UNIVERSITY OF CAMBRIDGE INTERNATIONAL EXAMINATIONS

GCE Advanced Level

MARK SCHEME for the October/November 2007 question paper

9698 PSYCHOLOGY

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

This mark scheme is published as an aid to teachers and candidates, to indicate the requirements of the examination. It shows the basis on which Examiners were instructed to award marks. It does not indicate the details of the discussions that took place at an Examiners' meeting before marking began.

All Examiners are instructed that alternative correct answers and unexpected approaches in candidates' scripts must be given marks that fairly reflect the relevant knowledge and skills demonstrated.

Mark schemes must be read in conjunction with the question papers and the report on the examination.

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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 Question Part 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 are considered. The answer shows a confident use of psychological terminology.	2
	KNOWLEDGE(2) [Evidence]	
	Some basic evidence is described and/or it is of peripheral relevance only and/or it is predominantly anecdotal.	1
	Appropriate psychological evidence is accurately described but is limited in scope and detail.	2
	Appropriate psychological evidence is accurately described and is reasonably wide ranging and detailed.	3
	Appropriate psychological evidence is accurately described and is wide ranging and detailed.	4
	UNDERSTANDING [What the knowledge means]	
	Some understanding of appropriate concepts and/or evidence is discernible in the answer.	1
	The answer clearly identifies the meaning of the theory/evidence presented.	2
	Maximum mark for part (a)	8
(b)	**EVALUATION ISSUES** [Assessing quality of data]	
	General evaluative comment OR issue identified OR evidence (max 2 marks if no Analysis/cross ref).	1
	Any two from: general evaluative comment/issue/evidence (max 3 marks if no Analysis/cross ref).	2
	Issue plus explanation of issue plus evidence.	3
	Two (or more) issues with elaboration and illustrative evidence.	4
	ANALYSIS [Key points and valid generalisations]	
	Key points (of evidence/study) are identified for a given issue (or number of issues), but no valid generalisations/conclusions are made.	1
	Key points (of evidence/study) are identified for a given issue (or number of issues), and valid generalisations/conclusions are made.	2
	CROSS REFERENCING [Compare and contrast]	
	Two or more pieces of evidence are offered for a given issue but the relationship between them is not made explicit.	1
	Two or more pieces of evidence are offered for a given issue and the relationship between them (comparison or contrast) is explicit.	2
	ANALYSIS [Structure of answer]	
	The essay has a basic structure (issues, evidence, analysis and cross referencing) and argument	1
	Structure sound and argument clear and coherent (issues, evidence, analysis and cross referencing).	2
	Maximum mark for part (b)	10

(c)	**APPLICATION** [Applying to new situations and relating to theory/method]	
	A suggestion (to apply psychological knowledge to the assessment request) has been attempted.	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 question part (c)	6
	Maximum mark for Question	24

PSYCHOLOGY AND EDUCATION

Section A

1 (a) Explain, in your own words, what is meant by the term 'individual differences in educational performance'. [2]

Typically: any difference in the performance of an individual which differs from the norm.

(b) Describe *one* gender difference in educational performance. [3]

Difficult to predict here as there are cultural differences in the performance of boys and girls. UK data shows that except for level 3 maths, girls outperform boys in everything else.

(c) Give *two* explanations for any difference in educational performance. [6]

Wide range of answers possible here. Any two factors from a long list including:
Biological: is 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 'behaviourist' approach to education. [2]

Typically: the education of children according to the behaviourist principles based on the learning theories of operant and classical conditioning.

(b) Describe *two* ways in which the behaviourist approach has been applied in education. [6]

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*.
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.
3. **Behaviour modification** applied to (a) children who misbehave and (b) children who are disadvantaged.
4. **Social learning** (e.g. Bandura) using teachers or other children as a role models.
5. Guthrie: context dependent learning & habit breaking

Candidates who describe the studies of Pavlov and/or skinner receive no credit. Their work was not applied to education. Candidates must extend their work.

(c) Give *one* weakness of the behaviourist approach to education. [3]

Any appropriate answer, such as focuses on behaviour and does not take into account cognitive aspects or humanistic aspects. Weakness could also be specific to an application that may have been used in (b) above.

SECTION B

3 (a) Describe how educational performance is assessed in schools. [8]

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 & Wales) SATs, GCSEs and GCEs or it may be they focus on tests used by psychologists as a diagnostic aid.

(b) Evaluate how 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) You are responsible for education in your country. Giving reasons for your answer, suggest how you would assess educational performance at different ages. [6]

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

Answer depends on assessment in different countries. Answer will also (presumably) relate to what is written in part (a).

4 (a) Describe what psychologists have discovered about special educational needs. [8]

Typically: SEN 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.

SEN includes any type of learning abnormality and most typically this would include **autism**, **dyslexia** (and related difficulties e.g. **dyscalculia**) **ADHD** (attention deficit with/without hyperactivity) or any other learning abnormality. The focus could be on the suggested causes of such abnormalities or could be on the problems a typical child may have in a classroom.

(b) Evaluate what psychologists have discovered about special educational needs. [10]

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

- the strengths and weaknesses of psychological perspectives;
- the implications for teachers;
- whether theory applies in practice;
- comparing/contrasting differing approaches.

(c) Giving reasons for your answer, suggest how *one* specific learning difficulty or disability may be overcome. [6]

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

Most likely:

1. Focus on different types of schooling: mainstream (integration) or specialist (segregation). Advantages and disadvantages of both.
2. Focus on what is done in class.

(a) Powell (2000) lists a number of strategies for children with autism

(b) Selikowitz (1998) lists strategies for overcoming dyslexia, with specific strategies depending on whether the problem is a reading, spelling or writing error.

PSYCHOLOGY AND ENVIRONMENT

Section A

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

Density refers to physical conditions (may be social or spatial). Crowding is a psychological state determined by perceptions of restrictiveness when exposed to spatial limitations. (Stokols, 1972).

(b) Describe *one* way in which density can be measured. [3]

Two possibilities here:
Spatial density: keep number of people same but change space/room size.
Social density: keep space same but change number of people.
Many studies to support either of these.

(c) Describe *two* animal studies on density and crowding. [6]

(a) Dubos (1965) and lemmings who are said to jump off a cliff;
(b) Christian (1960) where deer died on James Island due to stress caused by crowding;
(c) Calhoun (1962) who bred far too many rats in a behavioural sink.

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

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.

(b) Describe *one* type of crowd behaviour. [3]

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 & non-panicky]

(c) Briefly describe *two* explanations of crowd behaviour. [6]

Explanations of aggressive crowd behaviour: **Mob Psychology/contagion** 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. Schank & Abelson (1977) suggest people have **script schemata**.

SECTION B

7 (a) Describe what psychologists have discovered about climate and weather. [8]

Candidates may begin with a distinction between weather, relatively rapidly changing conditions and climate, average weather conditions over a period of time. They may consider Climatological determinism, Probabilism and Possibilism. Inclusion of this would be impressive.

Candidates could consider any aspect such as temperature, wind, storms (hurricanes, tornados) altitude and anything else that pertains. Note that the syllabus refers to performance, health and social behaviour so that should at least limit coverage a little.

Effects of heat is likely to be most common. **Performance**: Lots of lab studies show conflicting results mainly due to variations in design. Also many field studies e.g. Pepler (1972) in classrooms and Adam (1967) with soldiers. Still individual differences. Bell suggests an arousal response (inverted U theory); Provins (1966) suggests differing core temperatures and that heat affects attention. Wyndham believes in adaptation levels. **Social behaviour: aggression**: the long hot summer effect: heat causes riots (Goranson & King (1970) and US riot commission (1968) but only in 1967 and only in US! Baron & Bell (1976) propose negative affect-escape model to explain it and lab studies in support. Many other studies on heat & aggression.

Heat also may or may not affect **helping** (e.g. Page, 1978) and attraction (e.g. Griffit, 1970). Health: heat may cause heat exhaustion (sweating) or heat stroke (no sweating) or heart attacks. **Cold temperature** can also be covered. Causes hypothermia, frostbite, etc. Also affects performance and social behaviour (too cold to help or be aggressive). Not a lot on wind. Causes fear due to potential destruction. Increases helping in summer and decreases in winter (Cunningham, 1979). Cohn (1993) wind decreases domestic violence.

Barometric pressure (e.g. pilots, divers) a possibility but not a lot of material available.

Candidates may also, legitimately, consider the effects of the moon phases on behaviour; the effects of sunlight and seasonal affective disorder.

(b) Evaluate what psychologists have discovered about climate and weather. [10]

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

- the methods used by psychologists to study climate and weather;
- issues relating to individual and/or cultural differences;
- the implications the evidence has for society;
- comparing and contrasting theoretical explanations.

(c) Imagine that you are sitting in an examination. Using your psychological knowledge, suggest how the weather may affect your performance. [6]

Candidates likely to give anecdotal evidence. This is fine as long as reference to actual evidence as per general mark scheme.

Heat Performance: Lots of lab studies show conflicting results mainly due to variations in design. Also many field studies e.g. Pepler (1972) in classrooms and Adam (1967) with soldiers. Still **individual differences**. Bell suggests an arousal response (inverted U theory); Provins (1966) suggests differing core temperatures and that heat affects attention. Wyndham believes in adaptation levels. Very little on cold temperatures.

8 (a) Describe what psychologists have found out about architecture and behaviour. [8]

Candidates could look at:

A: Theories and effects of urban living on health and social behaviour:

Social behaviour – helping Altman (1969) use of phone; Amato (1983) bleeding leg; Newman & McCauley (1977) urban v rural friendliness; Milgram (1977) city handshake; Milgram (1970) stimulus overload; Franck et al (1974) students in city.

Social behaviour – crime Zimbardo (1969) deindividuation

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

B: Urban renewal and building design:

Porteus: Definitions urban renewal; Pruitt-Igoe project; Newman (1976) zone of TI & opps for surveillance; Van Dyke estate; Brownsville; Clason Point.

C: Community environmental design: Whyte (1980); Brower (1983)

(b) Evaluate what psychologists have found out about architecture and behaviour. [10]

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

- comparing social with physical explanations;
- the ethics of urban renewal;
- comparing theories of gentrification; [renovating areas for middle/upper class use]
- how psychologists gained their evidence (e.g. the 'single variable' versus the 'urban/rural' approach).

(c) Giving reasons for your answer, suggest what features would contribute to a successful community environmental design. [6]

Any appropriate suggestion to receive credit – most likely **Whyte (1980)** Emphasised design features that promote positive social interaction. Studied urban plazas. Over several years they observed and filmed 18 plazas in NYC. Counted how many people used each plaza on pleasant days and began to relate usage to various features of the plaza.

Used more if.

– Number of amenities rise. (e.g. places to sit). – Drinking fountains and pools are present.

– Foodstands. – Trees. – Accessible food outlets. – Activities to watch (jugglers, etc.).

– Sunny orientation. - Located on busy streets and not hidden away.

Sidney Brower (1983) in yet another project suggested:

– Keep the street front alive. – Give residents things to do and places to be.

– Reduce the speed and number of cars. – Residences should open to the street, not from some central courtyard. – Make parks more attractive to adults.

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 & new surgical intervention. In very exceptional circumstances, individuals seek excessive & 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 & 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 people can be encouraged to use health services. [3]

Most likely possibilities include:

1. **changing physician behaviour** (DiMatteo & DiNicola, 1982) such as changing communication style (Inui et al, 1976); change information presentation techniques (Ley et al, (1982).
2. **Educating** the public as to what is appropriate. A health promotion campaign? Use of fear appeal, providing information.

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) Outline *one* health belief model. [3]

Several models to choose from:

Becker & Rosenstock (1984) The health belief model. Related studies: Champion (1994) used HBM to inform women about benefits of mammography. Hyman et al (1994) perceived susceptibility not good predictor. Barriers and benefits better but ethnicity best. Aiken et al (1994) regular place to go and practitioner recommendation much better predictor than HBM.

Ajzen & Fishbein (1975) Theory of reasoned action. Related studies: Montano et al (1997) low income women questioned regarding attitude, subjective norm and intentions toward mammography. Found all significantly related to use. O'Callaghan et al (1997) better predictor is past experience/behaviour.

Ajzen (1985) Theory of planned behaviour. As above model but adds **perceived behavioural control**.

Weinstein et al (1998) The precaution adoption process model. Above merely identify variables. Stages people go through in their readiness to adopt a health related behaviour.

Prochaska et al (1992) The transtheoretical model. Five stages of behaviour change: PRECONTEMPLATION – no intention of changing. Isn't a problem. CONTEMPLATION – awareness of problem. Thoughts about changing but no action. PREPARATION – plans made to change behaviour. ACTION – plans put into action. MAINTENANCE – attempt to sustain changes and resistance to relapse.

(c) Describe two health enhancing behaviours. [6]

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.

Bland statement = 1 mark; details of same = 2; reference to how it would enhance = 3

Section B

11 (a) Describe what psychologists have discovered about pain. [8]

Candidates could focus on theories (but unlikely) or measures or management.
No distinction here between chronic and acute.
Measures of pain include:

1 self report/interview methods:
2 rating scales: e.g. visual analogue scale and category scale
3 pain questionnaires: e.g. MPQ (McGill Pain Questionnaire); MMPI often used too but is not pain specific.
4 behavioural assessment: e.g. UAB
5 psycho-physiological measures: use of EMG, ECG & EEG.

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 A. cognitive: attention diversion, non-pain imagery or cognitive redefinition. B. behavioural such as biofeedback.
Alternative such as physical therapy: tens, hydrotherapy and acupuncture

(b) Evaluate what psychologists have discovered about pain. [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 your psychological knowledge, suggest ways in which chronic pain can be reduced. [6]

Medical – use of surgical or chemical means: peripherally acting analgesics such as aspirin, centrally acting analgesics e.g. morphine or local anaesthetics. But these are less effective over time. More likely therefore:
Psychological A. cognitive: attention diversion, non-pain imagery or cognitive redefinition. B. behavioural such as biofeedback.
Alternatives such as physical therapy: tens, hydrotherapy and acupuncture.

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

Either general: **Theory A**: the person approach: accidents caused by the unsafe behaviour of people; Prevention is by changing the ways in which people behave; [fitting the person to the job] **Theory B**: the systems approach: accidents caused by unsafe systems at work; Prevention is by redesigning the work system; [fitting the job to the person].

Or specific. Lots of possibilities:

1. people may think they are accident prone (personality) and so self-fulfilling prophesy may apply.
2. people have an illusion of invulnerability – it won't happen to them.
3. people apply motion stereotypes and so do not consider alternatives.
4. people make errors.
5. people on shiftwork have low-point e.g. 2–5 am.

Any appropriate suggestion can receive credit.

(b) Evaluate what psychologists have found out about health and safety. [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 ways in which accidents in the workplace can be reduced. [6]

Under global heading of **health promotion campaigns** come many individual approaches which could take place in worksites specifically or as part of a community. Answers must be psychological.

1 Appeals to fear/fear arousal (Janis & Feshbach, 1953 and Leventhal 1967) is the traditional starting point. This is likely to be included because their *strong fear appeal* could be said to be unethical and are not the most effective. The Yale model (source of message/message/recipient) underlies so many attempts.

2 Providing information via media (e.g. Flay, 1987) 3 approaches: 1] provide negative info only; 2] for those who want to be helped provide first steps; 3] self help via tv audience. Study by Lewin (1992) healthy heart manual also relevant.

PSYCHOLOGY AND ABNORMALITY

Section A

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

Typically: any difference between culture or society or individuals in abnormality.

(b) Describe *one* cultural difference and *one* gender difference in abnormality. [6]

Abnormality does vary from culture to culture. For example, Russia has 51 per 10,000 cases of schizophrenia, Denmark has only 15 per 10,000. Not only are there different abnormalities, but there are very different treatment methods too.
There are gender differences and relationship differences. For example, divorced people are much more likely to be admitted to a US mental hospital (1183 per 100,000) than those who are married (136 per 100,000). The family also has a bearing. One gender difference is lupus (90% women in UK) but also cultural differences in lupus too.

(c) Suggest *one* way an abnormality described in part (b) may be treated. [3]

Most likely: depends on illness. Too many possibilities to list.

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

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

(b) Describe *two* types of abnormal affect. [6]

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) Give *one* way in which a type of abnormal affect may be treated. [3]

Most likely: **ECT** (electroconvulsive therapy)/electroplexy is very common.
Chemotherapy also common. Tranquilizers (e.g. chlorpromazine) for manic episodes and lithium for both manic and depressive episodes.
Psychotherapy also a possibility but less common and less successful.
Light box is most common treatment for SAD.

SECTION B

15 (a) Describe what psychologists have discovered about classifying and diagnosing abnormality. [8]

Many approaches could be taken here. Could be historical, moving from 'witchcraft' to the founders of modern classification such as Kraepelin and others. Emphasis could be on development of DSM and ICD, with details on the categories. This could be general: neuroses and psychoses to a much more specific breakdown. There could be a focus on approaches: medical, psychological, etc. Within these there could be a consideration of behavioural, psychoanalytic, humanistic, etc.

(b) Evaluate what psychologists have discovered about classifying and diagnosing 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 in abnormality;
- comparing and contrasting explanations of cause;
- deterministic explanations;
- nature versus nurture.

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

Most likely: candidates will focus on one of the above aspects, and this will determine the suggested way of overcoming the problem. For example DSM/ICD outlines 'affective disorders', one aspect of this is depression and one main treatment in certain countries is ECT. Answers must be based on appropriate evidence.

16 (a) Describe what psychologists have learned about abnormal adult development. [8]

Typically: general neurological degeneration that occurs as the human body deteriorates with age. Candidates will most likely focus on organic degeneration of the brain. Most well known are Alzheimer's disease and Picks. Both involve atrophy of brain cells resulting in pre-senile dementia.

(b) Evaluate what psychologists have learned about abnormal adult development. [10]

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

- points about defining and categorising abnormal development;
- implications for the individual and carers;
- comparing and contrasting explanations;
- problems with treatments.

(c) Giving reasons for your answer, suggest ways in which the effects of a degenerative abnormality may be reduced. [6]

Medication is most likely – treatments for Alzheimer's (& Picks) being developed all the time. 'Sonic Hedgehog' one of modern treatments.

PSYCHOLOGY AND ORGANISATIONS

Section A

17 (a) Explain, in your own words, what is meant by 'group conflict'. [2]

Typically: conflict is a behaviour by a person or group that is purposely designed to inhibit the attainment of goals by another person or group.

(b) Describe *two* ways in which group decision-making can go wrong. [3]

Most likely: 1. **Groupthink**: syndrome characterised by a concurrence-seeking tendency that overrides the ability of a cohesive group to make critical decisions (Janis, 1965)
2. **Group polarisation**: groups who make decisions that are more extreme than those made by individuals.

(c) Describe *one* way in which group conflict can be managed. [6]

Most likely: encourage evaluation; promoting open enquiry; use sub-groups; admit shortcomings; hold second-chance meetings; don't rush to a quick solution. But any logical suggestion will suffice.

18 (a) Explain, in your own words, what is meant by 'communication flow'. [2]

Typically: 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.).

(b) Describe *two* types of communication network. [6]

Most likely: Candidates will base their answers on communication networks (e.g. Leavitt's (1951) centralised and de-centralised). **Centralised** (flow directed through specific members): chain; 'Y'; and wheel. **Decentralised** (messages originate at any point via no specific group members): circle; all channel.

(c) Give *one* way in which communication flow can be improved. 3

Machin (1980) suggests the expectations approach; **Marchington** (1987) suggests 'team-briefing' Also: employee suggestion systems; grievance systems; open-door policies; employee surveys; participative decision making; corporate hotlines; brown bag meetings; skip-level meetings. Candidates may refer to **Tesser & Rosen's** (1985) the MUM effect, the reluctance to tell superiors of something bad.

Section B

19 (a) Describe what psychologists have discovered about the quality of working life. [8]

QWL involves all aspects of life at work. Answers could focus on any aspect of organisational psychology therefore. Most likely answers will focus on Job satisfaction: the feelings and attitudes about one's job. Two approaches: the global (overall satisfaction) and the facet (composed of different elements/facets) of the job.

QWL/satisfaction can be measured: there are many approaches (interviews, scales, surveys). More popular (in America) are the Minnesota Satisfaction Questionnaire (MSQ) and the Job Descriptive Index (JDI). In Britain Cooper et al's (1987) Occupation Stress Indicator is often used. All can be evaluated for reliability and validity.

Implications: poor performance, absenteeism, high turnover.

(b) Evaluate what psychologists have discovered about the quality of working life. [10]

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

- how psychologists gained their evidence;
- competing theoretical explanations;
- the usefulness of the theories;
- implications for management and workers.

(c) Giving reasons for your answer, suggest ways in which job satisfaction can be measured in teachers. [6]

Any suggestion based on psychological theory acceptable. Most likely: use of questionnaire/self report. Must be based on theory such as (USA) the Minnesota Satisfaction Questionnaire (MSQ) and the Job Descriptive Index (JDI). In Britain Cooper et al's (1987) Occupation Stress Indicator is often used.

20 (a) Describe what psychologists have discovered about human resource practices. [8]

The HRM looks at performance appraisal, reward systems and personnel selection processes. There are many aspects to performance appraisal such as job analysis.

(b) Evaluate what psychologists have discovered about human resource practices. [10]

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

- issues concerning reliability and validity;
- assumptions made by appraisal techniques;
- implications of HRM practices for leader-worker relationships;
- the usefulness of HRM practices.

(c) If you were Human Resource Manager, suggest how you could appraise the performance of employees. [6]

A performance appraisal is a formalised means of assessing worker performance. They are important to both employer and employee. 'Hard' appraisal includes quantifiable measure such as number of units produced in 1 hour. 'Soft' includes judgements or ratings done by line manager.