with no physical cause.

Less likely but to be given credit (and definitions vary as to whether this is a somatoform disorder) is **Body dysmorphic disorder**: in which the affected person is excessively concerned about and preoccupied by an imagined or minor defect in his or her physical features.

Most likely explanations:

Psychoanalytic: emotionally charged conflicts were repressed then converted into physical symptoms that serve as outlets.

Behavioural: often maladaptive behaviour – attention seeking?

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

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

- Points about defining and categorising abnormality
- Cultural and individual differences
- Comparing and contrasting explanations of cause
- Usefulness of therapies
- Implications of individual and society

(c) Giving reasons for your answer, suggest ways in which somatoform disorders may be overcome. [6]

Most likely:

Cognitive behaviour therapy: an approach that aims to influence dysfunctional emotions, behaviors and cognitions through a goal-oriented, systematic procedure. Phillips found that patients with BDD who were randomly assigned to Cognitive Behavior Therapy or no treatment, BDD symptoms decreased significantly in those patients undergoing CBT. BDD was eliminated in 82% of cases at post treatment and 77% at follow-up.

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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* types of selection interviews. [6]

Most likely: formal or informal interview. Riggio suggests:
Use structured interviews;
Make sure that interview questions are job related;
Provide rating or scoring of applicant responses;
Use trained interviewers;
Use a panel interview;
Use time efficiently.
Whilst these are not types, they should still be given credit.

(c) Outline *one* pitfall or weakness of personnel selection decisions. [3]

Question concerns decisions and not weaknesses of the interview. This means that a weakness could be if any of the list in **(b)** is not adhered to, it could be a weakness.
In addition: bias or misinterpretation on the part of the personnel officer/selection panel; failure to adhere to equal opportunities.

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

Job analysis is the systematic study of the tasks, duties and responsibilities of a job. It results in a job description and a job specification (information about the human characteristics needed).

(b) Briefly describe *two* job analysis techniques. [6]

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.

(c) Give *one* problem with job analysis techniques. [3]

Most likely:
Problem of bias of person administering test; test being inappropriate for task being assessed. Any appropriate problem acceptable.

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Section B

19 (a) Describe what psychologists have discovered about interpersonal communication systems. [8]

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

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

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

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

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

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

- The implications of various communications for speed
- Individual preference and/or satisfaction
- Comparing and contrasting alternative communication techniques
- How psychologists gather evidence in this area

(c) Giving reasons for your answer, suggest a suitable communication network for medical staff in a hospital. [6]

The most suitable network for this task is a wheel formation. This is a centralised type because the supervisor will be at the centre co-ordinating activity to the workers on the spokes of the wheel. Any other type of network would not be suitable. The supervisor will have more satisfaction with this network because they are in control whereas each worker will feel less satisfied. However, because the supervisor controls, communication is much quicker and more efficient as the supervisor will make decisions. Other networks with justification of suitability acceptable.

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20 (a) Describe what psychologists have found out about human factors in work design. [8]

Human factors are concerned with the design of tools, machines, work systems and work places to fit the skills and abilities of workers.

In industry operator-machine systems are central. Chapanis (1976) outlines the **operator-machine** system: human systems: senses, information processing/decision-making and controlling; machine system: controls, operation and display (feeding back to senses). Each factor can be considered in much more detail. **Displays**: these can be visual or auditory and factors determine which is most appropriate. **Decision-making** is also important as are the **controls** themselves. Controls can be of many types, but should be matched to the operator's body; they should be clearly marked and they should mirror the machine actions they produce. Keyboard controls on computers can also be considered.

Errors in operator-machine are important. There can be errors of:

Omission (failing to do something), commission (performing an act incorrectly), sequence errors (doing a step out of order) and timing errors – too quickly, slowly. Errors such as these can be rectified either by 1. changing the design or 2. selecting people who can operate the systems.

Workspace design: three main types here: seated, standing and combined.

(b) Evaluate what psychologists have found out about human factors in work design. [10]

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

- Matching machine to person or matching person to task
- Individual differences
- Methods for assessing machine-operator systems
- How psychologists gather evidence in this area

(c) Giving reasons for your answer, suggest how accidents in operator-machine systems can be reduced. [6]

Most likely: matching operator to machine (theory B rather than theory A); giving appropriate training; ensuring person is fit for task (no drugs, medication or alcohol or lack of sleep). Also acceptable would be safety behaviour training; taken economy for accident prevention (e.g. Fox) or safety campaigns (based on health promotion techniques).

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