AQA

ASSESSMENT and QUALIFICATIONS ALLIANCE

General Certificate of Education

Psychology 6186
Specification B

Unit 4 (PYB4)   Child Development and Options: Psychology of Atypical Behaviour *or* Health Psychology *or* Contemporary Topics

Mark Scheme

2007 examination - January series

Mark schemes are prepared by the Principal Examiner and considered, together with the relevant questions, by a panel of subject teachers. This mark scheme includes any amendments made at the standardisation meeting attended by all examiners and is the scheme which was used by them in this examination. The standardisation meeting ensures that the mark scheme covers the candidates' responses to questions and that every examiner understands and applies it in the same correct way. As preparation for the standardisation meeting each examiner analyses a number of candidates' scripts: alternative answers not already covered by the mark scheme are discussed at the meeting and legislated for. If, after this meeting, examiners encounter unusual answers which have not been discussed at the meeting they are required to refer these to the Principal Examiner.

It must be stressed that a mark scheme is a working document, in many cases further developed and expanded on the basis of candidates' reactions to a particular paper. Assumptions about future mark schemes on the basis of one year's document should be avoided; whilst the guiding principles of assessment remain constant, details will change, depending on the content of a particular examination paper.

PYB4

Quality of Written Communication

Candidates are required to:

- select and use a form and style of writing appropriate to purpose and to complex subject matter;

- organise relevant information clearly and coherently, using specialist vocabulary where appropriate;

- ensure spelling, grammar and punctuation are accurate, so that meaning is clear.

The assessment criteria for quality of written communication apply only to questions with 12 marks in A2 unit test questions. The following criteria should be applied in conjunction with the question mark scheme.

The bands for quality of written communication must be regarded as part of the mark scheme even though they are listed separately. If a candidate's quality of written communication fails to meet the achieved content band, then s/he will lose one mark.

Band 1: Excellent quality of written communication

The candidate expresses most ideas clearly and fluently, with consistently effective use of psychological terminology. Arguments are well structured, with appropriate use of sentences and paragraphs. There are few, if any, minor errors of grammar, punctuation and spelling. The overall quality of language is such that meaning is rarely, if ever, obscured.

Band 2: Good to average quality of written communication

The candidate expresses most ideas clearly and makes some appropriate use of psychological terminology. The answer is organised, using sentences and paragraphs. Errors of grammar, punctuation and spelling may be present but are mostly minor, such that they obscure meaning only occasionally.

Band 3: Average to poor quality of written communication

The candidate expresses basic ideas clearly but there may be some ambiguity. The candidate uses key psychological terminology inappropriately on some occasions. The answer may lack structure, although there is some evidence of use of sentences and paragraphs. There are occasional intrusive errors of grammar, punctuation and spelling which obscure meaning.

Band 4: Poor quality of written communication

The candidate shows deficiencies in expression of ideas resulting in frequent confusion and/or ambiguity. Answers lack structure, consisting of a series of unconnected ideas. Psychological terminology is used occasionally, although not always appropriately. Errors of grammar, punctuation and spelling are frequent, intrusive and often obscure meaning.

Note: The main body of the answer should be assessed for Quality of Written Communication. Neither a sketched plan at the start of an answer, nor a list of points at the end of an answer where a candidate has clearly run out of time, should be assessed for quality of written communication.

SECTION A: Child Development

1   **Total for this question: 20 marks**

(a)   The following are all aspects of the development of the self:

- categorical self;
- existential self;
- high self-esteem;
- low self-esteem.

In your answer book, write down which of the aspects of self listed above is illustrated by **each** of the following:

(i)   Meena is very pleased with herself when she gets a gold star for reading at school.

(ii)   Oscar can recognise a photograph of himself.

(iii) Charlie knows that he is a boy.   *(3 marks)*

[AO1 = 0, AO2 = 3]

AO2   (i)   high self-esteem
            (ii)   existential self
            (iii) categorical self

(b)   Describe **one** technique that psychologists have used to investigate attachment.   *(5 marks)*

[AO1 = 5, AO2 = 0]

AO1   Up to 5 marks for an effective description. Most candidates will describe Ainsworth's Strange Situation. Credit details as follows: controlled observation; various stages; mother with baby; stranger enters; mother leaves; recording of behaviour of child with stranger; recording of behaviour when mother returns; use of categorisation system; 3 categories - anxious avoidant, anxious resistant; secure. Other methods are also acceptable, eg Hazan and Shaver, Bowlby's 44 juvenile thieves.

(c)   Describe and discuss the role of caregiver-infant interactions in the development of attachment.
                                                                                (12 marks)

[AO1 = 5, AO2 = 7]

AO1   Up to 5 marks for knowledge and understanding of psychological theory and evidence in relation to caregiver-infant interaction. Candidates may focus on just one type of behaviour or area of research and expand on it, or may refer to several areas in less detail. Likely content: Ainsworth's sensitive responsiveness hypothesis; research into early bonding (Klaus and Kennell); turn-taking (Schaffer); animal studies (Harlow's privation research). Credit description of relevant evidence up to 3 marks.

AO2   Up to 7 marks for discussion of the role of interactions in the development of attachment. Possible evaluative points: attachments still possible even following severe deprivation (Tizard); issue of intentionality in research with young infants; implications of successful/unsuccessful caregiver-infant interactions; research issues, eg. validity of Ainsworth's work as a basis for sensitive responsiveness hypothesis; establishing cause and effect or the validity of measures used in research; different types of interactions with father/others; possible alternative explanations, eg cupboard love theory. Credit use of relevant evidence.

Mark Bands

12 – 10 marks   **Excellent answers**

There is detailed description showing sound knowledge and understanding. Discussion is balanced, with appropriate analysis. Evaluative comment is presented in the context of the discussion as a whole. The answer is well focused on the roles of interactions in attachment, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks   **Good to average answers**

Answer shows knowledge and understanding and there is an attempt to present an organised discussion. The answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. The answer is not as well balanced as for the top band.

6 – 4 marks   **Average to poor answers**

Answer shows some relevant knowledge and understanding but will probably lack detail and/or be quite unbalanced. Answers constituting reasonable description with minimal focus on the question are likely to be in this band. There may be considerable irrelevance and/or inaccuracy. Must be some discussion for 6 marks.

3 – 1 marks   **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief answer may come into this band.

Total AO1 marks for Question 1: 10
Total AO2 marks for Question 1: 10
Total marks for Question 1: 20

2   **Total for this question: 20 marks**

(a)   Using an example, outline what is meant by *enactive representation*.   *(3 marks)*

[AO1 = 2, AO2 = 1]

AO1   Encoding information/storing information/mental storage/remembering/memory (1).
            In the form of actions/movement/as a muscle memory (1).

AO2   1 mark for an example, eg a baby might remember the action of shaking a rattle.

(b)   Outline and briefly discuss **one** similarity between the theories of cognitive development proposed
        by Bruner and Vygotsky.   *(5 marks)*

[AO1 = 2, AO2 = 3]

AO1   Up to 2 marks for knowledge of a similarity between Bruner's and Vygotsky's theories of
            cognitive development. One mark for a similarity briefly noted/identified, 2 marks for a more
            detailed answer. The most likely similarity is emphasis on the social world/other
            people/peers/parents as a support for cognitive development, but any relevant answer should be
            credited. Points are likely to overlap here so take a liberal approach to what constitutes **one**
            similarity.

AO2   Up to 3 marks for discussion of the similarity. Credit evaluation, analysis and/or application,
            eg advantages/limitations of either theory; the implications for cognitive developmental theory;
            implications for education/child care practice; comparison with Piaget.

(c)   Describe and discuss Piaget's research into cognitive development in the pre-operational and
        concrete operational stages.   *(12 marks)*

[AO1 = 6, AO2 = 6]

AO1   Up to 6 marks for descriptions of Piaget's research. Expect reference to work on conservation
            (various substances), egocentrism (eg 3 mountains) seriation and class inclusion. Credit
            description of relevant evidence up to 3 marks for one study, accurate and in detail. Maximum
            3 marks if only one type of research, eg only conservation.

AO2   Up to 6 marks for discussion and analysis. Candidates are expected to offer a sound and
            comprehensive evaluation of the research for full marks. Marks may be awarded for each valid
            point, eg sampling problems; lack of realism; lack of human sense; complexity of
            procedures/instructions; contradictory findings, eg Hughes, Donaldson. Credit use of relevant
            evidence, eg discussing findings.

Mark Bands

12 – 10 marks   **Excellent answers**

There is detailed description of research showing sound knowledge and understanding. Discussion shows appropriate analysis. Evaluative comment is presented in the context of the discussion as a whole. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding. Note that reference to the sensorimotor and formal operations stages constitutes notable irrelevance.

9 – 7 marks   **Good to average answers**

Answer shows knowledge and understanding and there is an attempt to present an organised discussion. The answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. The answer is not as well balanced as for the top band. At the top of the band the answer should include reference to more than one type of study.

6 – 4 marks   **Average to poor answers**

Answer shows some relevant knowledge and understanding but will probably lack detail and/or be quite unbalanced. Answers constituting reasonable description with minimal focus on the question are likely to be in this band. There may be considerable irrelevance and/or inaccuracy.

3 – 1 marks   **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief answer may come into this band.

Total AO1 marks for Question 2: 10
Total AO2 marks for Question 2: 10
Total marks for Question 2: 20

3   **Total for this question: 20 marks**

(a)	Briefly describe how psychologists use the moral dilemma technique to investigate moral understanding. *(2 marks)*

[AO1 = 2, AO2 = 0]

AO1   1st mark - participant hears a story in which someone makes a moral decision/decides to act in a certain way.

2nd mark for **either** of the following: participant then answers questions about the story; answers are categorised/used to indicate level of moral judgement.

Can credit both elements if embedded in example.

(b)	According to some psychological theories, boys are morally more advanced than girls. With reference to **two different** theories of moral development, explain why this sex difference in moral understanding is thought to occur. *(6 marks)*

[AO1 = 2, AO2 = 4]

AO1   One mark each for correctly identifying Kohlberg's and Freudian/psychoanalytic theory as ones that suggest that male morality is more advanced.

AO2   Award up to 2 marks each for each explanation as follows:

Kohlberg: suggests males reach stage 4 (law and order) whilst most females remain at stage 3 (good-boy, good-girl) (1); this happens because women tend to reason more by responsibilities/empathy/care whereas men reason by rights (1).

Freud/psychoanalytic theory: suggests males identify more strongly with the same sex parent than girls (1), thus their internalised morality/superego/conscience is stronger (1).

(c)	Describe and discuss Gilligan's theory of moral development. *(12 marks)*

[AO1 = 6, AO2 = 6]

AO1   Up to 6 marks for knowledge of Gilligan's theory. Likely content: knowledge of named stages - self-interest; self-sacrifice; non-violence; explanations of each stage; reference to morality of care v morality of justice; descriptions of Gilligan's abortion research. Credit description of Gilligan's evidence up to 2 marks. Can also award one mark for description of other evidence.

AO2   Up to 6 marks for discussion and analysis. Candidates may offer an evaluation of both theory and research. Marks should be awarded for valid points, eg use of real-life dilemmas as opposed to hypothetical ones; some research shows no difference in orientation between males and females (Walker 84); comparisons with the work of other researchers, particularly Kohlberg; both males and females can switch from one orientation to the other (Johnston 88); type of reasoning (care v justice) depends more on type of dilemma than on gender of participant. Credit use of relevant evidence.

Mark Bands

12 – 10 marks   **Excellent answers**

There is detailed description of theory/research showing sound knowledge and understanding. Discussion shows appropriate analysis. Evaluative comment is presented in the context of the discussion as a whole. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks   **Good to average answers**

Answer shows knowledge and understanding and there is an attempt to present an organised discussion. The answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. The answer is not as well balanced as for the top band.

6 – 4 marks   **Average to poor answers**

Answer shows some relevant knowledge and understanding but will probably lack detail and/or be quite unbalanced. Answers constituting reasonable description with minimal focus on the question are likely to be in this band. There may be considerable irrelevance and/or inaccuracy.

3 – 1 marks   **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief answer may come into this band.

Total AO1 marks for Question 3: 10
Total AO2 marks for Question 3: 10
Total marks for Question 3: 20

4   **Total for this question: 20 marks**

(a)   Briefly discuss **one** explanation for dyslexia.   *(5 marks)*

[AO1 = 2, AO2 = 3]

AO1   Up to 2 marks for knowledge of an explanation for dyslexia. One mark for identification
            and/or vague description, second mark for extra detail/elaboration. Likely answers: genetics;
            phonological deficit.

AO2   Up to 3 marks for brief discussion. Candidates may focus on a single issue, eg supporting/
            contradictory evidence, or may refer very briefly to several issues.

(b)   Eva is in her second term at primary school. Her teacher thinks that Eva may be gifted because she
         has noticed how she differs from the other children in her class.

   (i)   Identify **three** differences between Eva and the other children in her class that could have
             led the teacher to think that Eva might be gifted.   *(3 marks)*

[AO1 = 3, AO2 = 0]

AO1   One mark for each difference identified to a maximum of 3 marks. Likely answers: Eva is well
            in advance of her peers; Eva has a special talent, eg for music/mathematics; Eva has a keen
            awareness of her own cognitive abilities; Eva has an exceptional memory; Eva copes well with
            novel problems; Eva finds it difficult to relate to children of her own age.

   Eva is given a formal psychological assessment and her parents are told that she is a gifted child.

   (ii)   Describe and discuss **two** possible implications for Eva and/or her family of her being
             identified as gifted. Refer to psychological evidence in your answer.   *(12 marks)*

[AO1 = 5, AO2 = 7]

AO1   Up to 5 marks for description of two possible implications to be awarded as follows: 1 mark for
            identifying an implication plus up to 2 marks for elaboration. Expect a variety of approaches to
            this question. Likely content: labelling leading to expectations from parents/teachers/self;
            effect on self-esteem; parental attitudes as a possible cause of problems (Freeman (1979); hot-
            housing; special provision; acceleration in school; enrichment facilities - extra-curricular/
            summer schools etc; peer relationship/prosocial difficulties. Credit description of relevant
            evidence up to 2 marks.

AO2   Up to 7 marks for discussion and analysis. Candidates might explore the relative advantages
            and disadvantages of high expectations and use of special provision. Evidence might be used
            to discuss the benefits of enrichment programmes (Stanley & Benbow 1983) or the positive
            effects of acceleration (Kulik & Kulik 1984). Quality of special provision and use of the whole
            child approach might also be discussed. Although not usually a direct consequence of being
            identified as gifted, candidates might also legitimately discuss the psychosocial difficulties
            encountered by gifted children. Credit use of relevant evidence.

Maximum 7 marks if only one implication is discussed
Maximum 8 marks if no evidence presented

Mark Bands

12 – 10 marks   **Excellent answers**

There is detailed knowledge of two implications with sound understanding. There is appropriate reference to evidence and appropriate analysis. Evaluative comment is presented in the context of the discussion as a whole. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks   **Good to average answers**

Answer shows knowledge and understanding and there is an attempt to present an organised discussion. For 9 marks there must be some relevant evidence. The answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. The answer is not as well balanced as for the top band. For 8/9 marks there must be reference to two implications.

6 – 4 marks   **Average to poor answers**

Answer shows some relevant knowledge and understanding but will probably lack detail and/or be quite unbalanced. Answers constituting reasonable description with minimal focus on the question are likely to be in this band. There may be considerable irrelevance and/or inaccuracy.

3 – 1 marks   **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief answer may come into this band.

Total AO1 marks for Question 4: 10
Total AO2 marks for Question 4: 10
Total marks for Question 4: 20

SECTION B: Options

5   **Total for this question: 20 marks**

(a)   Suzannah, aged 54 years, and Jack, aged 28 years, suffer from anxiety and extreme tiredness. They each visit the doctor for help.

Outline what is meant by *stereotyping*. Suggest **one** way in which stereotyping might affect the doctor's assessment in **each** case above.   *(4 marks)*

[AO1 = 2, AO2 = 2]

AO1   Up to 2 marks for an outline of stereotyping as follows: assumption/overgeneralisation about behaviours/attitudes/characteristics (1) based on membership of a group/single characteristic (1) (or similar).

AO2   One mark for each valid application which may be based on either gender or age.

Likely responses:
Jack is young/male therefore doctor might assume stress/to do with work, etc
Suzannah is older/female therefore doctor might assume depression/ menopause/loneliness/ empty nest syndrome, etc.

(b)   State what is meant by the *sick role* and the *expert role*. Briefly explain how **each** might affect diagnosis of abnormal behaviour.   *(4 marks)*

[AO1 = 2, AO2 = 2]

AO1   One mark each for knowledge of what is meant by each term:
Sick role - behaviours/attitudes adopted by one who defines him/her self as ill.
Expert role - behaviours attitudes adopted by one who is defined by virtue of status/job as more knowledgeable.

AO2   One mark each for explanation of how each could affect diagnosis of abnormal behaviour.
A variety of answers are possible, for example
Person adopting the sick role (presenting patient) might feel compelled to actively elicit diagnosis/exaggerate symptoms/selectively report experiences.
Person adopting expert role (doctor) feel obliged to offer diagnosis/treatment.

(c)   With reference to **two** different definitions, describe and discuss practical and/or ethical problems involved in defining abnormality.   *(12 marks)*

[AO1 = 6, AO2 = 6]

AO1   Up to 6 marks for knowledge of 2 definitions and identification/description of associated problems. Allow one mark for identification of each definition. Allow up to 4 marks for practical and ethical problems. Note: there may sometimes be lack of clear distinction.

Valid definitions: statistical infrequency; deviation from social norms; distress; maladaptiveness; cultural norms; deviation from good mental health.

Valid problems: statistical infrequency - ignores issue of desirability; cut-off point arbitrary; how to gauge distress; social norms - relative to time and place therefore social construction; distress - how to gauge and whose is more important? maladaptiveness - value-laden implying a certain way of life is acceptable and another is not; cultural relativity therefore not an absolute. Other valid issues may be credited.

Take care not to over-credit where candidates offer more than 2 definitions.
Credit description of relevant evidence up to 1 mark.

AO2   Up to 6 marks for expansion/discussion/analysis of the problems identified. Candidates should be awarded AO2 marks for application where they illustrate the issues using examples. As part of their discussion, candidates may offer other ways of defining abnormality and be credited with AO2 marks, however these should be integrated into the response as a whole and not simply listed or tacked on. Credit use of relevant evidence.

Maximum 7 marks if only one definition is discussed

Mark Bands

12 – 10 marks   **Excellent answers**

There is detailed knowledge of two definitions with sound understanding. Problems associated with each are clearly outlined. Analysis/application is presented in the context of the discussion as a whole. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks   **Good to average answers**

Answer shows knowledge and understanding of definitions and associated problems. There is an attempt to present an organised discussion. For 8 marks there must be reference to two definitions. The answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. The answer is not as well balanced as for the top band.

6 – 4 marks   **Average to poor answers**

Answer shows some relevant knowledge and understanding but will probably lack detail and/or be quite unbalanced/disorganised. Answers constituting reasonable description with minimal focus on the question are likely to be in this band. There may be considerable irrelevance and/or inaccuracy.

3 – 1 marks   **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief answer may come into this band.

Total AO1 marks for Question 5: 10
Total AO2 marks for Question 5: 10
Total marks for Question 5: 20

6   **Total for this question: 20 marks**

(a)   Using an example, explain what is meant by *obsessive-compulsive disorder*.   *(4 marks)*

[AO1 = 2, AO2 = 2]

AO1   One mark each for knowledge of each element of OCD:
Obsession - persistent intrusive thought (1)
Compulsion - performance of an action/behaviour (repeatedly) (1).

AO2   One mark each for each element of OCD illustrated in the example,
eg Obsession – worrying about the door being locked (1)
       Compulsion – repeatedly checking the door is locked (1).

(b)   Describe **one** explanation for post-traumatic stress syndrome (PTSS).   *(4 marks)*

[AO1 = 4, AO2 = 0]

AO1   Candidates should describe one explanation for PTSS for up to 4 marks.
Likely answers:
- biological vulnerability - family history of anxiety disorders, True et al 1993 twin studies;
- psychological vulnerability due to early exposure to unpredictable/uncontrollable events, eg family instability (Chorpita & Barlow 1998) (King 1996 study of 1600 Vietnam veterans); mediating effect of psychological preparedness, eg pre-operative inoculation;
- lack of social support, eg family, close friends (Vernberg et al 1996 - school children post Hurricane Andrew);
- neurological correlates - damage to the hippocampus (Gurvits et al 1996), leading to memory disruption; elevated levels of corticotropin-releasing factor.

Award one mark only if candidates merely identify the traumatic event as a cause.

(c)   Eating disorders have often been linked to pressures in society and family experiences. Discuss societal **and** family pressure as explanations of eating disorders. Refer to evidence in your answer.
          (12 marks)

[AO1 = 4, AO2 = 8]

AO1   Award up to 4 marks for knowledge of societal and family pressure explanations.
Usually award up to 2 marks for societal explanations and up to 2 marks for family explanations.

Likely content:
Social: social learning explanation; imitation; modelling; vicarious reinforcement; cultural desirability; Western ideals; media content (magazines/TV/celebrity); conformity.

Family: Modelling; reinforcement; psychodynamic explanations - enmeshed families/ family systems theory (Minuchin 1975); struggle for autonomy; exerting control; communication difficulties.

Credit description of relevant evidence up to 2 marks.

AO2   Up to 8 marks for evaluation, analysis, use of evidence. Possible discussions points: reference to cross-cultural differences in prevalence; changes in incidence that parallel cultural changes (eg TV); sex differences; counter-arguments in favour of biological explanations; blaming the family; problem establishing cause and effect; use of correlational data; class differences; scientific status of psychodynamic theory.

Examples of relevant evidence: Ogden 1992; Furnham & Baguma 1994 - ideal body shape; Wiseman et al 1992 - Miss America; Levine & Smolak 1995 - TV watching correlation; Humphrey 1989 - family communication; Pike & Rodin 1991 - family interaction patterns. Credit use of relevant evidence.

Maximum 7 marks if only one explanation (social or family) is discussed
Maximum 8 marks if no evidence is presented

Mark Bands

12 – 10 marks   **Excellent answers**

There is detailed knowledge of both explanations with sound understanding. Evaluation/analysis is presented in the context of the discussion as a whole. Evidence is relevant and clearly outlined. The answer is balanced, well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks   **Good to average answers**

Answer shows knowledge and understanding of both explanations (although an exceptional answer referring to just one might gain a maximum of 7 marks). There is an attempt to present an organised discussion. For 8 marks there must be reference to relevant evidence. The answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. The answer is not as well balanced as for the top band.

6 – 4 marks   **Average to poor answers**

Answer shows some relevant knowledge and understanding but will probably lack detail and/or be quite unbalanced/disorganised. Answers constituting reasonable description with minimal focus on the question are likely to be in this band. There may be considerable irrelevance and/or inaccuracy. There must be some discussion for 5/6 marks.

3 – 1 marks   **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief answer may come into this band.

Total AO1 marks for Question 6: 10
Total AO2 marks for Question 6: 10
Total marks for Question 6: 20

7   **Total for this question: 20 marks**

(a)   Describe how a cognitive therapist might treat a patient with unipolar depression.   *(4 marks)*

[AO1 = 4, AO2 = 0]

AO1   Up to 4 marks for a description of cognitive therapy for depression. Candidates are expected to describe elements of either CBT, RET or SIT but a generic approach involving features of two/all of these is also acceptable. Credit relevant points as follows: aim to change patient's negative set; involves identification of illogical/irrational beliefs; hypothesis generation; scientific testing of illogical beliefs; reinforcement of positive thoughts; patient as scientist/patient gathers data; results in cognitive restructuring; rational confrontation; use of positive self-statements. Allow one mark for naming a cognitive therapy.

(b)   Briefly discuss **one** explanation for bipolar depression.   *(4 marks)*

[AO1 = 2, AO2 = 2]

AO1   Up to 2 marks for knowledge of an explanation. Most candidates will offer the genetic explanation but candidates who outline any relevant alternative (eg biochemical/ psychodynamic explanations) should be able to access full credit.
One mark for vague, extremely brief answer. Two marks for some further detail and use of appropriate terms.

AO2   Up to 2 marks for comment on, or evaluation of, the explanation given. Candidates may make two brief points or expand on one. Likely issues: specific evidence for/against; use of correlation; use of twin studies; is it cause or effect; lack of evidence for Freud's theory of the tripartite personality.

(c)   Anthony, aged 24 years, has recently been diagnosed with schizophrenia. Two of his aunts have been treated for schizophrenia. When asked about his parents, he says they did not get on well. His mother was harsh, demanding and difficult to talk to. His father was hardly ever at home.

Discuss **at least two** explanations for schizophrenia. Refer to Anthony's case in your answer.
    (12 marks)

[AO1 = 4, AO2 = 8]

AO1   Up to 2 marks each for the two explanations. Given the text, the most likely answers are: genetic/heritability - chromosomes/DNA; linked to biochemical imbalance - the dopamine hypothesis - excess or increased sensitivity of dopaminergic neurons; psychodynamic theory - repressed conflict - regression to infancy; family/communication problems - the schizophrenogenic mother/passive father; double-bind communication; high expressed emotion.

Other valid explanations should be credited with AO1 marks although they are unlikely to lend themselves to the text for AO2 marks (abnormal brain structure - ventricle enlargement, frontal lobe activity; viral infection - influenza in second trimester; cognitive theory - attentional deficit, inability to distinguish between external stimuli and own thought).

Credit description of relevant evidence up to 1 mark.

AO2   Up to 6 marks for discussion and analysis. Candidates may be awarded up to 3 marks each for discussion of each explanation. Discussion points will vary according to the explanation chosen but could include use of evidence for/against; comment on evidence; issue of cause/effect; alternatives.

Reserve two marks for application: genetics/biochem - Anthony has relatives who also had schizophrenia; family - Anthony's mother is cold and unfeeling/poor communication in family; high EE. Credit use of relevant evidence.

Maximum 7 marks if only one explanation is discussed

Mark Bands

12 – 10 marks   **Excellent answers**

There is detailed knowledge of both explanations with sound understanding. Evaluation/analysis is presented in the context of the discussion as a whole. The answer is balanced, well focused, organised and mostly relevant with little, if any, misunderstanding. There must be valid application for 11/12 marks.

9 – 7 marks   **Good to average answers**

Answer shows knowledge and understanding of both explanations (although an exceptional answer referring to just one might gain a maximum of 7 marks). There is an attempt to present an organised discussion. The answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. The answer is not as well balanced as for the top band.

6 – 4 marks   **Average to poor answers**

Answer shows some relevant knowledge and understanding but will probably lack detail and/or be quite unbalanced/disorganised. Answers constituting reasonable description with minimal focus on the question are likely to be in this band. There may be considerable irrelevance and/or inaccuracy.

3 – 1 marks   **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief answer may come into this band.

Total AO1 marks for Question 7: 10
Total AO2 marks for Question 7: 10
Total marks for Question 7: 20

8   **Total for this question: 20 marks**

(a)   Outline **two** features of the psychodynamic approach to therapy.   *(4 marks)*

[AO1 = 4, AO2 = 0]

AO1   Award 1 mark for each feature identified plus another mark each for expanded description of the feature.
Likely answers: accessing repressed fears/wishes in the unconscious; retrospective analysis; association; dream interpretation; analysis of slips of the tongue; analysis of resistance; analysis of transference; catharsis.

Although not strictly a feature, reference to 'use of the case study method' may be awarded one mark.

(b)   Explain **one** way in which personal, social or cultural influences could affect the acceptability of a treatment or therapy for atypical behaviour. Illustrate your answer with reference to an example.
(4 marks)

[AO1 = 2, AO2 = 2]

AO1   One mark for identification and one mark for description of a relevant personal, social or cultural influence. A variety of answers are possible, eg family background, social class, religion, race/ethnicity, personality factors, co-morbid condition.

AO2   One mark for how/why the influence identified for AO1 could affect choice of treatment or therapy, and 1 mark for the example.

Example - a person from an ethnic minority background (AO1), where families and communities are close-knit, such as Indian (AO1), might be less inclined to accept treatment because the patient would rather choose to be cared for by their own community (AO2 explanation + AO2 example embedded).

(c)   Discuss the behaviourist approach to therapy. In your answer you should explain how behaviourist assumptions about the causes of atypical behaviour influence behaviourist therapies.   *(12 marks)*

[AO1 = 4, AO2 = 8]

AO1   Up to 4 marks for knowledge of the behaviourist approach to therapy. Candidates may gain marks through reference to general principles, eg use of classical or operant conditioning techniques, or through reference to specific aspects of named behaviourist therapies, eg systematic desensitisation, flooding, aversion therapy, etc. Maximum 2 AO1 marks for answers that do not include appropriate use of behaviourist terminology. Credit description of relevant evidence up to 2 marks.

AO2   Up to 6 marks for general discussion and analysis. Likely points: does not treat the cause; highly focused; effectiveness; ease of application; restores function; ethical issues. Credit reference to other therapies only if they are integrated into the discussion as a whole.

At least 2 marks should be awarded for an explanation of how behaviourist therapies are underpinned by behaviourist assumptions about the cause of atypical behaviour, eg since behaviourists believe atypical behaviour is learnt this means therapy involves learning more adaptive behaviours instead; behaviourists believe atypical behaviour is acquired through either association or reinforcement, therefore therapies use classical/operant techniques.

Credit use of relevant evidence.

Mark Bands

12 – 10 marks   **Excellent answers**

There is detailed knowledge of the behaviourist approach to therapy with sound understanding. Evaluation/analysis is presented in the context of the discussion as a whole. The answer is balanced, well focused, organised and mostly relevant with little, if any, misunderstanding. For 11/12 marks there must be some explanation of how behaviourist therapies are influenced by behaviourist assumptions about the cause of atypical behaviour.

9 – 7 marks   **Good to average answers**

Answer shows knowledge and understanding of the behaviourist approach to therapy. There is an attempt to present an organised discussion. The answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. The answer is not as well balanced as for the top band.

6 – 4 marks   **Average to poor answers**

Answer shows some relevant knowledge and understanding but will probably lack detail and/or be quite unbalanced/disorganised. Answers constituting reasonable description with minimal focus on the question are likely to be in this band. There may be considerable irrelevance and/or inaccuracy. Must be some discussion for 5/6 marks.

3 – 1 marks   **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief answer may come into this band.

Total AO1 marks for Question 8: 10
Total AO2 marks for Question 8: 10
Total marks for Question 8: 20

9   **Total for this question: 20 marks**

(a)	Visualisation is an example of a complementary approach to health.
	(i) Outline what is meant by a *complementary approach* to health. *(2 marks)*

[AO1 = 2, AO2 = 0]

AO1   Up to 2 marks for knowing what is meant by complementary:
An alternative approach to therapy/treatment (1)
Used in conjunction with or instead of traditional/conventional medicine (1)

(ii) Explain how visualisation can be used in this context.   *(2 marks)*

[AO1 = 0, AO2 = 2]

AO1

AO2   Up to 2 marks for explanation via example. Candidates are expected to suggest how
visualisation might be used alongside or instead of a more conventional treatment to treat any
condition. For example, they might describe how a person with high blood pressure (1) (who
is being treated with medication (1)), might derive benefit/additional benefit from visualisation
of tranquil scenes (1), etc.

(iii) Name and outline two complementary approaches to health, apart from visualisation. *(4 marks)*

[AO1 = 4, AO2 = 0]

AO1   One mark each for naming two complementary approaches other than visualisation. The most
likely answers will be aromatherapy and meditation, but other complementary treatments
should be credited. Award one further mark each for any valid descriptive point, eg
Aromatherapy - application of essential oils through massage/bathing/inhalation
Meditation - focusing mind on images/sounds/thoughts (+ mantra/posture) to induce relaxation.

(b) Discuss problems health psychologists have in defining health and illness.   *(12 marks)*

[AO1 = 4, AO2 = 8]

AO1   Up to 4 marks for identifying problems in defining health and illness. Likely problems: need to
consider the psychological and social as well as the physical; subjectivity; cultural/political/
historical relativity; cannot be reified; neither is absolute; need to consider illness-wellness
continuum. Credit references to different concepts of health, eg positive, negative and holistic.
Credit description of relevant evidence up to 1 mark.

AO2   Up to 8 marks for discussion/expansion of problems identified above in the context of health
psychology. Candidates should be credited for definitions offered and then deconstructed with
reference to the problems given above. Credit application where candidates use examples to
illustrate the issues. For example, the subjective nature of illness might mean that one person
with chronic arthritic pain might consider themselves to be ill, whilst another might accept it as
a normal part of the ageing process and still define themselves as healthy.
Credit use of relevant evidence.

Mark Bands

12 – 10 marks   **Excellent answers**

There is detailed knowledge of at least two problems of defining health/illness with sound understanding of concepts in health psychology. Discussion/analysis is clear and well argued. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks   **Good to average answers**

Answer shows knowledge and understanding of at least two problems of defining health/illness. There is an attempt to present an organised discussion. The answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding.

6 – 4 marks   **Average to poor answers**

Answer shows some relevant knowledge and understanding but will probably lack depth and/or be quite disorganised. Answers constituting reasonable description with minimal focus on the question are likely to be in this band. There may be considerable irrelevance and/or inaccuracy. Must be some discussion for 5/6 marks.

3 – 1 marks   **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief answer may come into this band.

Total AO1 marks for Question 9: 10
Total AO2 marks for Question 9: 10
Total marks for Question 9: 20

10   **Total for this question: 20 marks**

(a)   Outline the role of **two** factors involved in coronary heart disease (CHD).   *(4 marks)*

[AO1 = 4, AO2 = 0]

AO1   One mark each for each factor identified, plus a further mark each for outline.
Likely factors:
Personality type - Type A - excessive competitiveness, impatience, hostility and vigorous speech (Friedman and Rosenman (1959).
Degree of autonomy/control - Karasek & Theorell (1990) combination of high job demand and low autonomy increases risk.
Smoking - increases risk of CHD in middle age threefold.
Diet - high cholesterol levels increase risk. These are determined by amount of saturated fat consumed.
High blood pressure - increases risk. May be genetic or due to salt intake, alcohol consumption or obesity.

(b)   Briefly discuss psychological intervention in cases of coronary heart disease (CHD).   *(4 marks)*

[AO1 = 2, AO2 = 2]

AO1   Up to 2 marks for knowledge of one (or more) psychological intervention(s) used in CHD.
Award 1 mark for the intervention very briefly identified/outlined and 2 marks for intervention outlined with some detail.
Possible answers: behaviour change/rehabilitation programmes involving health education and counselling to increase exercise/change diet/ stop smoking; modification of Type A behaviour, eg the recurrent coronary prevention programme (Friedman et al 1986); modification of stress via stress management - identification of stress-inducing situations, self-monitoring, self-talk, relaxation, life-management.

AO2   Up to 2 marks for brief discussion of the intervention. Candidates are likely to refer to issues such as practicality and effectiveness. Evidence should be credited. Possible content: favourable effects of exercise/dietary programmes; reduction of re-infarction following Type A modification; controversy over relationship between Type A and CHD; combination effect - stress reduction better when combined with exercise (Bundy et al 1998); need for patient motivation.

(c)   Discuss **at least two** ways of measuring pain. Refer to empirical research in your answer.
                                                                                                    (12 marks)

[AO1 = 4, AO2 = 8]

AO1   Up to 2 marks for each way according to detail. Award 1 mark for identifying way with a further possible mark for description (maximum 2 marks if candidate just identifies two ways).
Self-report - interview, questionnaire, eg The McGill Pain Questionnaire which has 4 dimensions (location, feeling, over time, strength), rating scale, eg visual analogue scale - mark on a single dimension, diary method.
Behavioural analysis - cold-pressor stimulation to test tolerance to pain - controlled immersion of forearm in cold water for measured duration, observation - limping, grimacing, sleep duration, use of pain behaviour scale to assess performance on standardised activity tasks.
Physiological measures - EMG - electromyograph to measure electrical activity in muscles/muscle tension, GSR - skin conductance increases when patient experiences pain,

ECG - heart rate increases when patient experiences pain.
Candidates may choose two ways from the same category, eg two self-report measures.
Credit description of relevant evidence up to 1 mark.

AO2   Up to 8 marks for discussion, evaluation and use of evidence. Possible points: self-report may not be valid; subjectivity of pain; problems of particular measures of self-report, eg personal interpretation of words used on Qs ('smart', 'sting' etc); objectivity of behavioural measures; cold-pressor is a measure of tolerance not pain arising from a medical condition; tolerance depends on subjective experience; objectivity of physiological measures; physiological measures measure changes on physical state but do not always reflect subjective experience; sex differences in willingness to admit to pain (Goolkasian 1985). Credit use of relevant evidence.

Maximum 7 marks if only one way presented
Maximum 8 marks if no evidence presented

Mark Bands

12 – 10 marks   **Excellent answers**

There is detailed knowledge of two ways of measuring pain. Answer shows sound understanding of issues related to pain measurement. Discussion/evaluation of both ways is clear and well argued. Relevant evidence is presented. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks   **Good to average answers**

Answer shows knowledge and understanding of two ways of measuring pain. There is an attempt to present an organised discussion. For 8 marks there must be some relevant evidence presented. There may be some irrelevance and/or misunderstanding. An exceptional answer referring to only one way may gain a maximum of 7 marks.

6 – 4 marks   **Average to poor answers**

Answer shows some relevant knowledge and understanding but will probably lack depth and/or be quite disorganised. Answers constituting reasonable description but minimal effective discussion are likely to be in this band. There may be considerable irrelevance and/or inaccuracy, or focus almost entirely on one way. Must be some discussion for 5/6 marks.

3 – 1 marks   **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief answer may come into this band.

Total AO1 marks for Question 10: 10
Total AO2 marks for Question 10: 10
Total marks for Question 10: 20

11   **Total for this question: 20 marks**

(a)   Name and describe **one** psychological theory of lifestyle change.   *(4 marks)*

[AO1 = 4, AO2 = 0]

AO1   One mark for naming a relevant theory and up to 3 marks for description. Likely answers:
Self-efficacy (Bandura); planned behaviour (Ajzen); health belief model (Becker/Rosenstock).
For the description marks, award 1 mark for each feature of the theory outlined. For example,
self-efficacy - focus on perceived control; involves consideration of own confidence in ability
to perform the desired behaviour/achieve a goal; people with high self-efficacy are better able
to respond to stressors; depends on cognition, motivation, affect and selectivity.
Award a maximum of 1 mark for answers based on general psychological theory, eg SLT.

(b)   Ian is 42 years old. He works long hours and rarely finds time to eat regularly. He has smoked
since he was at school. He tried to give up once, but could not. Ian often feels unwell and his
doctor has told him that he would be a lot healthier if he could give up smoking and lose weight.
The doctor recommends a course to help him stop smoking and suggests he goes on a diet.

  (i)   Briefly discuss how the theory of lifestyle change you have described in your answer to part
(a) explains Ian's efforts to give up smoking.   *(4 marks)*

[AO1 = 0, AO2 = 4]

AO2   Here the marks are for application of knowledge of a theory of lifestyle change to the example,
eg (self-efficacy) Ian is likely to stop smoking if he believes in his ability to succeed - this
belief will affect his intention to try and his likely success. Ian will estimate chance of success/
failure on prior observations of self/others - he has failed before/Ian may see other people can
give up affecting his motivation; Ian has the motivation - his ill health; Ian does not respond
well to stress - smokes more if work is difficult.

  (ii)   The week after he visits the doctor, Ian goes to a nutrition expert who practises a behavioural
approach to dieting and weight loss.

Describe and discuss the behavioural approach to dieting and weight loss. Briefly refer to
the case of Ian in your answer.   *(12 marks)*

[AO1 = 6, AO2 = 6]

AO1   Up to 6 marks for knowledge/understanding of behavioural approach to dieting and weight
loss. Typical components of a behaviour program include: self-monitoring keeping record of
food eaten, when, where etc; stimulus control techniques, eg using lists, storing food out of
sight, etc; eating methodically, eg replacing utensils after each mouthful; contingency
contracting by use of a reward system. References to cognitive restructuring as a wider
component of behavioural programs should be credited, as should information about family-
based behavioural treatments for obese children. Credit also references to specific programs,
eg Stuart 1967, Straw 1983, Stunkard 1987) Aversion therapy involving pairing food with
unpleasant stimuli, although not effective, has been used, so should be credited. Credit both
specific techniques and the behavioural approach generally. Credit descriptions of relevant
evidence up to 2 marks.

AO2   Up to 4 marks for evaluation of behavioural techniques for weight loss and diet and 2 marks for application. Relevant discussion points: effectiveness including outcome of particular studies; relative usefulness with different client groups; drop out rates (usually low); comparison with other approaches including medical treatments; long-term outcomes – most patients report maintenance of lower weight for over a year. Consideration of alternative approaches (self-help groups, medication, very-low-calorie-diet VLCD, gastric restriction) should be credited where presented as part of the evaluation as a whole. Two marks are for application to the text: ways in which Ian might implement the techniques (given that he is not hospitalised); likelihood of success in his case; lifestyle factors that might help/hinder - used to eating on the run.
Credit use of relevant evidence.

Mark Bands

12 – 10 marks   **Excellent answers**

There is detailed knowledge of the behavioural approach to dieting and weight loss. Answer shows sound understanding of related issues, eg lifestyle factors. Discussion is clear and well argued. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding. Must be relevant application to the text for 11/12 marks.

9 – 7 marks   **Good to average answers**

Answer shows knowledge and understanding of the behavioural approach to dieting and weight loss. There is an attempt to present an organised discussion. The answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding.

6 – 4 marks   **Average to poor answers**

Answer shows some relevant knowledge and understanding but will probably lack depth and/or be quite disorganised. Answers constituting reasonable description but minimal effective discussion are likely to be in this band. There may be considerable irrelevance and/or inaccuracy.

3 – 1 marks   **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief answer may come into this band.

Total AO1 marks for Question 11: 10
Total AO2 marks for Question 11: 10
Total marks for Question 11: 20

12   **Total for this question: 20 marks**

(a)   Explain how the endocrine system is involved in the stress response.   *(4 marks)*

[AO1 = 2, AO2 = 2]

AO1   Up to 2 marks for knowledge of structures (adrenal medulla) and hormones (adrenaline and noradrenaline) relevant to sympathetic changes in the ANS and/or for knowledge of structures (pituitary & adrenal cortex) and hormones (adrenocorticotrophic hormone ACTH) relevant to the resistance response.
Note - full mark answers need not cover all of the above.

AO2   Up to 2 marks for explanation of the physiological effects of some/all of the above. For example, adrenaline and noradrenaline secretion lead to increased heart-rate, blood pressure, etc. ACTH secretion leads to control/conservation of blood sugar.

(b)   Explain how biofeedback has been used to manage stress.   *(4 marks)*

[AO1 = 2, AO2 = 2]

AO1   Up to 2 marks for knowledge of the procedure. Any 2 marks as follows: technique involving the continuous monitoring of own bodily responses (heart-rate, blood pressure, muscle tension) (1); to enable the person to exert conscious control of autonomic functioning (1) incorporating reward/positive reinforcement for desired change (1).

AO2   Up to 2 marks for application to stress. Candidate is expected to explain how the process would be used. For example, a person suffering from stress would have high blood pressure/high heart-rate/increased muscle tension. These will fluctuate minutely on the continuous display - reinforcement given when the reading goes down slightly. After a while the patient can consciously work towards reduction in reading.

(c)   Describe and discuss the role of **at least two** defence mechanisms in enabling people to cope with stress.   *(12 marks)*

[AO1 = 6, AO2 = 6]

AO1   Up to 6 marks for knowledge and description of the role of at least two defence mechanisms, usually three for each. Relevant defence mechanisms include: rationalisation; denial, displacement; projection, regression and repression. A maximum of two marks can be awarded for simply naming two or more mechanisms. For further credit there must be some valid description/explanation of the function/role of defence mechanisms in general and/or specific named mechanisms. Credit description of relevant evidence up to 2 marks.

AO2   Up to 6 marks for discussing the role played by at least two defence mechanisms in enabling a person to cope with stress. Likely discussion points: appropriateness and effectiveness; application to different circumstances; alternative ways of coping including use of social support, more problem-focused strategies; theoretical underpinnings; empirical validation/refutation; usefulness of emotion-focused strategies in general. Credit use of relevant evidence.

Maximum 7 marks if only one defence mechanism presented

Mark Bands

12 – 10 marks   **Excellent answers**

There is detailed knowledge of at least two defence mechanisms. Answer shows sound understanding of their role in coping with stress. Any references to alternative ways of coping are integrated into the discussion as a whole. Discussion is clear and well argued. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks   **Good to average answers**

Answer shows knowledge and understanding of at least two defence mechanisms and their role in coping with stress. There is an attempt to present an organised discussion. The answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. An otherwise excellent answer focussing on just one defence mechanism may gain up to 7 marks.

6 – 4 marks   **Average to poor answers**

Answer shows some relevant knowledge and understanding but will probably lack depth and/or be quite disorganised. Answers constituting reasonable description but minimal effective discussion are likely to be in this band. There may be considerable irrelevance and/or inaccuracy.

3 – 1 marks   **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief answer may come into this band.

Total AO1 marks for Question 12: 10
Total AO2 marks for Question 12: 10
Total marks for Question 12: 20

13   **Total for this question: 20 marks**

| (a) | Briefly explain **one** reason for self-disclosure. | *(2 marks)* |

[AO1 = 1, AO2 = 1]

AO1   One mark for giving a reason for self-disclosure. Possible answers: demonstrates developing trust; to deepen engagement in the relationship; as a reciprocation - if someone discloses to you then you tend to offer some disclosure in return.

AO2   One mark for elaboration of the given reason. Accept expansion via use of an example.

(b)   Sadia and Omar finally started a conversation at their local gym, where they had often seen each other before. When they found out that they both enjoyed films, they decided to go to the cinema together. At the end of the date, Omar told Sadia how much he liked her. "That's great," she said, "because I really like you too."

Identify **three** factors affecting interpersonal attraction. Illustrate **each** factor with reference to the description of Sadia and Omar. *(6 marks)*

[AO1 = 3, AO2 = 3]

AO1   Award up to three marks, one mark for each valid factor:
- similarity
- familiarity/proximity
- reciprocal liking

Candidates who offer physical attractiveness as a factor may be credited under AO1 but will not gain any credit for AO2.

AO2   Award one mark for linking each factor given above to the text:
Similarity - both like going to the gym/both like films
Familiarity/proximity - have often seen each other before
Reciprocal liking - content of the conversation.

(c)   Describe and discuss the nature-nurture debate in relation to sexual orientation. Refer to evidence in your answer. *(12 marks)*

[AO1 = 6, AO2 = 6]

AO1   Up to 6 marks for knowledge of the nature- nurture debate re sexual orientation and associated evidence. Credit accurate references to genes and heritability - linkage research LeVay and Hamer 1994, hormones (levels of androgens) and brain structure (LeVay - smaller hypothalamus in males). Credit social learning and learning explanations for the nurture side of the debate. Whilst most answers will focus primarily on homosexuality accept answers relating to any type of sexual orientation. Credit description of relevant evidence up to 3 marks.

AO2   Up to 6 marks for discussion and analysis of the nature-nurture debate in this context. Candidates are likely to explore the validity of the alternative explanations. Possible issues: Freudian theory of universal bisexuality with differentiation occurring at the Phallic stage; evidence for social learning theory and upbringing; more general environment, eg hedonism and eroticism condoned (Blumstein and Schwartz). Discussion could also focus on flaws in the nature hypothesis, eg lack of evidence for the androgen hypothesis. Credit also implications of accepting either argument. Credit interactionism. Credit use of relevant evidence.

Maximum 8 marks if no evidence presented

Mark Bands

12 – 10 marks   **Excellent answers**

There is detailed knowledge of the nature-nurture debate in relation to sexual orientation. Answer shows sound appreciation of both sides of the debate. Relevant evidence is clearly presented. Discussion is clear and well argued. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks   **Good to average answers**

Answer shows knowledge and understanding of the nature-nurture debate in relation to sexual orientation with some understanding of both sides of the debate. There is an attempt to present an organised discussion. The answer is mostly focused on the question, although there may be some irrelevance and/or misunderstanding. For 9 marks there must be some relevant evidence.

6 – 4 marks   **Average to poor answers**

Answer shows some relevant knowledge and understanding but will probably lack depth and/or be quite disorganised. Answers constituting reasonable description but minimal effective discussion are likely to be in this band. There may be considerable irrelevance and/or inaccuracy.

3 – 1 marks   **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief answer may come into this band.

Total AO1 marks for Question 13: 10
Total AO2 marks for Question 13: 10
Total marks for Question 13: 20

14   **Total for this question: 20 marks**

(a)   The following are effects associated with paranormal research:

        Effect A   The behaviour of the researcher influences the outcome of the research.

        Effect B   Cues in an experimental situation enable the participant to guess the purpose of the study.

    (i)   Name Effect A. Give an example to show how this could occur in an investigation of extrasensory perception (ESP).   *(2 marks)*

[AO1 = 1, AO2 = 1]

AO1   Experimenter effect/experimenter bias (1).

AO2   Relevant ESP example (1) This need not be from published research but just an example that might occur.

    (ii)   Name Effect B. Give an example to show how this could occur in an investigation of extrasensory perception (ESP).   *(2 marks)*

[AO1 = 1, AO2 = 1]

AO1   Demand characteristics (1).

AO2   Relevant ESP example (1) This need not be from published research but just an example that might occur.

(b)   Outline **one** strength and **one** limitation of restricted-choice experiments in paranormal research.
    (4 marks)

[AO1 = 4, AO2 = 0]

AO1   One mark for identifying a strength, eg easier to analyse, no ambiguity, no need to categorise responses, more objective.
One mark for identifying a limitation, eg can lead to guessing, greater element of chance in the data, greater possibility of cheating.

        One mark each for elaboration of the strength and the limitation. These marks might be gained through use of example to illustrate the point.

(c)   Discuss the evidence for and against psychokinesis (PK). Refer to **both** micro **and** macro methods in your answer.   *(12 marks)*

[AO1 = 4, AO2 = 8]

AO1   Up to 4 marks for knowledge of evidence - 2 marks for knowledge of micro evidence (note the evidence should be clearly identifiable as micro, ie movement only detected by statistical means and not visible to naked eye) and 2 marks for knowledge of macro evidence (note the evidence should be clearly identifiable as macro, ie movement visible to naked eye). Relevant evidence, eg Uri Geller, Rhine, Schmidt, Cox etc. Credit description of relevant evidence up to 4 marks.

AO2 Up to 8 marks for analysis and evaluation of both methods which may be discussion of general issues and problems with research in this area, such as file-drawer problem, use of anecdotal findings, etc, and/or may involve specific discussion and critical consideration of research findings cited. There may be reference to statistical significance as support for existence of PK. Evaluation of both sides of argument should be demonstrated, together with criticism/ evaluation of evidence cited.

Credit use of relevant evidence.

Maximum 7 marks if only micro or macro methods presented

Mark Bands

12 – 10 marks **Excellent answers**

There is detailed knowledge of both methods. Answer shows sound understanding of issues related to PK evidence. Discussion is balanced (for and against), clear and well argued. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks **Good to average answers**

Answer shows knowledge and understanding of both methods. There is an attempt to present an organised and balanced discussion. The answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. An otherwise excellent answer focussing on just one method may gain up to 7 marks.

6 – 4 marks **Average to poor answers**

Answer shows some relevant knowledge and understanding but will probably lack depth and/or be quite disorganised. Answers constituting reasonable description but minimal effective discussion are likely to be in this band. There may be considerable irrelevance and/or inaccuracy. Must be some discussion or application for 5/6 marks.

3 – 1 marks **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief answer may come into this band.

Total AO1 marks for Question 14: 10
Total AO2 marks for Question 14: 10
Total marks for Question 14: 20

15   **Total for this question:** *20 marks*

(a)   Explain what is meant by *withdrawal* in relation to substance abuse.   *(3 marks)*

[AO1 = 2, AO2 = 1]

AO1   Experiencing opposite physiological effects that a substance induced/negative effects (1)
           Upon stopping use of a substance that has been used for long time (1)

AO2   One mark for further explanation, eg linking to a substance/effects that might result/
           consequence of dependence.

(b)   Briefly discuss the abuse of **one** depressant substance.   *(5 marks)*

[AO1 = 2, AO2 = 3]

AO1   One mark for identifying a relevant depressant (solvents - glue, lighter fuel etc), alcohol,
           tranquilisers (benzodiazapines - valium, Librium, etc), opiates (narcotics).

           Plus 1 mark for knowledge of the effect of a depressant on the nervous system: slows down
           central nervous system activity.

AO2   Up to 3 marks for discussion. A wide variety of issues might be discussed here:
           Effects of the substance (large doses lead to unconsciousness)
           Implications for the user (alleviate stress but can incapacitate entirely)
           Addiction/dependence - increased dosage
           Polysubstance effect - use is more effective when combined with other substances. Evidence
           (Bourne 1974 -can stop, Bootzin 1993 - role of environmental stressors, Ashton 2002 -
           polysubstance effect)
           Historical context (US soldiers using heroin in Vietnam, middle class women using
           valium/librium in 1960s)

(c)   Describe and discuss the use of aversion strategies in the treatment of substance abuse. Refer to
       evidence in your answer.   *(12 marks)*

[AO1 = 6, AO2 = 6]

AO1   Up to 6 marks for description of aversion technique/s and relevant evidence. Likely points:
           based on classical conditioning; learning by association between two stimuli in time (temporal
           contiguity); involves creating a fear of a substance; by pairing of the undesirable substance
           with a stimulus which elicits an unpleasant response; conditioning diagram should also be
           credited (UCS, UCR etc). Candidates should also be credited for description of specific
           examples, eg Danaher 1977 - rapid smoking, Lang & Marlatt 1982 antabuse v electric shocks.
           Credit description of relevant evidence up to 3 marks.

AO2   Up to 6 marks for discussion. Likely points: deals with problem behaviour and not cause; has a
           goal with measurable outcomes; ethical issues (stress, need for informed consent); crudeness of
           early methodologies (use of shocks); comparative effectiveness of actual versus imaginal
           aversion therapy; need for patient commitment; generalisation to real life; to role of cognitive
           factors. Credit analysis of specific studies. Alternative strategies should be credited where
           integrated into the discussion as a whole. Credit use of relevant evidence.

Maximum 8 marks if no evidence presented

Mark Bands

12 – 10 marks   **Excellent answers**

There is detailed knowledge of the method of aversion therapy as used in cases of substance abuse, and sound understanding of related issues. Evidence is relevant and clearly presented. Discussion is balanced, clear and well argued. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks   **Good to average answers**

Answer shows knowledge and understanding of aversion therapy as used in cases of substance abuse. There is an attempt to present an organised and balanced discussion. The answer is mostly focused on the question although there may be some irrelevance and/or misunderstanding. For 9 marks there must be reference to evidence.

6 – 4 marks   **Average to poor answers**

Answer shows some relevant knowledge and understanding but will probably lack depth and/or be quite disorganised. Answers constituting reasonable description but minimal effective discussion are likely to be in this band. There may be considerable irrelevance and/or inaccuracy.

3 – 1 marks   **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief answer may come into this band.

Total AO1 marks for Question 15: 10
Total AO2 marks for Question 15: 10
Total marks for Question 15: 20

16   **Total for this question: 20 marks**

(a)   Explain **two** ways in which psychoanalytic theory might be used to explain offending behaviour.
(4 marks)

[AO1 = 2, AO2 = 2]

AO1   One mark each for identifying two ways in which psychoanalytic theory might explain offending behaviour. Possible answers:
- maternal deprivation (Bowlby) -> delinquency and/or affectionless psychopathy
- superego - weak
- superego - over-harsh
- superego - deviant
- defence mechanisms.

AO2   One further mark each for explanation of the two ways identified under AO1. For example: a weak superego would arise from inadequate identification with same sex parent and would result in an inability to distinguish right from wrong.

(b)   Describe Eysenck's theory of the Criminal Personality.   *(4 marks)*

[AO1 = 4, AO2 = 0]

AO1   Up to 4 marks for description of the Criminal Personality theory. Marks should be awarded on a point by point basis for the following: criminals inherit a personality that pre-disposes them to offend; typical criminal type is the neurotic-extravert; extraverts are cortically under-aroused so seek excitement; neurotics are unpredictable and emotionally unstable; extravert personalities are not easy to condition (cannot be socialised); later included the dimension of psychoticism - cold, hostile behaviour. Maximum 2 marks for knowledge of Eysenck's personality theory, without link to crime

(c)   Discuss the use of behaviour modification in the treatment of offending. Refer to evidence in your answer.   *(12 marks)*

[AO1 = 4, AO2 = 8]

AO1   Up to 4 marks for knowledge of behaviour modification techniques used for treatment of offenders. Likely content: based on operant conditioning principles; learning by association between response and consequence; use of positive/negative reinforcement; token economy systems using secondary reinforcement; role of punishment; description of specific programmes, eg Hobbs and Holt (1976) - token economy in YOI; Cullen and Seddon (1981) - TE in YOI; Cohen and Filipcjak (1971) re-offending rates post TE. Maximum 2 marks for answers based solely on aversion therapy. Credit description of relevant evidence up to 2 marks.

AO2   Up to 8 marks for discussion. Relevant issues: ethical issues of control/manipulation; human rights issues - punishment should not involve deprivation of basic needs; ignores reasons for offending; focuses simply on change in behaviour; comparative effectiveness of other therapies - move towards cognitive therapy; token economy = token learning; generalisation beyond the institutional setting; evidence against effectiveness, eg Ross and Mackay (1976); evaluating effectiveness; recidivism. Credit also application via use of example – 1 mark. Credit use of relevant evidence.

Maximum 8 marks if no evidence presented

Mark Bands

12 – 10 marks   **Excellent answers**

There is detailed knowledge of behaviour modification techniques as used in the treatment of offending. Answer shows sound understanding of issues related to the use of behaviour modification. Evidence is relevant and clearly presented. Discussion is balanced, clear and well argued. The answer is well focused, organised and mostly relevant with little, if any, misunderstanding.

9 – 7 marks   **Good to average answers**

Answer shows knowledge and understanding of behaviour modification techniques. There is an attempt to present an organised and balanced discussion. The answer is mostly focused on the question, although there may be some irrelevance and/or misunderstanding. For 9 marks there must be some reference to evidence.

6 – 4 marks   **Average to poor answers**

Answer shows some relevant knowledge and understanding but will probably lack depth and/or be quite disorganised. Answers constituting reasonable description but minimal effective discussion are likely to be in this band. There may be considerable irrelevance and/or inaccuracy. Must be some discussion or application for 5/6 marks.

3 – 1 marks   **Poor answers**

Answer must have some relevant content, perhaps fair description related to the question. There are probably substantial inaccuracies and/or irrelevance. A valid but extremely brief answer may come into this band.

Total AO1 marks for Question 16: 10
Total AO2 marks for Question 16: 10
Total marks for Question 16: 20

ASSESSMENT OBJECTIVE GRID - UNIT 4: CHILD DEVELOPMENT AND OPTIONS

CHILD DEVELOPMENT

Question		AO1	AO2	Total
1	(a)	0	3	
	(b)	5	0	
	(c)	5	7	20
2	(a)	2	1	
	(b)	2	3	
	(c)	6	6	20
3	(a)	2	0	
	(b)	2	4	
	(c)	6	6	20
4	(a)	2	3	
	(b) (i)	3	0	
	(b) (ii)	5	7	20

PSYCHOLOGY OF ATYPICAL BEHAVIOUR

Question		AO1	AO2	Total
5	(a)	2	2	
	(b)	2	2	
	(c)	6	6	20
6	(a)	2	2	
	(b)	4	0	
	(c)	4	8	20
7	(a)	4	0	
	(b)	2	2	
	(c)	4	8	20
8	(a)	4	0	
	(b)	2	2	
	(c)	4	8	20

HEALTH PSYCHOLOGY

Question			AO1	AO2	Total
9	(a)	(i)	2	0	
	(a)	(ii)	0	2	
	(a)	(iii)	4	0	
	(b)		4	8	20
10	(a)		4	0	
	(b)		2	2	
	(c)		4	8	20
11	(a)		4	0	
	(b)	(i)	0	4	
	(b)	(ii)	6	6	20
12	(a)		2	2	
	(b)		2	2	
	(c)		6	6	20

CONTEMPORARY TOPICS IN PSYCHOLOGY

Question			AO1	AO2	Total
13	(a)		1	1	
	(b)		3	3	
	(c)		6	6	20
14	(a)	(i)	1	1	
	(a)	(ii)	1	1	
	(b)		4	0	
	(c)		4	8	20
15	(a)		2	1	
	(b)		2	3	
	(c)		6	6	20
16	(a)		2	2	
	(b)		4	0	
	(c)		4	8	20