UNIVERSITY OF CAMBRIDGE INTERNATIONAL EXAMINATIONS

GCE Advanced Level

MARK SCHEME for the October/November 2010 question paper for the guidance of teachers

9698 PSYCHOLOGY

9698/33 Paper 3 (Specialist Choices), maximum raw mark 70

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UNIVERSITY of CAMBRIDGE
International Examinations

Section A

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

Section B

Q	Description	Marks
(a)	**KNOWLEDGE (1)** [Terminology and concepts]	
	Some appropriate concepts and theories are considered. An attempt is made to use psychological terminology appropriately.	1
	Range of appropriate concepts and theories is considered. The answer shows a confident use of psychological terminology.	2
	KNOWLEDGE (2) [Evidence]	
	Some basic evidence is described and/or it is of peripheral relevance only and/or it is predominantly anecdotal.	1
	Appropriate psychological evidence is accurately described but is limited in scope and detail.	2
	Appropriate psychological evidence is accurately described and is reasonably wide-ranging and detailed.	3
	Appropriate psychological evidence is accurately described and is wide-ranging and detailed.	4
	UNDERSTANDING [What the knowledge means]	
	Some understanding of appropriate concepts and/or evidence is discernible in the answer.	1
	The answer clearly identifies the meaning of the theory/evidence presented.	2
	Maximum mark for part **(a)**	8
(b)	**EVALUATION ISSUES** [Assessing quality of data]	
	General evaluative comment OR issue identified OR evidence (max 2 marks if no analysis/cross ref).	1
	Any two from: general evaluative comment/issue/evidence (max 3 marks if no analysis/cross ref).	2
	Issue plus explanation of issue plus evidence.	3
	Two (or more) issues with elaboration and illustrative evidence.	4
	ANALYSIS [Key points and valid generalisations]	
	Key points (of evidence/study) are identified for a given issue (or number of issues), but no valid generalisations/conclusions are made.	1
	Key points (of evidence/study) are identified for a given issue (or number of issues), and valid generalisations/conclusions are made.	2

	CROSS-REFERENCING [Compare and contrast]	
	Two or more pieces of evidence are offered for a given issue but the relationship between them is not made explicit.	1
	Two or more pieces of evidence are offered for a given issue and the relationship between them (comparison or contrast) is explicit.	2
	ANALYSIS [Structure of answer]	
	The essay has a basic structure (issues, evidence, analysis and cross-referencing) and argument.	1
	Structure sound and argument clear and coherent (issues, evidence, analysis and cross-referencing).	2
	Maximum mark for part **(b)**	10
(c)	**APPLICATION** [Applying to new situations and relating to theory/method]	
	A suggestion (to apply psychological knowledge to the assessment request) has been attempted.	1
	A suggestion (to apply psychological knowledge to the assessment request) has been applied effectively. One detailed or several applications considered.	2
	KNOWLEDGE (2) [Evidence]	
	Basic evidence is referred to but not developed and/or it is of peripheral relevance only and/or it is predominantly anecdotal.	1
	Appropriate psychological theory/evidence is explicitly applied.	2
	UNDERSTANDING [What the knowledge means]	
	Some understanding (of the relationship between application and psychological knowledge) is evident in the answer OR there is clear understanding of the suggested application(s).	1
	The answer shows a clear understanding of the relationship between psychological knowledge and the suggested application AND there is clear understanding of the suggested application(s).	2
	Maximum mark for part **(c)**	6
	Maximum mark for **Section B**	24

PSYCHOLOGY AND EDUCATION

Section A

1 (a) Explain, in your own words, what is meant by 'assessment of special educational needs'. [2]

A special educational need is 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. This is for 1 mark. For 2 marks, the assessment component of the question must also be mentioned.

(b) Describe <u>one</u> cause and <u>one</u> effect of a learning difficulty or disability. [6]

Most likely difficulty or disability is **dyslexia**, which accounts for 80% of all learning difficulties. It affects boys more than girls. Can be auditory (dysphonetic dyslexia); visual (dyseidetic dyslexia) or mixed/classic.
Effects: 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.
Causes of dyslexia: family research indicates that individuals have a greater likelihood of suffering from dyslexia if one or both parents have the disorder and **Owen** (**1978**) reported a concordance rate for monozygotic (identical) twins of 100%.
Is there a link between testosterone and dyslexia? **Geschwind** and **Galaburda** (**1985**) hypothesised that "several behavioural and medical conditions, including dyslexia, are more prevalent in males due to increased levels of testosterone, which inhibits development of the left side of the brain".
Carlson (**1994**) reports a number of studies showing that brain abnormalities may be responsible for cases of dyslexia. Postmortems of people with a history of dyslexia show that they have abnormalities in the planum temporale, part of Wernicke's area. In comparison with non-dyslexics, whose cells are arranged in regular columns, the cells of people with dyslexia show irregular arrangement. Scanning techniques have also confirmed that the planum temporale on the left side of the brain is much smaller in people with dyslexia than in non-sufferers.
Other possibilities include:

- **Dyscalculia** affects mathematical performance, affecting around 1% of the population.
- **Dyspraxia** involves problems with fine and/or gross motor co-ordination, leading to problems with physical activities in subjects like science and physical education.
- **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.

(c) Describe <u>one</u> way in which a learning difficulty or disability can be assessed. [3]

Assessment by IQ test is possible but unlikely for a particular difficulty or disability.
More likely are:
Screening tests: these tests are designed to be used on very large numbers of children, to narrow down the group of children who might need a more thorough test for possible dyslexia. They are not tests for dyslexia, but are designed to help researchers focus on children who appear to be having difficulties with their learning, and who might be dyslexic.
Comprehensive tests: comprehensive tests for dyslexia look at the whole child and examine the root cause of any learning difficulties in the light of research into dyslexia and its causes. The word 'comprehensive' means 'thorough', and these tests examine which brain functions are interfering with the child's acquisition of normal school learning. Tests of reading, spelling, drawing, maths and intelligence are given, as well as visual tests, laterality tests, visual scanning tests, sequencing and other tests.

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

Typically: term is what it says. Common-sense definitions acceptable.
1 mark partial answer; 2 marks answer with elaboration.

(b) Suggest <u>two</u> ways in which learning effectiveness could be improved. [6]

Any appropriate answer based on student study skills. Most likely:
1. McCarthy's (1990) **4-MAT** system. Includes: motivation, concept development, practice and application. This is teacher-based: the teacher matches teaching styles with learning styles.
2. **PQRST**: preview, question, read, self-recitation, test. Intended to improve ability to study and remember material in a textbook.
3. **SPELT** (Mulcahy, 1986): Strategies for Effective Learning, Thinking. This is concerned with learning how to learn.

Memory techniques are also worth credit.

(c) Describe <u>one</u> problem with a study skill of your choice. [3]

Most likely, candidates will choose one aspect referred to in question part **(b)** above.
Any appropriate problem to receive credit.

SECTION B

3 (a) Describe what psychologists have found out about disruptive behaviour in schools. [8]

A **definition** of disruptive behaviour might be a good place to start, such as "behaviour that proves unacceptable to the teacher" (Fontana, 1995) but right away there are problems. Who does the defining? Major **types** are:

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

Various tables list the frequency of disruptive behaviours. For example, The Elton Report (UK, 1989) found 'talking out of turn' to be the most frequent, accounting for 53% of disruptions each day. In a US study from 1848, 'misbehaving to girls' was most common.

Candidates may then provide an **explanation** for these behaviours, which may be behavioural (e.g. maladaptive learning), cognitive or social. Other causes could be biological, e.g. genetic, chemical, such as diet, etc.

Candidates may focus on a **specific example**, such ADD and ADHD (attention deficit with or without the hyperactive element). Other causes are also perfectly acceptable.

Finally, candidates may look at **corrective and preventative strategies** for modifying disruptive behaviour. Such strategies are detailed in part **(c)** below.

(b) Evaluate what psychologists have found out about disruptive behaviour in schools. [10]

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

- problems with defining, categorising and types of problems
- the methods used by psychologists to assess problem behaviour
- ethical issues
- the challenges a problem child presents for teachers and educators. Methodology used to study problem behaviours.

(c) Imagine you are the teacher of a disruptive class. Giving reasons for your answer, suggest ways in which you can control the disruptive behaviour. [6]

There are a number of **preventative** strategies and there are a number of **corrective** strategies. If the class is disruptive, then the preventative strategies have not worked and corrective strategies are needed. Such strategies could include:

- **Reasoning** – presenting to the child reasons for not engaging in deviant behaviour and/or reasons for engaging in alternative behaviour. Parke (1974) found reference to actual object more successful in younger children for example. Preferable to punishment?
- **Behaviour modification techniques** –
  (a) **positive reinforcement**. Can be intrinsic (internal) and so not directly under teacher control (but teacher could create situation leading to satisfaction, etc.) and extrinsic (external): attention, praise, stars, etc. Bijou and Sturges (1959) classify extrinsic reinforcers into five categories: consumables, manipulatables, visual and auditory stimuli, social stimuli and tokens. O'Leary & Becker (1967) used tokens to eliminate deviant responses with much success, although others (Kazdin & Bootzin, 1972) did not. Premack (1965) outlines the 'Premack Principle', where children behaving appropriately engage in a reinforcing activity – one that the child enjoys. Michael (1967) describes 7 principles one should be wary of when attempting to control behaviour through consequences.
  (b) **Modelling**. Punishing one student may inhibit the same behaviour in another; rewarding one student may lead to copying behaviour by another.
  (c) **Punishment**. Can be: (1) presentation of unpleasant consequences, such as facial gestures, reprimands, detention, time-out, physical punishment, etc.; (2) removal of pleasant consequences. Many studies illustrate all these variations. For example, Bratner & Doherty (1983) distinguish three types of time-out: isolation, exclusion and non-exclusion.

Note that any other strategy or technique can receive credit.

4 (a) Describe how <u>one</u> psychological perspective of your choice has been applied to education. [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.

For the **cognitive approach**, typically candidates will include the work of Piaget. His contribution is significant and covers a wide range of aspects such as readiness for teaching mathematics and the type of book a child should read at a particular age. More typically will be the **readiness approach**, a central component of **discovery learning**. If candidates focus on his theory of cognitive development without explicitly linking it to education, this strategy should receive no credit. Piaget is not the only relevant psychologist. Gagne (1977) outlines a number of **cognitive strategies**; Bruner (1966) has looked at **discovery learning**; Ausubel (1977) proposes a **theory of meaningful verbal learning (subsumption)**.

For the **humanistic approach** (e.g. Rogers, 1951), every individual is the centre of a continually changing world of experience. Four features are at the heart: **affect** (emphasis on thinking and feeling, not just information acquisition); **self concept** (children to be positive about themselves); **communication** (attention to positive human relationships) and **personal values** (recognition and development of positive values). Maslow (1970) advocates **student-centred teaching**, where teachers are learning facilitators rather than didactic instructors. Dennison (1969) advocates the **open classroom**. Dunn & Griggs (1988) propose that each child has a **personal and unique learning style** and so traditional education should change radically, providing a 'staggering range of options'. Johnson et al. (1984) believe students see education to be competitive when it should be **co-operative**, involving circles of knowledge, learning together and student team learning.

(b) Evaluate how <u>one</u> psychological perspective of your choice has been applied to education. [10]

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

- the strengths and weaknesses of psychological perspectives
- the implications the perspectives have for teachers
- whether theory applies in practice
- contrasting alternative perspectives

(c) Giving reasons for your answer, suggest how a teacher could use the Behaviourist approach to improve poor attendance. [6]

Candidates must use **behaviour modification techniques** and candidates must focus on attendance.

(a) **Positive reinforcement**. Can be intrinsic (internal) and so not directly under teacher control (but teacher could create situation leading to satisfaction, etc.) and extrinsic (external): attention, praise, stars, etc.
Bijou and Sturges (1959) classify extrinsic reinforcers into five categories: consumables, manipulatables, visual and auditory stimuli, social stimuli and tokens.
O'Leary & Becker (1967) used tokens to eliminate deviant responses with much success, although others (Kazdin & Bootzin, 1972) did not.
Premack (1965) outlines the 'Premack Principle', where children behaving appropriately engage in a reinforcing activity – one that the child enjoys.
Michael (1967) describes 7 principles one should be wary of when attempting to control behaviour through consequences.

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

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

(d) **Negative reinforcement**. For example, lessons stop being boring when students co-operate.

(e) Candidates may also make a distinction between primary and secondary reinforcers.

PSYCHOLOGY AND ENVIRONMENT

Section A

5 (a) Explain, in your own words, what is meant by the term 'positive uses of sound (music)'. [2]

Wanted sound is positive and such sounds (probably music) can be beneficial in many ways. This is opposite from noise, which is unwanted sound and so is negative.

(b) Briefly describe <u>two</u> studies which have made positive use of sound. [6]

Candidates could focus on:

1. Music played in doctor/dental waiting rooms (and even whilst undergoing treatment) to distract patients from worry. E.g. Chafin (2004) listening to classical music can reduce blood pressure.
2. Muzak, used in shops, supermarkets, etc. to encourage people to buy certain products.
3. The use of music in studying (Mozart effect).
4. Music and mood: North (2003) found classical music led to more profit in restaurant. Fox (1983) found that industrial music helps production-line workers.
5. Studies on animals show cows produce more milk and hens lay more eggs.

(c) Briefly describe <u>one</u> study showing the negative effects of noise on social behaviour. [3]

Social behaviour can include a number of factors such as aggression (ASB), helping (PSB) and attraction.
Aggression: likely to be popular as many unethical lab studies involving electric shock, e.g. Geen & O'Neal (1969); Donnerstein & Wilson (1976). Noise makes aggressive people more aggressive.
Helping: also popular with both lab and natural studies by Matthews & Canon (1975) and Page (1977). Noise decreases helping behaviour, but other variables are important.
Some candidates may look at **attraction** but evidence here reveals no clear conclusion.

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

SAD (Seasonal Affective Disorder) is a type of winter depression that affects an estimated half a million people every winter between September and April, in particular during December, January and February. SAD usually occurs in women and begins in early adulthood. For many people, SAD is a seriously disabling illness, preventing them from functioning normally without continuous medical treatment. For others, it is a mild but debilitating condition causing discomfort but not severe suffering.

(b) Briefly describe <u>two</u> effects climate may have on health. [6]

Candidates may focus on SAD and the symptoms of SAD include:
Depression: low mood, worse than and different from normal sadness; negative thoughts and feelings; guilt and loss of self-esteem.
Sleep problems: the need to sleep more; a tendency to oversleep; difficulty staying awake during the day and/or disturbed sleep with very early morning wakening.
Lethargy: fatigue, often incapacitating, making it very difficult or impossible to carry out normal routines.
Over-eating: craving for carbohydrates and sweet foods leading to an increase in weight.
Also, impaired cognitive function, social problems, anxiety, loss of libido, sudden mood changes in spring.
Also possible (why more people die during heatwaves):
Heat exhaustion: faintness, nausea, vomiting, headache, restlessness. Caused by demands on circulatory system.
Heat stroke: confusion, staggering, headache, delirium, coma, death. Caused by a breakdown of sweating mechanism so no sweating.

(c) Describe <u>one</u> way in which the symptoms of seasonal affective disorder may be reduced. [3]

Light therapy has proved effective in up to 85% of diagnosed cases. Exposure should be for up to four hours per day (average 1–2 hours) to very bright light, at least 10× the intensity of ordinary domestic lighting. Light treatment is used daily in winter, starting in early autumn when the first symptoms appear. It consists of sitting two to three feet away from a specially designed light box, usually on a table, allowing the light to shine directly through the eyes.

SECTION B

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

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

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

(b) **Human studies**: 1. **performance**: Aiello et al. (1975b) found impaired task performance. In lab studies both Bergman (1971) and Freedman et al. (1971) report that density variations do not affect task performance. But task is crucial: no effect if task is simple; effect if task is complex. Saegert et al. (1975) in high social density supermarket and railway station found impairment of higher level cognitive skills (e.g. cognitive maps). Heller et al. (1977) suggests there is no effect on task performance when there is high social or spatial density and there is no interaction, but 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 learned about crowding and density. [10]

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

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

(c) Giving reasons for your answer, suggest what can be done to prevent the negative effects of crowding from arising. [6]

Could be 'standard' answer including aspects below:

- have greater ceiling height (Savinar, 1975)
- have rectangular rooms rather than square rooms (Desor, 1972)
- ensure well-defined corners to rooms (Rotton, 1987b)
- ensure room has a visual escape or distraction (e.g. a window or picture) (Baum et al., 1976)
- increase brightness (colours or lights) (Mandel et al., 1980)
- sociofugal seating (facing away) better than sociopetal (facing toward) (Wener, 1977)

Or any other logical aspect accepted. Cannot be coping with effects of crowding.

8 (a) Describe what psychologists have found out about personal space and territory. [8]

Question is personal space and territory, so both aspects must be included.

Personal space: candidates may begin with definitions or look at types: alpha personal space = objective, externally measurable distance; beta personal space = subjective experience of space. They could look at the functions of personal space, such as **overload** (Scott, 1993), **intimacy equilibrium** (Argyle & Dean, 1965), **ethological model** (Evans & Howard, 1973), **proxemics** (Hall, 1966), **privacy regulation** (Altman, 1975).
Candidates may look at how personal space is **measured**: simulation; stop-distance; naturalistic observation or direct invasion of space.
Many studies could be included. Three '**classics**' for personal space are:

- Felipe and Sommer (1966). At a 1,500-bed mental institution an experimental confederate approached and sat next to lone patients. Felipe and Sommer (1966) also performed a more ethical study in a library.
- Middlemist, Knowles, and Matter (1976) looked at the effects of invasion on physiological arousal, performing a study in a three-urinal men's lavatory!
- Konecni et al. (1975) and in a similar study Smith and Knowles (1979) stood close to pedestrians waiting to cross a road.

Territory
Altman (1975): **types of territory**

1. **Primary territory**: "a private area owned by an individual";
2. **Secondary territory**: "an area that is used regularly but is shared with others";
3. **Public territory**: "can only be occupied temporarily on a first come, first served basis".

Gender differences: males claim larger territories than females, e.g. Smith et al. (1981) beach study; Jason et al. (1981) study of women on a beach. Sundstrom & Sundstrom (1977) similar study but on bench.
Cultural differences: Smith et al. (1981): French & German beaches; Edney et al. (1974) US beaches found: French less territorial; Germans much more marking. Worchel & Lollis (1982) compared Greek with American responses to dropped bags of litter.
Defence of public territory: Ruback & Snow (1993) person drinking at water fountain invaded. Found non-conscious racism: white invaded by white left quickly. African-Americans stayed longer when invaded by white. Ruback et al. (1989) those on phone spent longer on phone when someone else was waiting than in a no one waiting control.
Defence of primary territory (e.g. home): Newman (1976): **defensible space**: physical space that is characterised by a high level of social responsibility and personal safety. Certain buildings are more likely to be vandalised/burgled because of their design. Evidence from Pruitt-Igoe building: 33 high-rise blocks each with 80 apartments. After 3 years = very high crime rate and 70% were empty. Why? Newman: (1) **zone of territorial influence** – an area which appears to belong to someone; (2) **opportunities for surveillance** – if it can be seen by occupants, then no vandalism. High-rise have many semi-public areas: entrance-halls, lifts = not belong to anyone so no markers so vandalism. Also no opportunities for surveillance so vandalism. Pruitt-Igoe – one had a chain fence around it. Vandalism 80% lower than other buildings and vacancy rate 5%.

(b) Evaluate what psychologists have found out about personal space and territory. [10]

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

- the methods psychologists use to study space and territory
- laboratory versus real-life studies
- ethical issues
- the usefulness of personal space/territory studies
- competing theoretical explanations

(c) Giving reasons for your answer, suggest <u>one</u> way you could measure the personal space of each student in your classroom. [6]

Possibilities include**:**

- simulation: paper and pencil measure done by placing a drawing of a person on a sheet of paper and then drawing another person at an appropriate distance.
- stop-distance: person stands at a given point and another person walks toward them and stops where they feel comfortable. The distance between toes, for example, can be measured.
- naturalistic observation: a possibility but difficult to control and measure.
- direct invasion of space: a possibility but unethical.
- CIDS (comfortable interpersonal distance scale) – Duke & Nowicki (1972): a paper and pencil measure where people place themselves at the centre and imagine others walking towards them. They mark on the paper where they would like the person to stop.

PSYCHOLOGY AND HEALTH

Section A

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

Two components required here for maximum marks. First is the term pain. This could be a formal definition, e.g. Merksey & Bogduk, 1994: 'an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage'. Second component is the acknowledgement of the term measuring.

(b) Outline <u>two</u> ways in which pain can be measured in adults. [6]

Appropriate **measures** of pain include:
- self report/interview methods
- rating scales: e.g. visual analogue scale and category scale
- pain questionnaires: e.g. MPQ (McGill Pain Questionnaire); Minnesota Multiphasic Personality Inventory (MMPI) often used too but is not pain-specific
- behavioural assessment, e.g. UAB Pain Behaviour Scale

Also possible but highly unlikely are psycho-physiological measures: use of EMG, ECG and EEG.

(c) Describe <u>one</u> way in which pain can be controlled. [3]

Management of pain includes:
- **Medical** – use of surgical or chemical means: peripherally acting analgesics such as aspirin, centrally acting analgesics, e.g. morphine or local anaesthetics.
- **Psychological** – cognitive: attention diversion, non-pain imagery or cognitive redefinition. Also biofeedback.

Alternatives such as physical therapy: tens, hydrotherapy and acupuncture.

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

Two components required for both marks here. The first is an awareness of what substance abuse is. This may be done through a distinction between use, misuse and abuse, or it may be done through a more formal definition such as that by Rosenman and Seligman (1984). The second component is an awareness of how use or misuse can be prevented from becoming abuse.

(b) Briefly describe <u>one</u> way in which substance abuse can be prevented and <u>one</u> way in which people can quit substance abuse. [6]

Preventing – most likely possibilities include:

- **public health approaches** – warnings on products, increase price/tax, ban advertising, etc.
- **health promotion programmes** usually in schools, e.g. Flay (1983), Evans (1984) social inoculation, Botvin (1985) life skills training.

Quitting – most likely (if smoking):

- **going it alone** – most people just give up (but don't succeed)
- **drug therapy** – nicotine replacement if smoker; use of emetic for alcoholics, etc.
- **behaviour therapies** – aversion therapy most common but also many self-management strategies.

Also appropriate are the methods of fear arousal warnings and providing information strategies.

(c) Describe <u>one</u> reason why people abuse a substance. [3]

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**.
Drugs: similar reasons to above.
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.

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**
- ask practitioner to estimate
- ask patient to estimate (self report)
- estimate of family member/medical personnel.

[2] **Objective**
- quantity accounting (pill count) where number of pills remaining is measured
- medication dispensers which record and count times when used
- biochemical tests such as blood or urine sample
- tracer/marker method: add tracer to medication, e.g. riboflavin (vitamin B2) fluoresces under ultraviolet light
- 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:

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

[3] Cultural factors

[4] Relationship between person and medical service:

(a) speed of service, (b) practitioner's personality: Byrne & Long (1976) distinguish between doctor-centred and patient-centred personality. Savage and Armstrong (1990) study on this, (c) male/female practitioner: Hall et al. (1994) found female doctors asked more questions of patients and made more positive statements to patients. Patients talked more to female doctor. Law & Britten (1995) Is a woman doctor better than a man.

(b) Evaluate what psychologists have 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
- the usefulness/applications of adherence research
- implications for patient's health and/or practitioner satisfaction

(c) Giving reasons for your answer, suggest ways in which a medical practitioner can improve adherence to medical advice. [6]

Most likely possibilities include:

- changing physician behaviour (DiMatteo & DiNicola, 1982); sending doctors 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)
- use behavioural methods: tailor the treatment; give prompts and reminders; encourage self-monitoring; provide targets and contracts.

Candidates could focus either on improving the patient 'end' or that of the practitioner. Practitioner more logical as they could attend training courses (e.g. Inui) or they could be more patient-centred rather than doctor-centred. Any appropriate suggestion based on psychological evidence is acceptable.

In addition to changing any of the above features, such as changing to patient- rather than doctor-centred style, there are specific suggestions to change physician behaviour. DiMatteo & DiNicola (1982) suggest sending doctors on training courses; alternatively changing communication style (Inui et al., 1976), Taylor (1986); change information presentation techniques (Ley et al., (1982). Tapper-Jones (1988) suggests using visual material such as diagrams, emphasising key information and having the patient repeat what has been said. Kulik and Carlino (1987) all improve patient satisfaction.

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

Answers are likely to include:
[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 is not the most effective. The Yale model (source of message/message/recipient) underlies so many attempts. Study by Leventhal (1967) also relevant.
[2] **Providing information** via media (e.g. Flay, 1987) 3 approaches: 1) provide negative info only; 2) for those who want to be helped provide first steps; 3) self-help via tv audience. Lewin (1992) healthy heart project too.
[3] **Behavioural methods**: provision of instructions, programmes, diaries to use as reinforcers.
Also worth credit would be programmes in:

- **Schools**, e.g. Walter (1985) in US and Tapper et al. (2003) in UK with food dudes.
- **Worksites**, e.g. Johnson & Johnson in US and Gomel (1985) in Australia.
- **Communities**, e.g. Farquhar's (1977) three community study. Also see part **(c)** below.

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

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

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

(c) Using psychological evidence, suggest a campaign to reduce heart disease in a community. [6]

Answers must focus on heart disease.
Lots of possibilities here and candidates will refer to studies of health promotion. As with all part **(c)** questions, candidates should refer to a technique which is based on psychological knowledge rather than a common-sense, anecdotal suggestion. For example, it would be legitimate to refer to a fear-arousal approach, or 'providing information', or through mass communication.
Most likely possibilities include:

- the three community study (Farquhar et al., 1977) 42,000 people
- Minnesota Heart Health Program (Blackburn et al., 1984) 350,000 people
- Pawtuckett Heart Health Program (Lasater et al., 1984) 170,000 people
- Pennsylvania county health improvement program (Stunkard et al., 1985), 220,000
- Stanford five city project (Farquhar et al., 1984) 359,000 people
- Any appropriate community campaign conducted in the country of the candidate.

PSYCHOLOGY AND ABNORMALITY

Section A

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

Diagnosis is the process of identifying a medical condition or disease by its signs, symptoms, and from the results of various diagnostic procedures. In terms of abnormality, Maher (1966) believes that *psychopathology* is classified on the basis of *symptoms*, the classification being called *diagnosis* (and the rest of the quote for no marks), the methods used to try to change the behaviours are called *therapies*, and these are often carried out in *mental* or *psychiatric hospitals*. If the deviant behaviour ceases, the patient is described as *cured*.

(b) Describe <u>one</u> way in which abnormality is classified. [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 in DSM or ICD.

(c) Describe <u>two</u> types of abnormality. [6]

Any two types acceptable. Most likely schizophrenia, affective disorder, anxiety disorders such as obsessive-compulsive disorder, abnormal affect due to trauma, such as amnesia and fugue. These are more likely because they are topic areas for this syllabus.

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

Typically: following a traumatic event, most people get over it. In some people though, traumatic experiences set off a reaction that can last for many months or years. This is called Post-Traumatic Stress Disorder, or PTSD for short.

(b) Describe <u>two</u> characteristics or symptoms of a trauma response of your choice. [6]

Characteristics of PTSD include:

- **Flashbacks and nightmares**: you find yourself re-living the event, again and again.
- **Avoidance and numbing**: it can be just too upsetting to re-live your experience over and over again.
- **Being "on guard"**: you find that you stay alert all the time, as if you are looking out for danger.
- **Other symptoms**: muscle aches and pains, diarrhoea, irregular heartbeats, headaches, feelings of panic and fear, depression, drinking too much alcohol, using drugs (including painkillers).

Candidates may consider the characteristics of any other trauma response, such as:

- **Psychogenic fugue**: leaving one's home, work and life and taking a new identity with loss of memory of the previous identity.
- **Psychogenic amnesia**: losing one's memory because of psychological reasons.

(c) Outline <u>one</u> way in which a trauma response could be treated. [3]

It depends on the type of trauma.
Most likely: PTSD, which is best treated with systematic desensitisation or cognitive behavioural therapy. This can include:

- **Exposure therapy.** This therapy helps people face and control their fear. It exposes them to the trauma they experienced in a safe way. It uses mental imagery, writing, or visits to the place where the event happened. The therapist uses these tools to help people with PTSD cope with their feelings.
- **Cognitive restructuring.** This therapy helps people make sense of the bad memories. Sometimes people remember the event differently from how it happened. They may feel guilt or shame about what is not their fault. The therapist helps people with PTSD look at what happened in a realistic way.

For amnesia, systematic desensitisation would be inappropriate. Psychotherapy, a type of counselling, is the main treatment for dissociative disorders. This treatment uses techniques designed to encourage communication of conflicts and increase insight into problems. Cognitive therapy (as above) focuses on changing dysfunctional thinking patterns and resulting feelings and behaviors.

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. 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 for individual and society

(c) Giving reasons for your answer, suggest how abnormality was treated historically. [6]

During the Middle Ages, a belief in witchcraft spread throughout Europe. Many people with mental illness were considered to be witches and were killed by burning, hanging, or drowning.
One early treatment was the branding of a patient's head with a red hot iron to "bring the animal to his senses". An English treatment involved using a rotating device in which the afflicted person was placed and then whirled around at a high speed. Even as late as the nineteenth century, another similar "treatment" device was used. This one swung the mentally ill person around while he was in a harness. This treatment supposedly "calmed the nerves".
The gyrator, as its name suggests, was a contraption similar to a spoke on a wheel. The patient was strapped to the board head outward and the wheel was rotated at a high rate of speed, sending the blood racing to his head and supposedly relieving his congested brain.
Other 'treatments' involved deliberately giving patients malaria because it was believed that a person could not have schizophrenia and malaria at the same time.

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

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

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

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

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

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

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

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

(c) You are a psychiatrist. Giving reasons for your answer, suggest what characteristics you would look for in order to diagnose a particular type of schizophrenia. [6]

Diagnosis based on the self report of the person and family members, friends or co-workers. Observation by a psychiatrist, clinical psychologist or similar in a clinical assessment. DSM IV-TR criteria must be met for someone to be so diagnosed. Two or more of the following, each present for a significant portion of time during a one-month period: delusions, hallucinations, disorganised speech, grossly disorganised behaviour or catatonic behaviour. Negative symptoms, i.e. affective flattening (lack or decline in emotional response), alogia (lack or decline in speech), or avolition (lack or decline in motivation).
Social/occupational dysfunction: one or more major areas of functioning, such as work, interpersonal relations, or self-care, are markedly below the level achieved prior to the onset.

PSYCHOLOGY AND ORGANISATIONS

Section A

17 (a) Explain, in your own words, what is meant by the term 'improving motivation' [2]

Generally if there is no motivation in an employee, then that employee's quality of work will deteriorate. Therefore this question requires an acknowledgement of how to motivate an employee. For example, aiming to increase desire to do a good or faster/better job.

(b) Briefly describe <u>two</u> theories of motivation to work. [6]

A number of theories to choose from. Can do a range with less detail or a 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] McClelland's **achievement-motivation theory** (1961): three work-related needs: need for achievement (get job done, success, etc.); need for power (direct and control others; be influential); need for affiliation (desire to be liked and accepted; friendship). Methodology used: TAT (thematic apperception test): look at picture then relate story it suggests. Is a projective test and so scoring can be unreliable. Good application: match profiles to jobs; achievement training programmes.

[2] **Job design theories**: if job well designed and satisfying needs = good motivation. [a] Herzberg's **two factor theory** (1966): job satisfaction and job dissatisfaction are two separate factors. Motivators = responsibility, achievement, recognition, etc. = job satisfaction. 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, so decision-making is 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.

(c) Describe <u>one</u> way in which motivation to work can be improved other than by financial reward. [3]

Many theorists, such as Maslow and McGregor, place money low down on the list of motivators. For McGregor, praise and recognition are much more important. Also praise, respect, recognition, empowerment and a sense of belonging are said to be far more powerful motivators than money.
Mayo believed that workers could be motivated by acknowledging their social needs and making them feel important.
Robbins and Judge (2007) identify 5 motivators:

- recognition of employees' individual differences, and clear identification of behaviour deemed worthy of recognition
- allowing employees to participate
- linking rewards to performance
- rewarding of nominators
- visibility of the recognition process.

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

Chemers (2002) defines leadership as the "process of social influence in which one person can enlist the aid and support of others in the accomplishment of a common task". However, a formal definition is not required. More simply, it is the ability to guide a group to achieve a goal.

(b) Describe <u>two</u> theories of leadership. [6]

Many theories to choose from:
1. Universalist theories of leadership: [1] The great man theory (Wood, 1913); [2] McGregor (1960) Theory X and Theory Y.
2. 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*.
3. Charismatic (or transformational) leaders have the determination, energy, confidence and ability to inspire followers.
Contingency theories of leadership: [1] Fiedler's contingency model (Fiedler, 1967); [2] House's (1971) *path-goal theory*; [3] Vroom and Yetton (1973) propose a *decision-making theory;* [4] Dansereau et al. (1975) – *leader-member exchange model*.

(c) Describe <u>one</u> study of leader-worker interaction. [3]

Most likely: **Dansereau** et al. (1975) whose *leader-member exchange model* suggests that it is the quality of interaction between leaders and group members that is important. This model has received much acclaim due to the success it has achieved when applied to real life situations. E.g. **Scandura and Graen** (1984) found that following a training programme, where the aim was to improve the quality of leader-member relationships, led to both group productivity and satisfaction increasing significantly.

Section B

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

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

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

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

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

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

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

- the implications of various communications for speed
- individual preference and/or satisfaction
- comparing and contrasting alternative communication techniques
- how psychologists gather evidence in this area

(c) Giving reasons for your answer, suggest a suitable communication network for teachers in a school. [6]

The most logical network for this task is a wheel formation. This is a centralised type, because the head teacher will be at the centre co-ordinating activity to the teachers on the spokes of the wheel. But other types of network will be used, although they would be less suitable. For example, teachers will talk to each other but not communicate the information to all other teachers. The head teacher will have more satisfaction with this network because they are in control. Also, because the supervisor controls, communication is much quicker and more efficient as the head will make decisions.

20 (a) Describe what psychologists have discovered 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 and letters of recommendation.
(8) Consideration throughout of equal opportunities.

Most likely:
Once all information about applicants has been gathered, how is a final decision made? Many decisions are subjective, but other strategies operate:
- multiple regression model: combines each factor statistically
- multiple cut-off model: applicants must obtain a minimum score on each factor to be successful
- multiple hurdle model: decisions made at various stages (e.g. end of day 1 if interview is two-day or even short-listing for interview.

(b) Evaluate what psychologists have discovered about the selection of people for work. [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 you, as personnel officer, would ensure the pitfalls of selection interviews are avoided. [6]

Most likely:
Riggio (1990) suggests six possibilities:
- use structured (formal) interviews
- make sure that the interview and questions are job-related
- ensure there is a rating or scoring system for applicant responses
- use trained interviewers
- use a team of interviewers rather than just one
- use the interview time efficiently

Added to this, adherence to equal opportunities should be evident throughout.