Cambridge Assessment International Education

Cambridge International AS & A Level

PSYCHOLOGY **9990/31**

Paper 3 Specialist Options: Approaches, Issues and Debates **May/June 2024**

1 hour 30 minutes

1455008045

You must answer on the enclosed answer booklet.

You will need: Answer booklet (enclosed)

INSTRUCTIONS

- Answer **eight** questions in total:
  - Answer questions from **two** options.
  - Answer **all** questions from the options you have studied.
- Follow the instructions on the front cover of the answer booklet. If you need additional answer paper, ask the invigilator for a continuation booklet.

INFORMATION

- The total mark for this paper is 60.
- The number of marks for each question or part question is shown in brackets [ ].

This document has **8** pages. Any blank pages are indicated.

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Answer questions from **two** options.
Answer **all** questions from the options you have studied.

Section A: Clinical Psychology

Answer **all** questions.

1 Sarah is always thinking about germs. At work she eats lunch alone as she believes this will protect her colleagues. She always washes her hands for 15 minutes in very hot water. She feels better after this, but after 45 minutes she wants to wash again. When Sarah gets home, she washes her clothing, shoes and coat. One day, when Sarah had sat next to a colleague, she could not sleep that night as she was convinced that he would get ill.

Explain how Sarah meets the diagnostic criteria for obsessive-compulsive disorder (OCD). [4]

2 **(a)** Outline what is meant by the determinism versus free-will debate. [2]

(b) Explain **one** strength of applying the determinism side of the determinism versus free-will debate to the biochemical explanation for depressive disorder (unipolar). [2]

3 Olivia has a bipolar disorder and is receiving cognitive restructuring as therapy. In her first session she said:

'My life used to be 100% perfect! I had an amazing job and friends. I stayed up one night to research an expensive holiday. Recently everything has changed. I am not working and have no energy. No one likes me, not even my family, as I am not fun to be with. I have cancelled the holiday. Why does this keep happening to me? I feel amazing for a while and then it all changes and I am depressed again.'

(a) Suggest how cognitive restructuring can help Olivia with both her depressive and manic episodes. [4]

(b) Explain **one** strength of using cognitive restructuring therapy with Olivia. [2]

4 **(a)** Describe the behavioural explanation and the psychodynamic explanation of fear-related disorders. [6]

(b) Evaluate the behavioural explanation and the psychodynamic explanation of fear-related disorders, including a discussion about longitudinal studies.

Evaluation in your answer can include strengths, weaknesses and a discussion of issues and debates. [10]

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Section B: Consumer Psychology

Answer **all** questions.

5 Snyder and DeBono (1985) found that high self-monitors and low self-monitors have different preferences for advertising strategies. This finding could be used for advertising winter coats.

(a) Suggest **one** advertising strategy for winter coats that would appeal to high self-monitors. [2]

(b) Suggest **one** advertising strategy for winter coats that would appeal to low self-monitors. [2]

6 **(a)** Outline 'satisficing' as a model of consumer decision-making. [2]

(b) Explain how satisficing as a model of consumer decision-making is reductionist. [2]

7 Zahra works in a large store that sells a wide range of goods. She notices that customers in the store spend a long time looking at the computers, comparing prices and asking questions. She also notices that when customers select grocery items they only briefly look at what they put into their shopping trolley.

(a) **(i)** Explain **one** reason why the customers shopping for computers are using system 2 for decision-making. [2]

(ii) Explain **one** reason why the customers shopping for groceries are using system 1 for decision-making. [2]

(b) Explain **one** problem with identifying whether a customer is using system 1 or system 2 for decision-making. [2]

8 **(a)** Describe what psychologists have discovered about:
- the features of menu design which have positive and negative impacts, and
- the effect of food name on menu item choice. [6]

(b) Evaluate what psychologists have discovered about:
- the features of menu design which have positive and negative impacts, and
- the effect of food name on menu item choice,

including a discussion about generalisations from findings.

Evaluation in your answer can include strengths, weaknesses and a discussion of issues and debates. [10]

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Section C: Health Psychology

Answer **all** questions.

9 A professor wants to improve doctors' verbal communication with patients.

(a) Suggest **one** way to improve the doctors' verbal communication with patients. [2]

(b) Explain why your suggestion in part **(a)** would be better for these patients. [2]

10 **(a)** Outline what is meant by the nature versus nurture debate. [2]

(b) Explain **one** strength of the gate control theory of pain, from the nurture side of the debate. [2]

11 Becky has broken her leg and is in a lot of pain. She has tried both biochemical and psychological treatments for the pain. Her doctor has suggested that she uses an alternative treatment.

(a) Outline **two** alternative treatments that Becky could use to manage her pain. [4]

(b) For **one** of the treatments outlined in part **(a)**:

Explain **one** weakness of this way for Becky to manage her pain. [2]

12 **(a)** Describe what psychologists have discovered about:
- unrealistic optimism, and
- positive psychology. [6]

(b) Evaluate what psychologists have discovered about:
- unrealistic optimism, and
- positive psychology,

including a discussion about the idiographic versus nomothetic approach.

Evaluation in your answer can include strengths, weaknesses and a discussion of issues and debates. [10]

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Section D: Organisational Psychology

Answer **all** questions.

13 Feba is a manager in an IT company. She has decided to monitor her employees while they work from home to improve their productivity on their tasks.

(a) Suggest **one** way that Feba could monitor the productivity of her employees while they work at home. [2]

(b) Explain why the way you have given in part **(a)** would improve productivity on tasks. [2]

14 **(a)** Outline what is meant by 'holism', including an example from Thomas-Kilmann's five conflict-handling modes. [2]

(b) Explain **one** weakness of holism, using an example from Thomas-Kilmann's five conflict-handling modes. [2]

15 Joseph works on a production line in a car factory. He forgot to use eye protection during his shift and damaged his eye.

(a) **(i)** Explain the type of human error made by Joseph. [2]

(ii) Suggest **one** way the management at this car factory could avoid this type of human error. [2]

(b) For the way you suggested in part **(a)(ii)**:

Explain **one** weakness of this way to avoid this type of human error. [2]

16 **(a)** Describe what psychologists studying motivation to work have discovered about:
- Maslow's hierarchy of needs, and
- McClelland's theory of achievement motivation. [6]

(b) Evaluate what psychologists studying motivation to work have discovered about:
- Maslow's hierarchy of needs, and
- McClelland's theory of achievement motivation,

including a discussion about determinism versus free-will.

Evaluation in your answer can include strengths, weaknesses and a discussion of issues and debates. [10]

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Surname	StemUp Model Solution
Answer booklet	Write the question number in the left-hand margin at the start of each answer.

Question number

Answers for paper 9990/31

Section A: Clinical Psychology

1 Sarah has obsessions: persistent, intrusive and unwanted thoughts about germs, such as the irrational belief that sitting next to a colleague will make him ill. She also has compulsions: repetitive, ritualistic behaviours such as washing her hands for 15 minutes in very hot water and washing her clothing, shoes and coat when she gets home. The compulsion reduces the anxiety caused by the obsession, as she feels better after washing, but the anxiety returns and after 45 minutes she wants to wash again. This is time-consuming (well over an hour a day) and causes significant distress and impairment: she eats lunch alone, so her social and work life is affected, and she could not sleep because of her worry.

2(a) The debate about the extent to which human behaviour is caused by internal or external factors beyond our control (determinism), or is the result of individual choice, so that behaviour is self-determined (free will).

2(b) A strength is application to everyday life. Because the deterministic biochemical explanation identifies a cause of depression, low levels of serotonin, a treatment can be found that targets that cause. For example, SSRIs block the reuptake of serotonin into the presynaptic neuron, raising serotonin levels and so reducing the symptoms of depression.

3(a) The therapist would first explain the cognitive triad to Olivia: her thoughts about

Question number	
	herself, the world and her future, and how these thoughts affect her mood and behaviour. Using homework diaries, she would identify her irrational thoughts and then challenge them with the therapist, replacing them with more rational ones. For her manic episodes, the therapist would challenge her overly positive thinking, e.g. that her life was '100% perfect', replacing it with 'my life can be good, but no one's life is perfect', so she is less likely to act impulsively, like staying up all night planning an expensive holiday. For her depressive episodes, the therapist would challenge the thought that 'no one likes me, not even my family' by asking for evidence, replacing it with the more realistic view that people in her life do like her, which should lift her mood.
3(b)	It has long-term effectiveness, because Olivia learns how to recognise her automatic overly positive and overly negative thoughts. After therapy has ended, if she starts a manic episode she can replace a thought such as 'my life is perfect' with 'my life is good, not perfect' by herself, so relapse is less likely.
4(a)	The behavioural explanation says phobias are learned through classical conditioning. A neutral stimulus (NS) is paired with an unconditioned stimulus (UCS) that naturally causes fear (UCR). After one very frightening pairing or repeated pairings, the NS becomes a conditioned stimulus (CS) that produces fear on its own, the conditioned response (CR). In Watson and Rayner (1920), Little Albert, aged about 9 months, was shown a white rat (NS) while a steel bar was struck with a hammer behind him (UCS), which made him cry (UCR). After several pairings the rat alone (CS) made him cry (CR), and the fear generalised to similar objects such as a rabbit and a fur coat. The phobia is maintained by operant conditioning, as avoiding the object reduces anxiety. The psychodynamic explanation says a phobia is the result of unconscious conflict. Unacceptable impulses or fears, often from a psychosexual stage in childhood, are

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repressed into the unconscious to protect the ego, and the fear is displaced onto an object that symbolises the conflict. Freud (1909) described Little Hans, who developed a phobia of horses. Hans was in the phallic stage and experiencing the Oedipus complex: he desired his mother and feared his father would castrate him. This fear of his father was displaced onto horses, as the black noseband and blinkers reminded him of his father's moustache and glasses.

4(b) Both explanations are supported by longitudinal studies. Watson and Rayner followed Albert for several months and Freud followed Hans from about age 3 to 5, so both could show how a phobia develops and changes over time, rather than taking a snapshot. Data were also recorded as events happened, e.g. Hans's father wrote letters to Freud describing conversations with Hans, so there was no recall bias, which increases validity. Freud's study was holistic, as the letters gave in-depth detail about Hans's fantasies before and after his phobia resolved. However, longitudinal research is time-consuming and risks attrition; with a single participant, losing him would end the study. A close relationship can also reduce objectivity: Hans's father was a follower of Freud and may have interpreted Hans's words to fit Freud's theory.

Validity differs between the explanations. Watson's data came from observation of a baby, so there were no demand characteristics, and the difference between calm and crying is clear, so it is unlikely to be misinterpreted. However, ecological validity is low, as no one is deliberately conditioned with repeated loud noises in real life. Freud's data were qualitative and open to interpretation, and he dismissed the simpler explanation that Hans had seen a horse fall in the street, so the psychodynamic explanation is less valid.

Both are case studies of one young boy, so the findings cannot be generalised to all people with phobias. There are also ethical problems, as Albert was caused distress and the fear was not removed.

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	On nature versus nurture, the behavioural explanation is entirely nurture, as phobias are learned. This cannot explain why many people with phobias recall no frightening experience. The psychodynamic explanation includes both, since everyone passes through the psychosexual stages (nature) but experiences decide whether conflicts are resolved (nurture). Both are deterministic: Albert had no choice in learning his fear and Hans's phobia came from unconscious forces, although both allow some free will through therapy, e.g. systematic desensitisation or psychoanalysis. Overall, the behavioural explanation is more scientific and better supported, as it is testable and leads to effective treatments, while the psychodynamic explanation is unfalsifiable, but both rely on longitudinal case studies that are detailed yet hard to generalise.
	Section B: Consumer Psychology
5(a)	High self-monitors prefer advertisements that appeal to image (soft sell). The advert could show a group of fashionable people, or a celebrity they aspire to be like, wearing the coat while walking through shimmering snow at night into the opening of an art gallery, so the coat is linked to a glamorous, stylish image.
5(b)	Low self-monitors prefer advertisements that appeal to quality (hard sell). The advert could show a woman buying the coat and then taking it out of storage every winter for several years, looking older each time, with a voiceover about its waterproof, hard-wearing material, showing it is good quality and worth the money.
6(a)	Satisficing is when a consumer searches among the available products only until they find one that is acceptable or 'good enough' for their needs, and then they buy it, rather than looking for the best option. For example, a shopper tries on a

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	few dresses and buys the first one that is good enough.
6(b)	It is reductionist because it only considers the cognitive level of explanation: the consumer judging whether a product is good enough. It ignores other levels such as environmental factors, e.g. a consumer may buy because of the store layout, atmosphere or a marketing campaign, and it cannot explain impulse buys or luxury purchases that are far more than 'good enough'.
7(a)(i)	System 2 thinking is slow, effortful, conscious and logical. Computers are expensive and come in many different types, so customers want to put effort into comparing prices and asking questions to make sure the computer meets their needs, e.g. enough storage and the right software.
7(a)(ii)	System 1 thinking is fast, automatic, intuitive and unconscious. Groceries are cheap items that customers buy frequently and they already know which ones they want, so there is no need to put effort into the decision and they only briefly look at what they put in the trolley.
7(b)	System 1 and system 2 are cognitive processes, so they cannot be seen and must be inferred from what a customer does or says. Behaviour can be misinterpreted: a customer who spends a long time looking at computers may actually be distracted and then pick the first one that looks good, so the wrong type of thinking would be identified, lowering validity.
8(a)	Menus help customers decide what to order, but they also communicate the restaurant's brand and image and should match its decor and style. Pavesic (2005) reviewed menu design and described how restaurants can direct customers towards dishes with the best profit margin. Eye-tracking research shows that

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	customers do not read a menu from start to finish but scan it, spending on average about 109 seconds looking at it. Positive features include 'eye magnets', such as a box around an item, an image or a different coloured font, which draw attention, while less profitable items can be de-emphasised with small fonts and no highlighting. Main courses should come first as most diners order one. Negative features include menus that are hard to read, overemphasise prices, use space poorly, have a monotonous design or are too big. Research shows that dishes with descriptive names are rated as more appealing. Lockyer (2006) investigated the effect of menu item names on choice. Four focus groups with 48 self-selected participants in Hamilton, New Zealand discussed five menus with the same items but different wording, and 200 people answered a survey with open and closed questions rating the appeal of items. Content analysis was used on the qualitative data. There were large individual differences, but participants preferred items they would not cook at home; the seasonal menu had the highest appeal and the French-style menu the lowest, and surveyed participants preferred the elaborate menu using words such as 'delicious' and 'flavourful'. Choices also changed with the occasion, e.g. a romantic or a business meal.
8(b)	Generalisation from findings is a strength for Pavesic, because his review drew on a wide variety of menu designs and restaurants, so his recommendations can be applied widely. Lockyer used only five menus, so his findings are less generalisable, although five different styles were tested. His sample was quite large, 48 in the focus groups and 200 in the survey, with a wide range of ages and backgrounds, but all came from one city in New Zealand and there were more females than males, so the results may not generalise to men or to other cultures where food names carry different associations. Lockyer's study also has limited ecological validity. Focus groups discussing menus

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and imagining scenarios, such as a meal with a mother-in-law, are not the same as choosing food in a real restaurant, where hunger, price and the people present may change choices. However, the menus were realistic and based on real menus. Validity was improved because the survey checked the focus group results, and content analysis made the qualitative data more systematic. However, self-reports may be affected by social desirability, e.g. claiming to prefer healthy-sounding dishes. Rating scales give more objective data that cannot be misinterpreted, although participants may use scales differently, while the focus group comments are subjective.

Both areas have strong application to everyday life: Pavesic gives detailed advice on good design and mistakes to avoid, focused on increasing sales. Lockyer is less useful because the most popular menu differed between the focus groups and the survey, showing individual differences, so restaurants cannot rely on one naming style working for all customers.

Overall, the research is practical, but more field studies in real restaurants across cultures are needed before the findings can be confidently generalised.

Section C: Health Psychology

9(a) The professor could train the doctors to explain both the diagnosis and the treatment using simple, everyday language, so that any medical terminology is avoided or clearly explained in terms the patient understands, because McKinlay (1975) found that patients often do not understand medical terms.

9(b) Using simple language means the patients will understand their diagnosis and treatment, so they will feel less anxious or embarrassed about asking questions. Therefore, when they carry out the treatment at home they will know how to do it correctly, e.g. how to use an inhaler, so they are more likely to adhere and recover.

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10(a)	The debate about the extent to which human behaviour is the result of innate, inherited (genetic) characteristics (nature) or of the environment and what we learn from experience (nurture).
10(b)	Gate control theory (Melzack and Wall, 1965) suggests psychological factors can open or close the pain gate, so pain perception can be changed by learning. This gives good application to everyday life, as patients can be taught techniques such as attention diversion or non-pain imagery to close the gate and reduce pain.
11(a)	Acupuncture: fine needles are inserted into specific points on the skin around Becky's leg. This stimulates sensory nerves under the skin and in the muscles, which causes the release of endorphins, the body's natural painkillers, reducing her pain. TENS (transcutaneous electrical nerve stimulation): electrodes are placed on the skin near the broken leg and a mild electric current is passed between them. This floods the nervous system, reducing its ability to transmit pain signals to the spinal cord and brain, so less pain is felt.
11(b)	Acupuncture may cause Becky other problems. Bleeding or bruising can occur where the needles are inserted, and unsterilised needles could cause infection, so she may end up with new discomfort in her leg as well as the pain from the break.
12(a)	Unrealistic optimism is a reason for disregarding health advice. It is the belief that you are less likely than other people to experience negative health events and more likely to experience positive ones, so a person may ignore advice, e.g. after a heart attack believing it will not happen again without changing their diet. Weinstein

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(1980) asked college students at Rutgers University to rate their own chances, compared with other students, of experiencing 42 future life events. They rated their chances as above average for positive events and below average for negative events. In Study 2, students listed factors they thought affected their own chances of 8 events; when other students read these lists, their unrealistic optimism was reduced, showing that optimism occurs when people focus on their own advantages and ignore that others have them too.

Positive psychology (Seligman) focuses on strengths and well-being rather than illness. It describes the pleasant life (enjoying daily pleasures and positive emotions, e.g. good food or hobbies), the good life (using your strengths, good relationships and satisfying work) and the meaningful life (having a purpose greater than yourself, e.g. serving others through charity work). Shoshani and Steinmetz (2014) carried out a two-year longitudinal study in Israel: 537 seventh to ninth grade students took part in a one-year positive psychology programme of 15 lessons delivered by trained teachers, and were compared with 501 students at a similar control school. Questionnaires such as the Brief Symptoms Inventory and Rosenberg Self-Esteem Scale showed significant decreases in distress, anxiety and depression in the intervention group, while symptoms in the control group increased, and self-esteem, self-efficacy and optimism improved.

12(b) Both areas take a mainly nomothetic approach, as they aim to establish general laws. Unrealistic optimism suggests most people believe they are less likely than others to suffer poor health, and positive psychology suggests everyone becomes happier through the pleasant, good and meaningful life. This is useful because it allows general interventions, e.g. a school programme for all students. However, an idiographic view would argue that what makes one person happy, or the health risks they ignore, is unique to them, so general laws may not help every individual, and group averages in Shoshani and Steinmetz hide students who did not improve.

Question number

Both use psychometric questionnaires, such as Weinstein's ratings of 42 events. These give quantitative, objective data that are easy to compare and reliable, but they lack depth, so they cannot explain why people feel optimistic, and self-reports are open to social desirability, e.g. students wanting to appear happy after the programme.

Generalisation is limited. Weinstein used students from one American university, and Study 2 used 120 female psychology students, who are young and healthy and may be more optimistic than older people. Shoshani and Steinmetz used a large sample, but only Israeli middle-school students.

There are cultural differences: both ideas come from a Western perspective. Unrealistic optimism may reflect access to good medical care, and people in countries with poorer care may be less optimistic. The meaningful and pleasant life may be harder in poorer societies, where people have little time for leisure or charity.

Shoshani and Steinmetz was a longitudinal field experiment with a control group, so it can show change over time and that the programme caused improvement, and it has strong application to everyday life, supporting well-being education in schools. Unrealistic optimism mainly offers an individual explanation, ignoring situational factors such as advice from doctors.

Overall, the research is useful and well supported, but its nomothetic approach means it should be combined with an idiographic understanding of each person.

Section D: Organisational Psychology

13(a) Feba could use electronic performance monitoring by setting up a webcam on each employee's home computer. She would be able to see when her employees are working and record how long they take to complete and submit each task, so she can measure their productivity.

Question number	
13(b)	Claypoole and Szalma (2019) found that sustained attention on a task improved when participants were monitored by a webcam compared with a control group who were not monitored. So Feba's employees should concentrate more and be more productive, as they feel pressure to work while being watched.
14(a)	Holism means explaining behaviour by looking at the whole picture, including all the components that make it up. Thomas-Kilmann's model is holistic as it considers the people involved, the situation and the best strategy, suggesting each conflict may need a different mode, e.g. compromising in one case, competing in another.
14(b)	It is difficult to establish a single cause of the conflict or one clear solution. For example, employees may appear to be using the avoiding mode, but the manager cannot tell whether this is true for everyone involved or what is really causing the conflict, so it is hard to know how to resolve it.
15(a)(i)	Joseph made an error of omission, where an action that should have been performed is not performed. He should have put on his eye protection before working on the production line, but he forgot to do so.
15(a)(ii)	Management could introduce a token economy. Workers who are seen wearing their eye protection at the start of and during each shift are given a token that can be exchanged for goods, which positively reinforces remembering their safety equipment.
15(b)	It may be difficult for managers to monitor whether every worker is wearing their eye protection. Car factories are very busy, especially at shift changes, so

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managers may not see each employee, and workers may only wear it when a manager is watching, so errors of omission could still happen.

16(a) Maslow's hierarchy of needs proposes that people are motivated by needs arranged in a pyramid, from basic to more complex. In the original five-level model: physiological needs (food, drink, warmth, e.g. enough pay and breaks at work), safety needs (security and protection from harm, e.g. job security and safety procedures), social needs (belonging and relationships, e.g. friendly colleagues), esteem needs (achievement, status and recognition, e.g. promotion) and self-actualisation (realising your full potential, e.g. challenging, creative work). A lower need must be satisfied before a worker is motivated by the next level. The model was later extended to include cognitive, aesthetic and transcendence needs. Saeednia (2011) developed a measure of basic needs satisfaction for young children in Tehran from interviews, which was found to be reliable.

McClelland's theory of achievement motivation is not a hierarchy. It says all workers have three needs, with one usually dominant: the need for achievement (to master tasks and succeed through hard work rather than luck, preferring moderately difficult goals and feedback), the need for affiliation (to be liked and accepted, maintaining good relationships with colleagues) and the need for power (to influence and control others). McClelland argued that good managers have a high need for power rather than achievement or affiliation. These needs are measured with the Thematic Apperception Test (TAT), in which people make up stories about ambiguous pictures.

16(b) On determinism versus free will, Maslow's theory came from the humanistic approach, which emphasises free will and personal growth, as workers can choose to strive towards self-actualisation. However, the hierarchy itself is deterministic, because a worker cannot be motivated by a higher need until the lower ones are

Question number

met, which suggests a fixed order. Yet some people seek esteem or creative fulfilment even when poorly paid, e.g. artists, which supports free will. McClelland's theory is less deterministic as it is not a hierarchy, but it still suggests our dominant need, learned from experience, determines how we behave at work.

Both have strong applications to everyday life. Maslow is widely taught on management courses, as managers can make sure workers feel safe and secure before expecting them to strive for success. McClelland helps managers match people to roles, e.g. giving high achievers challenging targets.

Validity is a problem. It is very difficult to measure where an employee is on the hierarchy or how satisfied their needs are. The TAT gives qualitative data that the researcher must interpret, so it is subjective and may be unreliable. Saeednia's measure was more valid, as the child's interview answers were checked with parents and educators.

Both theories show cultural bias, as they focus on individual needs, a Western view. In collectivist cultures, social or group needs may come first, so the order of Maslow's hierarchy may not apply. Saeednia's study was in Tehran, a wealthy city, so it may not apply to rural areas.

On individual versus situational explanations, each worker has different needs, an individual view, but employers can change the situation, e.g. pay, security and teams, to change motivation.

Overall, both are useful frameworks, but Maslow is more deterministic, and McClelland gives a more flexible account of how motivation differs between workers.

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PSYCHOLOGY **9990/32**

Paper 3 Specialist Options: Approaches, Issues and Debates **May/June 2024**

1 hour 30 minutes

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You must answer on the enclosed answer booklet.

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Answer questions from **two** options.
Answer **all** questions from the options you have studied.

Section A: Clinical Psychology

Answer **all** questions.

1 Craig has a phobia of blood and injections. He watches someone having an injection on television, feels faint and now he is too frightened to turn on his television.

Suggest how applied tension could treat Craig's phobia so that he can watch television. [4]

2 **(a)** Outline what is meant by 'nurture', including an example from the behavioural explanation of fear-related disorders. [2]

(b) Explain **one** weakness of the behavioural explanation of fear-related disorders from the nurture side of the nature versus nurture debate. [2]

3 Dr Begum is a clinician who sees a patient, Joan. Joan describes how she spends her day feeling miserable and not knowing what to do with her time. She thinks it is her own fault because she cannot decide if she wants to go out, so she stays in. Joan wants to sleep but this is also difficult.

(a) Suggest how Dr Begum could use the Beck depression inventory (BDI) with Joan. [4]

(b) Explain **one** reason why the Beck depression inventory (BDI) is valid. [2]

4 **(a)** Describe electro-convulsive therapy (ECT) and cognitive-behavioural therapy (CBT) for the treatment and management of schizophrenia. [6]

(b) Evaluate ECT and CBT for the treatment and management of schizophrenia, including a discussion about the idiographic versus nomothetic approach.

Evaluation in your answer can include strengths, weaknesses and a discussion of issues and debates. [10]

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Section B: Consumer Psychology

Answer **all** questions.

5 A pizza restaurant is redesigning its menu to encourage more purchases of mushroom pizza.

Suggest **two** menu design features that could help to sell more mushroom pizzas. [4]

6 **(a)** Outline what is meant by 'individual and situational explanations'. [2]

(b) Explain **one** reason why 'overload' in relation to personal space supports the situational side of the debate about individual and situational explanations. [2]

7 Customers at a supermarket frequently purchase one tin of tomatoes at a time. The manager of the supermarket wants to encourage customers to buy multiple tins of tomatoes.

(a) Suggest **one** way the manager could use her understanding of 'point of purchase decisions' to encourage customers to purchase multiple tins of tomatoes. [2]

(b) **(i)** For the suggestion you gave in part **(a)**:

Explain how this could change the customers' thinking so that they purchase multiple tins of tomatoes. [2]

(ii) For the suggestion you gave in part **(a)**:

Explain **one** problem with this suggestion. [2]

8 **(a)** Describe the study by North et al. (2003) on musical style and restaurant customers' spending. [6]

(b) Evaluate this study by North et al., including a discussion about ecological validity.

Evaluation in your answer can include strengths, weaknesses and a discussion of issues and debates. [10]

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Section C: Health Psychology

Answer **all** questions.

9 Dr Munsi is concerned that some of her elderly patients with heart disease do not take their medication every day. Dr Munsi uses the Health Belief Model to design a leaflet to reduce non-adherence in her elderly patients.

Suggest what Dr Munsi could include in her leaflet to reduce non-adherence in the elderly patients, using the Health Belief Model. [4]

10 **(a)** Outline what is meant by 'application to everyday life', including a measure of non-adherence as an example. [2]

(b) Explain **one** problem with measuring non-adherence in everyday life. [2]

11 Zainab has two daughters who are 8 and 17 years old. Zainab wants to help her daughters to continue to experience good mental health. She reads a book on positive psychology about the pleasant life, the good life and the meaningful life.

(a) **(i)** Suggest **one** way Zainab could encourage her 8-year-old daughter to have a 'pleasant life'. [2]

(ii) Suggest **one** way Zainab could encourage her 17-year-old daughter to have a 'meaningful life'. [2]

(b) Explain **one** reason why using positive psychology might **not** lead to an improvement in mental health for Zainab's daughters. [2]

12 **(a)** Describe a study investigating reasons for delay in seeking treatment and a study on Munchausen syndrome. [6]

(b) Evaluate a study investigating reasons for delay in seeking treatment and a study on Munchausen syndrome, including a discussion about the case study method.

Evaluation in your answer can include strengths, weaknesses and a discussion of issues and debates. [10]

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Section D: Organisational Psychology

Answer **all** questions.

13 Arjun is being bullied at work by his manager, Tia. When Arjun is interviewed about the bullying, he says it started when Tia was promoted to manager. Tia can become stressed at work and this increases the bullying. Arjun worries about the bullying all the time and thinks that Tia is encouraging his team to talk to others about him.

Suggest why Tia is bullying Arjun, using your knowledge of the causes of bullying at work. [4]

14 **(a)** Outline Herzberg's two factor theory of job satisfaction. [2]

(b) Explain why Herzberg's two factor theory of job satisfaction can be applied to different cultures. [2]

15 **(a)** Sally manages the production line of a toy factory. A recent survey of her employees has shown that they are not satisfied with their jobs.

Suggest **two** job design techniques that Sally could use with her employees to improve their job satisfaction. [4]

(b) For **one** of the job design techniques you suggested in part **(a)**:

Explain **one** weakness of this job design technique. [2]

16 **(a)** Describe what psychologists have discovered about:
- token economy used to reduce accidents at work, and
- monitoring accidents and risk events. [6]

(b) Evaluate what psychologists have discovered about:
- token economy used to reduce accidents at work, and
- monitoring accidents and risk events,

including a discussion about objective and subjective data.

Evaluation in your answer can include strengths, weaknesses and a discussion of issues and debates. [10]

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Surname	StemUp Model Solution
Answer booklet	Write the question number in the left-hand margin at the start of each answer.

Question number

Answers for paper 9990/32

Section A: Clinical Psychology

1 Craig faints at the sight of blood and injections because his blood pressure drops suddenly. In applied tension (developed by Öst) a therapist would teach him to tense the muscles of his arms, legs and torso for about 10 to 15 seconds until he feels warmth in his face, then release the tension for 20 to 30 seconds, repeating this five times. This raises his blood pressure so he does not faint. He would practise this several times a day, then use it while gradually watching people having injections on television, starting with short clips, until he can turn on his television and watch without feeling faint.

2(a) Nurture is the view that behaviour is caused by the environment and is learned through experience. For example, the behavioural explanation says a phobia is learned by associating a neutral stimulus with an unconditioned stimulus, such as a loud noise, until the stimulus alone produces a conditioned fear response.

2(b) It ignores nature. Some people develop a phobia without ever having a frightening experience with the object, which suggests genetic or evolutionary factors are involved. As evidence shows phobias can be learned (Little Albert) and can run in families, it is impossible to know how much any phobia is due to learning.

3(a) Dr Begum could give Joan the Beck Depression Inventory, a self-report questionnaire of 21 items. For each item Joan chooses one of four statements,

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	scored from 0 to 3, that best describes how she has felt over the past two weeks, e.g. from 'I do not feel sad' (0) to 'I am so sad or unhappy that I can't stand it' (3). Joan is likely to score highly on items about sadness, indecisiveness (she cannot decide whether to go out), self-blame (she thinks it is her own fault), loss of interest and changes in sleep. Dr Begum would add up the scores: a total of 21 to 30 indicates moderate depression and 31 to 40 severe depression, so this would help her diagnose Joan and measure the severity, and she could repeat it later to see if treatment is working.
3(b)	It has 21 items, so it measures a wide range of symptoms of depression, both cognitive (e.g. sadness, self-blame) and physical (e.g. sleep, tiredness), matching the ICD-11 criteria. This means patients with different patterns of symptoms are all correctly identified, so it really measures depression.
4(a)	In electro-convulsive therapy (ECT) the patient is given a general anaesthetic and a muscle relaxant. Electrodes are placed on the scalp, either on one side (unilateral) or both sides (bilateral), and a finely controlled electric current is passed through the brain for a very short time, causing a brief seizure. It is usually given in a course of several sessions and is used for severe cases, e.g. during acute psychotic episodes that have not responded to drugs. It is thought to increase the release of neurotransmitters such as dopamine and serotonin. Cognitive-behavioural therapy (CBT) is a talking therapy, often lasting 5 to 20 weeks. The therapist and patient agree problem-focused goals, and the therapist uses cognitive restructuring to challenge delusions. For example, if the patient believes they are followed by spies, the therapist asks why spies would be interested and suggests other explanations. The patient learns to check the credibility of their thoughts, ignore or tolerate voices and cope with symptoms,

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with homework between sessions. Sensky et al. (2000) randomly allocated 90 patients whose schizophrenia had not responded to medication to CBT or a befriending control, delivered by two experienced nurses for a mean of 19 sessions over 9 months. Both groups improved after treatment, but at a 9-month follow-up, assessed by blind raters, only the CBT group continued to show reduced positive and negative symptoms.

4(b) ECT takes a nomothetic approach: it follows the general law that a seizure will improve symptoms in all patients, and the procedure is the same for everyone. However, it has an idiographic element as it does not work for everyone and the number of sessions and side effects vary between patients. CBT is partly nomothetic, as it assumes restructuring cognitions within a therapeutic relationship benefits everyone, but it is mainly idiographic, as each patient's delusions, goals and coping strategies are unique. This makes CBT more tailored but harder to standardise and test.

Sensky's study is strong evidence for CBT. It was a randomised controlled experiment with blind raters and a befriending control for the attention patients received, so improvements can be attributed to CBT. As a longitudinal study it showed effects lasted 9 months after treatment, though such studies risk attrition. The sample of 90 from several clinics in England generalises well to patients resistant to medication, but not to those who respond well to drugs.

On ethics, ECT can cause memory loss and confusion, and it is not fully understood why it works. Patients detained in hospital may have ECT without full consent, and a psychotic person may not be able to give fully informed consent. CBT is more ethical, as patients cannot be forced to engage in it and it has no physical side effects, although these concerns must be balanced against the benefit of relieving severe symptoms.

On effectiveness and appropriateness, ECT works quickly, which is valuable in acute

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	episodes or when there is a risk of harm, but effects may be short term. CBT needs the patient to be able to talk about their thoughts, so it may be unsuitable for patients with severe disorganised thinking or strong negative symptoms, and it is slow and costly in therapist time. ECT is reductionist, treating schizophrenia as a purely biological problem, while CBT is more holistic but does not treat any biological cause. Overall, CBT has stronger evidence and fewer ethical issues, while ECT is best kept for severe cases that have not responded to other treatments.
	Section B: Consumer Psychology
5	The restaurant could use an 'eye magnet' for the mushroom pizza, putting a picture of it inside a box or printing it in a different coloured font. Eye-tracking shows customers scan menus rather than read them, so this draws their attention to the mushroom pizza, making them more likely to order it. It could also change the name from 'Mushroom pizza' to a descriptive, sensory name such as 'Rich, earthy wild mushroom pizza with melted mozzarella'. Research shows descriptive names make dishes seem more appealing and tasty, so more customers would choose it over the plainly named pizzas.
6(a)	An individual explanation is the view that behaviour is caused by factors within the person, such as innate traits or personality. A situational explanation is the view that behaviour is caused by the environment or situation the person is in.
6(b)	Overload occurs when personal space is invaded and too much sensory information is received, which causes stress and a desire to leave. The stress is caused by factors in the situation, such as the smell, touch and body heat of the people invading our space, rather than by the person's own personality.

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7(a)	She could use a multiple-unit promotion at the point of purchase, putting signs on the shelf next to the tins of tomatoes saying 'Tomatoes on sale: buy 5 tins for £2.00'.
7(b)(i)	The promotion acts as an anchor, making a larger than normal purchase seem attractive. Customers think the only way to get the discount is to buy 5 tins, and they believe they are saving money, so they buy 5 instead of 1. Wansink et al. (1998) found that multiple-unit promotions increased sales.
7(b)(ii)	Customers may later check the price of a single tin and realise they were not really saving money, or that the discount applied to one tin anyway. They may feel manipulated by the supermarket and shop elsewhere, so sales could fall in the long term.
8(a)	North et al. (2003) aimed to investigate the effect of musical style on customers' spending in a restaurant. It was a field experiment with an independent measures design, carried out in an upmarket restaurant in Britain. The opportunity sample was 393 diners, with roughly equal numbers of males and females: 142 heard pop music, 120 classical music and 131 no music. Each condition was played on six evenings over 18 evenings (three weeks), counterbalanced by day of the week. The researchers recorded the spend per head on starters, main courses, desserts, coffee, bar drinks and wine, and the total time spent in the restaurant. The total spend per head was highest with classical music (£32.51) compared with pop music (£29.46) and no music (£29.73). Spending on starters (classical £4.92, pop £4.04, none £3.93) and coffee (classical £1.06, pop £0.80, none £0.53) was greatest with classical music, while there was little difference for main courses and desserts. The researchers concluded that classical music

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	increases spending, probably because it creates an upmarket atmosphere that makes customers willing to spend more.
8(b)	The study has high ecological validity. It was a field experiment in a real restaurant where diners ate and paid as normal, and background music is a normal part of eating out, so their spending behaviour was natural. As diners did not know they were in a study, there were no demand characteristics. However, the natural setting means extraneous variables were less controlled: a busy evening might slow service so fewer people order dessert, and the counterbalancing by day of the week only partly controls for this. The data were mainly quantitative, the amount spent, which is objective and easily compared. However, very little qualitative data were collected, so the study cannot show why classical music increased spending, and North et al. could only suggest explanations, e.g. an upmarket atmosphere. This is somewhat reductionist, although they did consider several explanations, which is more holistic. The sample was large, with a mix of genders, but it was one expensive restaurant in one UK city, so diners probably had high disposable incomes and the results may not generalise to cheaper restaurants or other cultures where classical music has different associations. There are ethical issues: diners did not consent and were not debriefed. However, the study caused no harm, only spending was recorded and it was confidential, so this is acceptable. The findings support a situational explanation, as the music influenced spending. However, individual factors still matter, as diners chose food based on preference, budget and the occasion, so this is soft rather than hard determinism. Overall, the study is useful for restaurant owners, as its high ecological validity means the effect is likely to occur in real life, though it should be replicated in other restaurants.

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	Section C: Health Psychology
9	The Health Belief Model says people adhere if they perceive themselves as susceptible to a serious illness and the benefits of action outweigh the barriers. The leaflet could explain the short and long-term symptoms of heart disease, such as heart attack, so the elderly patients see how serious it is and that they are at risk if they miss medication. It could explain what each medication does to protect the heart, increasing perceived benefits. It could reduce barriers by listing the clinic and pharmacy opening hours and transport links, explaining likely side effects honestly, and using large print so it is easy to read, with a space for Dr Munsi to write when to take each pill as a cue to action.
10(a)	Application to everyday life is the extent to which research or a measure has practical uses in the real world. For example, blood and urine samples are useful because they show the practitioner whether the patient is really taking their medication, so the treatment can be adjusted.
10(b)	Objective tests such as blood or urine samples are not available for all conditions, so practitioners often rely on self-report. Patients may be embarrassed that they have not followed their treatment, or may not remember, so they say they have adhered, which makes the measure less valid.
11(a)(i)	A pleasant life involves enjoying daily pleasures. Zainab could encourage her 8-year-old to do something she enjoys every day when she gets home from school, such as playing her favourite game or reading a story together, so she experiences positive emotions daily.

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11(a)(ii)	A meaningful life involves having a purpose greater than yourself, such as serving others. Zainab could help her 17-year-old find a charity where she could volunteer a few hours each week, e.g. at an animal shelter, giving her life a sense of purpose.
11(b)	The daughters may be under stress, e.g. the 17-year-old has important exams. Time spent on pleasant or meaningful activities, such as volunteering, takes time away from schoolwork, so the stress of falling behind could make her mental health worse rather than better.
12(a)	Safer et al. (1979) investigated reasons for delay in seeking treatment. 93 patients (38 male, 55 female, average age 44) in the waiting rooms of four clinics in a large city hospital were interviewed for about 45 minutes and completed questionnaires; patients with severe illness were excluded. Total delay was divided into three stages: appraisal delay (time to decide symptoms mean illness), illness delay (time to decide to seek help) and utilisation delay (time to actually attend). Appraisal delay was longer when patients had less pain and when they read about their symptoms; illness delay was longer when they imagined negative consequences of being ill; and utilisation delay was longer when they were worried about cost or felt the symptoms could not be cured. Strong sensory signals such as severe pain shortened delay. Munchausen syndrome is a disorder in which a person pretends to be ill or deliberately produces symptoms to gain medical attention. Aleem and Ajarim (1995) reported a case study of a 22-year-old woman who had been admitted to hospital many times since age 17 with swellings, mainly of her breast, which did not respond to treatment. Doctors became suspicious as there was no physical cause, and on the psychiatric ward nurses found a needle with faecal material, which she had been injecting into her breast tissue. When confronted she became

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angry, left the hospital and did not return.

12(b) Aleem and Ajarim used the case study method. This gave detailed, in-depth, mainly qualitative data about a rare disorder, giving insight into how Munchausen syndrome presents and how hard it is to diagnose, which may lead to further research and help doctors recognise it. However, as only one woman was studied, the findings cannot be generalised to all people with Munchausen syndrome, especially as she left before treatment so the causes could not be explored. The researchers may also be biased in their interpretation. Safer et al. was not a case study, as it used 93 patients, so its findings are more generalisable, though they came from one city hospital and patients with mild complaints, so they may not apply to serious illness.

Safer et al. used interviews and questionnaires. Interviews allowed follow-up questions and in-depth data, but self-reports are open to social desirability, e.g. patients exaggerating how quickly they came, and to recall problems in estimating delay. Aleem and Ajarim's data came from medical records and staff observation, which are more objective, though the patient's own account was limited.

Both are fairly holistic. Safer et al. explain delay at several levels, from physical sensations such as pain to cognitive appraisals and practical costs, and Aleem and Ajarim consider the full history of the patient.

Safer et al. is both nomothetic, as the three-stage model applies to anyone who delays, and idiographic, as the factors affecting each stage are unique to each person. Aleem and Ajarim is mainly idiographic, though it confirms general symptoms of the disorder.

Both have application to everyday life: Safer helps reduce delays, e.g. by cutting costs or waiting times, and Aleem and Ajarim warns doctors of the signs of Munchausen syndrome.

Overall, both are useful, but the case study is the less generalisable of the two.

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Section D: Organisational Psychology

13 Bullying can be caused by situational and individual factors. One situational factor is the change in power: the bullying started when Tia was promoted, so it may be predatory bullying where she uses her power over Arjun, perhaps due to poor leadership or competition for status. Tia's work stress increases the bullying, so she may be displacing her frustration onto Arjun rather than dealing with it. Individual factors in the victim may also play a part: Arjun worries all the time and is suspicious that his team is talking about him, so he may be anxious and sensitive, which can provoke aggression in others or make him notice subtle behaviours he interprets as bullying.

14(a) Herzberg's theory says job satisfaction and dissatisfaction are independent and caused by two different factors. Motivators, such as achievement, recognition, responsibility and rewarding work, produce satisfaction, while hygiene factors, such as salary, job security and working conditions, only prevent dissatisfaction.

14(b) Different cultures value different motivators and hygiene factors, but the theory still works because an organisation can tailor them. For example, time off for religious festivals may be an important hygiene factor in some countries, so a multinational company can offer it there and still prevent dissatisfaction.

15(a) Sally could use job rotation, where workers on the toy production line regularly change tasks, e.g. moving from assembling toys to painting or packing every few hours. This gives more variety, so they feel less bored with repetitive work, increasing job satisfaction.
She could also use vertical job enlargement (enrichment), giving workers more

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	responsibility, such as letting a team set its own shift rota or check quality. This would increase satisfaction because they feel trusted and have more control over their working lives.
15(b)	If a worker is put in charge of the shift rota, it may be done unfairly: they might give themselves and their friends the best shifts. This could cause resentment in the rest of the team, so job satisfaction might fall instead of rising.
16(a)	A token economy uses operant conditioning to reduce accidents. Workers receive tokens, such as stamps, as positive reinforcement for working without accidents or following safety procedures, and exchange them for goods. Fox et al. (1987) introduced a token economy at two open-pit mines in the USA. Workers earned stamps each month for working without lost-time injuries, with extra stamps if their whole group had none, for no equipment-damaging accidents and for behaviour that prevented an accident or injury; stamps could be exchanged for thousands of items in local stores. Days lost through injury, the number of lost-time injuries and the costs of accidents all fell greatly, the savings far exceeded the cost of the scheme, and the improvements lasted for years. Monitoring accidents and risk events means recording each accident by its type and the circumstances and cause, so procedures can be changed. Recording minor injuries and near misses is important because they often come before serious accidents. Swat (1997) carried out a three-year study in four old industrial plants in Lodz, Poland, with 2964 employees. 83 accidents were analysed for frequency, severity and causes, using safety supervisors' reports, accident records and interviews. 45.8% of accidents were caused by poor housekeeping, and accident types differed between plants, e.g. slips and falls were common in a meat processing plant but rare in a furniture plant. A further study found that 95% of accidents went unreported. Swat concluded that minor accidents should be

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recorded by circumstance and housekeeping controls included in safety monitoring.

16(b) The data in both studies were partly objective, as they came from the organisations' accident records, e.g. the number of lost-time injuries in Fox et al., which are recorded systematically and are not open to the researcher's interpretation, making them reliable and comparable. However, they are also subjective: accidents must be reported and described by employees, from memory, which can be inaccurate or affected by social desirability. Swat found 95% of accidents were not reported, so records may underestimate accidents. In Fox et al., workers had an incentive not to report injuries to keep their tokens, which may lower validity. Swat's interviews with supervisors also gave subjective data.

Both explanations are situational: rewards in the environment, or poor housekeeping procedures, cause the change in accidents, which means organisations can fix them. However, individual differences matter, as some workers value the rewards more than others and some are more accident prone.

Both were longitudinal, so they showed long-term changes, e.g. Fox et al. showed the reduction lasted for years, although other changes over that time, such as new equipment, could also explain the fall.

Generalisation is limited: two mines in the USA and four old plants in Poland are large samples but specific settings, so findings may not apply to offices or other cultures.

Both are nomothetic, offering general laws, and have strong applications to everyday life, as token economies saved money and Swat gives clear guidance on recording accidents. However, token economies only change behaviour while rewards continue and do not build intrinsic motivation to work safely.

Overall, both are effective, but conclusions depend on how accurately accidents are recorded.

Cambridge Assessment International Education

Cambridge International AS & A Level

PSYCHOLOGY **9990/33**

Paper 3 Specialist Options: Approaches, Issues and Debates **May/June 2024**

1 hour 30 minutes

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You must answer on the enclosed answer booklet.

You will need: Answer booklet (enclosed)

INSTRUCTIONS

- Answer **eight** questions in total:
  - Answer questions from **two** options.
  - Answer **all** questions from the options you have studied.
- Follow the instructions on the front cover of the answer booklet. If you need additional answer paper, ask the invigilator for a continuation booklet.

INFORMATION

- The total mark for this paper is 60.
- The number of marks for each question or part question is shown in brackets [ ].

This document has **8** pages. Any blank pages are indicated.

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Answer questions from **two** options.
Answer **all** questions from the options you have studied.

Section A: Clinical Psychology

Answer **all** questions.

1 Sarah is always thinking about germs. At work she eats lunch alone as she believes this will protect her colleagues. She always washes her hands for 15 minutes in very hot water. She feels better after this, but after 45 minutes she wants to wash again. When Sarah gets home, she washes her clothing, shoes and coat. One day, when Sarah had sat next to a colleague, she could not sleep that night as she was convinced that he would get ill.

Explain how Sarah meets the diagnostic criteria for obsessive-compulsive disorder (OCD). [4]

2 **(a)** Outline what is meant by the determinism versus free-will debate. [2]

(b) Explain **one** strength of applying the determinism side of the determinism versus free-will debate to the biochemical explanation for depressive disorder (unipolar). [2]

3 Olivia has a bipolar disorder and is receiving cognitive restructuring as therapy. In her first session she said:

'My life used to be 100% perfect! I had an amazing job and friends. I stayed up one night to research an expensive holiday. Recently everything has changed. I am not working and have no energy. No one likes me, not even my family, as I am not fun to be with. I have cancelled the holiday. Why does this keep happening to me? I feel amazing for a while and then it all changes and I am depressed again.'

(a) Suggest how cognitive restructuring can help Olivia with both her depressive and manic episodes. [4]

(b) Explain **one** strength of using cognitive restructuring therapy with Olivia. [2]

4 **(a)** Describe the behavioural explanation and the psychodynamic explanation of fear-related disorders. [6]

(b) Evaluate the behavioural explanation and the psychodynamic explanation of fear-related disorders, including a discussion about longitudinal studies.

Evaluation in your answer can include strengths, weaknesses and a discussion of issues and debates. [10]

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Section B: Consumer Psychology

Answer **all** questions.

5 Snyder and DeBono (1985) found that high self-monitors and low self-monitors have different preferences for advertising strategies. This finding could be used for advertising winter coats.

(a) Suggest **one** advertising strategy for winter coats that would appeal to high self-monitors. [2]

(b) Suggest **one** advertising strategy for winter coats that would appeal to low self-monitors. [2]

6 **(a)** Outline 'satisficing' as a model of consumer decision-making. [2]

(b) Explain how satisficing as a model of consumer decision-making is reductionist. [2]

7 Zahra works in a large store that sells a wide range of goods. She notices that customers in the store spend a long time looking at the computers, comparing prices and asking questions. She also notices that when customers select grocery items they only briefly look at what they put into their shopping trolley.

(a) **(i)** Explain **one** reason why the customers shopping for computers are using system 2 for decision-making. [2]

(ii) Explain **one** reason why the customers shopping for groceries are using system 1 for decision-making. [2]

(b) Explain **one** problem with identifying whether a customer is using system 1 or system 2 for decision-making. [2]

8 **(a)** Describe what psychologists have discovered about:
- the features of menu design which have positive and negative impacts, and
- the effect of food name on menu item choice. [6]

(b) Evaluate what psychologists have discovered about:
- the features of menu design which have positive and negative impacts, and
- the effect of food name on menu item choice,

including a discussion about generalisations from findings.

Evaluation in your answer can include strengths, weaknesses and a discussion of issues and debates. [10]

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Section C: Health Psychology

Answer **all** questions.

9 A professor wants to improve doctors' verbal communication with patients.

(a) Suggest **one** way to improve the doctors' verbal communication with patients. [2]

(b) Explain why your suggestion in part **(a)** would be better for these patients. [2]

10 **(a)** Outline what is meant by the nature versus nurture debate. [2]

(b) Explain **one** strength of the gate control theory of pain, from the nurture side of the debate. [2]

11 Becky has broken her leg and is in a lot of pain. She has tried both biochemical and psychological treatments for the pain. Her doctor has suggested that she uses an alternative treatment.

(a) Outline **two** alternative treatments that Becky could use to manage her pain. [4]

(b) For **one** of the treatments outlined in part **(a)**:

Explain **one** weakness of this way for Becky to manage her pain. [2]

12 **(a)** Describe what psychologists have discovered about:
- unrealistic optimism, and
- positive psychology. [6]

(b) Evaluate what psychologists have discovered about:
- unrealistic optimism, and
- positive psychology,

including a discussion about the idiographic versus nomothetic approach.

Evaluation in your answer can include strengths, weaknesses and a discussion of issues and debates. [10]

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Section D: Organisational Psychology

Answer **all** questions.

13 Feba is a manager in an IT company. She has decided to monitor her employees while they work from home to improve their productivity on their tasks.

(a) Suggest **one** way that Feba could monitor the productivity of her employees while they work at home. [2]

(b) Explain why the way you have given in part **(a)** would improve productivity on tasks. [2]

14 **(a)** Outline what is meant by 'holism', including an example from Thomas-Kilmann's five conflict-handling modes. [2]

(b) Explain **one** weakness of holism, using an example from Thomas-Kilmann's five conflict-handling modes. [2]

15 Joseph works on a production line in a car factory. He forgot to use eye protection during his shift and damaged his eye.

(a) **(i)** Explain the type of human error made by Joseph. [2]

(ii) Suggest **one** way the management at this car factory could avoid this type of human error. [2]

(b) For the way you suggested in part **(a)(ii)**:

Explain **one** weakness of this way to avoid this type of human error. [2]

16 **(a)** Describe what psychologists studying motivation to work have discovered about:
- Maslow's hierarchy of needs, and
- McClelland's theory of achievement motivation. [6]

(b) Evaluate what psychologists studying motivation to work have discovered about:
- Maslow's hierarchy of needs, and
- McClelland's theory of achievement motivation,

including a discussion about determinism versus free-will.

Evaluation in your answer can include strengths, weaknesses and a discussion of issues and debates. [10]

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Surname	StemUp Model Solution
Answer booklet	Write the question number in the left-hand margin at the start of each answer.

Question number

Answers for paper 9990/33

Section A: Clinical Psychology

1 Sarah has obsessions: persistent, intrusive and unwanted thoughts about germs, such as the irrational belief that sitting next to a colleague will make him ill. She also has compulsions: repetitive, ritualistic behaviours such as washing her hands for 15 minutes in very hot water and washing her clothing, shoes and coat when she gets home. The compulsion reduces the anxiety caused by the obsession, as she feels better after washing, but the anxiety returns and after 45 minutes she wants to wash again. This is time-consuming (well over an hour a day) and causes significant distress and impairment: she eats lunch alone, so her social and work life is affected, and she could not sleep because of her worry.

2(a) The debate about the extent to which human behaviour is caused by internal or external factors beyond our control (determinism), or is the result of individual choice, so that behaviour is self-determined (free will).

2(b) A strength is application to everyday life. Because the deterministic biochemical explanation identifies a cause of depression, low levels of serotonin, a treatment can be found that targets that cause. For example, SSRIs block the reuptake of serotonin into the presynaptic neuron, raising serotonin levels and so reducing the symptoms of depression.

3(a) The therapist would first explain the cognitive triad to Olivia: her thoughts about

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	herself, the world and her future, and how these thoughts affect her mood and behaviour. Using homework diaries, she would identify her irrational thoughts and then challenge them with the therapist, replacing them with more rational ones. For her manic episodes, the therapist would challenge her overly positive thinking, e.g. that her life was '100% perfect', replacing it with 'my life can be good, but no one's life is perfect', so she is less likely to act impulsively, like staying up all night planning an expensive holiday. For her depressive episodes, the therapist would challenge the thought that 'no one likes me, not even my family' by asking for evidence, replacing it with the more realistic view that people in her life do like her, which should lift her mood.
3(b)	It has long-term effectiveness, because Olivia learns how to recognise her automatic overly positive and overly negative thoughts. After therapy has ended, if she starts a manic episode she can replace a thought such as 'my life is perfect' with 'my life is good, not perfect' by herself, so relapse is less likely.
4(a)	The behavioural explanation says phobias are learned through classical conditioning. A neutral stimulus (NS) is paired with an unconditioned stimulus (UCS) that naturally causes fear (UCR). After one very frightening pairing or repeated pairings, the NS becomes a conditioned stimulus (CS) that produces fear on its own, the conditioned response (CR). In Watson and Rayner (1920), Little Albert, aged about 9 months, was shown a white rat (NS) while a steel bar was struck with a hammer behind him (UCS), which made him cry (UCR). After several pairings the rat alone (CS) made him cry (CR), and the fear generalised to similar objects such as a rabbit and a fur coat. The phobia is maintained by operant conditioning, as avoiding the object reduces anxiety. The psychodynamic explanation says a phobia is the result of unconscious conflict. Unacceptable impulses or fears, often from a psychosexual stage in childhood, are

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repressed into the unconscious to protect the ego, and the fear is displaced onto an object that symbolises the conflict. Freud (1909) described Little Hans, who developed a phobia of horses. Hans was in the phallic stage and experiencing the Oedipus complex: he desired his mother and feared his father would castrate him. This fear of his father was displaced onto horses, as the black noseband and blinkers reminded him of his father's moustache and glasses.

4(b) Both explanations are supported by longitudinal studies. Watson and Rayner followed Albert for several months and Freud followed Hans from about age 3 to 5, so both could show how a phobia develops and changes over time, rather than taking a snapshot. Data were also recorded as events happened, e.g. Hans's father wrote letters to Freud describing conversations with Hans, so there was no recall bias, which increases validity. Freud's study was holistic, as the letters gave in-depth detail about Hans's fantasies before and after his phobia resolved. However, longitudinal research is time-consuming and risks attrition; with a single participant, losing him would end the study. A close relationship can also reduce objectivity: Hans's father was a follower of Freud and may have interpreted Hans's words to fit Freud's theory.

Validity differs between the explanations. Watson's data came from observation of a baby, so there were no demand characteristics, and the difference between calm and crying is clear, so it is unlikely to be misinterpreted. However, ecological validity is low, as no one is deliberately conditioned with repeated loud noises in real life. Freud's data were qualitative and open to interpretation, and he dismissed the simpler explanation that Hans had seen a horse fall in the street, so the psychodynamic explanation is less valid.

Both are case studies of one young boy, so the findings cannot be generalised to all people with phobias. There are also ethical problems, as Albert was caused distress and the fear was not removed.

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	On nature versus nurture, the behavioural explanation is entirely nurture, as phobias are learned. This cannot explain why many people with phobias recall no frightening experience. The psychodynamic explanation includes both, since everyone passes through the psychosexual stages (nature) but experiences decide whether conflicts are resolved (nurture). Both are deterministic: Albert had no choice in learning his fear and Hans's phobia came from unconscious forces, although both allow some free will through therapy, e.g. systematic desensitisation or psychoanalysis. Overall, the behavioural explanation is more scientific and better supported, as it is testable and leads to effective treatments, while the psychodynamic explanation is unfalsifiable, but both rely on longitudinal case studies that are detailed yet hard to generalise.
	Section B: Consumer Psychology
5(a)	High self-monitors prefer advertisements that appeal to image (soft sell). The advert could show a group of fashionable people, or a celebrity they aspire to be like, wearing the coat while walking through shimmering snow at night into the opening of an art gallery, so the coat is linked to a glamorous, stylish image.
5(b)	Low self-monitors prefer advertisements that appeal to quality (hard sell). The advert could show a woman buying the coat and then taking it out of storage every winter for several years, looking older each time, with a voiceover about its waterproof, hard-wearing material, showing it is good quality and worth the money.
6(a)	Satisficing is when a consumer searches among the available products only until they find one that is acceptable or 'good enough' for their needs, and then they buy it, rather than looking for the best option. For example, a shopper tries on a

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	few dresses and buys the first one that is good enough.
6(b)	It is reductionist because it only considers the cognitive level of explanation: the consumer judging whether a product is good enough. It ignores other levels such as environmental factors, e.g. a consumer may buy because of the store layout, atmosphere or a marketing campaign, and it cannot explain impulse buys or luxury purchases that are far more than 'good enough'.
7(a)(i)	System 2 thinking is slow, effortful, conscious and logical. Computers are expensive and come in many different types, so customers want to put effort into comparing prices and asking questions to make sure the computer meets their needs, e.g. enough storage and the right software.
7(a)(ii)	System 1 thinking is fast, automatic, intuitive and unconscious. Groceries are cheap items that customers buy frequently and they already know which ones they want, so there is no need to put effort into the decision and they only briefly look at what they put in the trolley.
7(b)	System 1 and system 2 are cognitive processes, so they cannot be seen and must be inferred from what a customer does or says. Behaviour can be misinterpreted: a customer who spends a long time looking at computers may actually be distracted and then pick the first one that looks good, so the wrong type of thinking would be identified, lowering validity.
8(a)	Menus help customers decide what to order, but they also communicate the restaurant's brand and image and should match its decor and style. Pavesic (2005) reviewed menu design and described how restaurants can direct customers towards dishes with the best profit margin. Eye-tracking research shows that

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	customers do not read a menu from start to finish but scan it, spending on average about 109 seconds looking at it. Positive features include 'eye magnets', such as a box around an item, an image or a different coloured font, which draw attention, while less profitable items can be de-emphasised with small fonts and no highlighting. Main courses should come first as most diners order one. Negative features include menus that are hard to read, overemphasise prices, use space poorly, have a monotonous design or are too big. Research shows that dishes with descriptive names are rated as more appealing. Lockyer (2006) investigated the effect of menu item names on choice. Four focus groups with 48 self-selected participants in Hamilton, New Zealand discussed five menus with the same items but different wording, and 200 people answered a survey with open and closed questions rating the appeal of items. Content analysis was used on the qualitative data. There were large individual differences, but participants preferred items they would not cook at home; the seasonal menu had the highest appeal and the French-style menu the lowest, and surveyed participants preferred the elaborate menu using words such as 'delicious' and 'flavourful'. Choices also changed with the occasion, e.g. a romantic or a business meal.
8(b)	Generalisation from findings is a strength for Pavesic, because his review drew on a wide variety of menu designs and restaurants, so his recommendations can be applied widely. Lockyer used only five menus, so his findings are less generalisable, although five different styles were tested. His sample was quite large, 48 in the focus groups and 200 in the survey, with a wide range of ages and backgrounds, but all came from one city in New Zealand and there were more females than males, so the results may not generalise to men or to other cultures where food names carry different associations. Lockyer's study also has limited ecological validity. Focus groups discussing menus

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and imagining scenarios, such as a meal with a mother-in-law, are not the same as choosing food in a real restaurant, where hunger, price and the people present may change choices. However, the menus were realistic and based on real menus. Validity was improved because the survey checked the focus group results, and content analysis made the qualitative data more systematic. However, self-reports may be affected by social desirability, e.g. claiming to prefer healthy-sounding dishes. Rating scales give more objective data that cannot be misinterpreted, although participants may use scales differently, while the focus group comments are subjective.

Both areas have strong application to everyday life: Pavesic gives detailed advice on good design and mistakes to avoid, focused on increasing sales. Lockyer is less useful because the most popular menu differed between the focus groups and the survey, showing individual differences, so restaurants cannot rely on one naming style working for all customers.

Overall, the research is practical, but more field studies in real restaurants across cultures are needed before the findings can be confidently generalised.

Section C: Health Psychology

9(a) The professor could train the doctors to explain both the diagnosis and the treatment using simple, everyday language, so that any medical terminology is avoided or clearly explained in terms the patient understands, because McKinlay (1975) found that patients often do not understand medical terms.

9(b) Using simple language means the patients will understand their diagnosis and treatment, so they will feel less anxious or embarrassed about asking questions. Therefore, when they carry out the treatment at home they will know how to do it correctly, e.g. how to use an inhaler, so they are more likely to adhere and recover.

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10(a)	The debate about the extent to which human behaviour is the result of innate, inherited (genetic) characteristics (nature) or of the environment and what we learn from experience (nurture).
10(b)	Gate control theory (Melzack and Wall, 1965) suggests psychological factors can open or close the pain gate, so pain perception can be changed by learning. This gives good application to everyday life, as patients can be taught techniques such as attention diversion or non-pain imagery to close the gate and reduce pain.
11(a)	Acupuncture: fine needles are inserted into specific points on the skin around Becky's leg. This stimulates sensory nerves under the skin and in the muscles, which causes the release of endorphins, the body's natural painkillers, reducing her pain. TENS (transcutaneous electrical nerve stimulation): electrodes are placed on the skin near the broken leg and a mild electric current is passed between them. This floods the nervous system, reducing its ability to transmit pain signals to the spinal cord and brain, so less pain is felt.
11(b)	Acupuncture may cause Becky other problems. Bleeding or bruising can occur where the needles are inserted, and unsterilised needles could cause infection, so she may end up with new discomfort in her leg as well as the pain from the break.
12(a)	Unrealistic optimism is a reason for disregarding health advice. It is the belief that you are less likely than other people to experience negative health events and more likely to experience positive ones, so a person may ignore advice, e.g. after a heart attack believing it will not happen again without changing their diet. Weinstein

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(1980) asked college students at Rutgers University to rate their own chances, compared with other students, of experiencing 42 future life events. They rated their chances as above average for positive events and below average for negative events. In Study 2, students listed factors they thought affected their own chances of 8 events; when other students read these lists, their unrealistic optimism was reduced, showing that optimism occurs when people focus on their own advantages and ignore that others have them too.

Positive psychology (Seligman) focuses on strengths and well-being rather than illness. It describes the pleasant life (enjoying daily pleasures and positive emotions, e.g. good food or hobbies), the good life (using your strengths, good relationships and satisfying work) and the meaningful life (having a purpose greater than yourself, e.g. serving others through charity work). Shoshani and Steinmetz (2014) carried out a two-year longitudinal study in Israel: 537 seventh to ninth grade students took part in a one-year positive psychology programme of 15 lessons delivered by trained teachers, and were compared with 501 students at a similar control school. Questionnaires such as the Brief Symptoms Inventory and Rosenberg Self-Esteem Scale showed significant decreases in distress, anxiety and depression in the intervention group, while symptoms in the control group increased, and self-esteem, self-efficacy and optimism improved.

12(b)

Both areas take a mainly nomothetic approach, as they aim to establish general laws. Unrealistic optimism suggests most people believe they are less likely than others to suffer poor health, and positive psychology suggests everyone becomes happier through the pleasant, good and meaningful life. This is useful because it allows general interventions, e.g. a school programme for all students. However, an idiographic view would argue that what makes one person happy, or the health risks they ignore, is unique to them, so general laws may not help every individual, and group averages in Shoshani and Steinmetz hide students who did not improve.

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Both use psychometric questionnaires, such as Weinstein's ratings of 42 events. These give quantitative, objective data that are easy to compare and reliable, but they lack depth, so they cannot explain why people feel optimistic, and self-reports are open to social desirability, e.g. students wanting to appear happy after the programme.

Generalisation is limited. Weinstein used students from one American university, and Study 2 used 120 female psychology students, who are young and healthy and may be more optimistic than older people. Shoshani and Steinmetz used a large sample, but only Israeli middle-school students.

There are cultural differences: both ideas come from a Western perspective. Unrealistic optimism may reflect access to good medical care, and people in countries with poorer care may be less optimistic. The meaningful and pleasant life may be harder in poorer societies, where people have little time for leisure or charity.

Shoshani and Steinmetz was a longitudinal field experiment with a control group, so it can show change over time and that the programme caused improvement, and it has strong application to everyday life, supporting well-being education in schools. Unrealistic optimism mainly offers an individual explanation, ignoring situational factors such as advice from doctors.

Overall, the research is useful and well supported, but its nomothetic approach means it should be combined with an idiographic understanding of each person.

Section D: Organisational Psychology

13(a) Feba could use electronic performance monitoring by setting up a webcam on each employee's home computer. She would be able to see when her employees are working and record how long they take to complete and submit each task, so she can measure their productivity.

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13(b)	Claypoole and Szalma (2019) found that sustained attention on a task improved when participants were monitored by a webcam compared with a control group who were not monitored. So Feba's employees should concentrate more and be more productive, as they feel pressure to work while being watched.
14(a)	Holism means explaining behaviour by looking at the whole picture, including all the components that make it up. Thomas-Kilmann's model is holistic as it considers the people involved, the situation and the best strategy, suggesting each conflict may need a different mode, e.g. compromising in one case, competing in another.
14(b)	It is difficult to establish a single cause of the conflict or one clear solution. For example, employees may appear to be using the avoiding mode, but the manager cannot tell whether this is true for everyone involved or what is really causing the conflict, so it is hard to know how to resolve it.
15(a)(i)	Joseph made an error of omission, where an action that should have been performed is not performed. He should have put on his eye protection before working on the production line, but he forgot to do so.
15(a)(ii)	Management could introduce a token economy. Workers who are seen wearing their eye protection at the start of and during each shift are given a token that can be exchanged for goods, which positively reinforces remembering their safety equipment.
15(b)	It may be difficult for managers to monitor whether every worker is wearing their eye protection. Car factories are very busy, especially at shift changes, so

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managers may not see each employee, and workers may only wear it when a manager is watching, so errors of omission could still happen.

16(a) Maslow's hierarchy of needs proposes that people are motivated by needs arranged in a pyramid, from basic to more complex. In the original five-level model: physiological needs (food, drink, warmth, e.g. enough pay and breaks at work), safety needs (security and protection from harm, e.g. job security and safety procedures), social needs (belonging and relationships, e.g. friendly colleagues), esteem needs (achievement, status and recognition, e.g. promotion) and self-actualisation (realising your full potential, e.g. challenging, creative work). A lower need must be satisfied before a worker is motivated by the next level. The model was later extended to include cognitive, aesthetic and transcendence needs. Saeednia (2011) developed a measure of basic needs satisfaction for young children in Tehran from interviews, which was found to be reliable.

McClelland's theory of achievement motivation is not a hierarchy. It says all workers have three needs, with one usually dominant: the need for achievement (to master tasks and succeed through hard work rather than luck, preferring moderately difficult goals and feedback), the need for affiliation (to be liked and accepted, maintaining good relationships with colleagues) and the need for power (to influence and control others). McClelland argued that good managers have a high need for power rather than achievement or affiliation. These needs are measured with the Thematic Apperception Test (TAT), in which people make up stories about ambiguous pictures.

16(b) On determinism versus free will, Maslow's theory came from the humanistic approach, which emphasises free will and personal growth, as workers can choose to strive towards self-actualisation. However, the hierarchy itself is deterministic, because a worker cannot be motivated by a higher need until the lower ones are

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met, which suggests a fixed order. Yet some people seek esteem or creative fulfilment even when poorly paid, e.g. artists, which supports free will. McClelland's theory is less deterministic as it is not a hierarchy, but it still suggests our dominant need, learned from experience, determines how we behave at work.

Both have strong applications to everyday life. Maslow is widely taught on management courses, as managers can make sure workers feel safe and secure before expecting them to strive for success. McClelland helps managers match people to roles, e.g. giving high achievers challenging targets.

Validity is a problem. It is very difficult to measure where an employee is on the hierarchy or how satisfied their needs are. The TAT gives qualitative data that the researcher must interpret, so it is subjective and may be unreliable. Saeednia's measure was more valid, as the child's interview answers were checked with parents and educators.

Both theories show cultural bias, as they focus on individual needs, a Western view. In collectivist cultures, social or group needs may come first, so the order of Maslow's hierarchy may not apply. Saeednia's study was in Tehran, a wealthy city, so it may not apply to rural areas.

On individual versus situational explanations, each worker has different needs, an individual view, but employers can change the situation, e.g. pay, security and teams, to change motivation.

Overall, both are useful frameworks, but Maslow is more deterministic, and McClelland gives a more flexible account of how motivation differs between workers.