Cambridge Assessment International Education

Cambridge International AS & A Level

PSYCHOLOGY **9990/32**

Paper 3 Specialist Options: Approaches, Issues and Debates **February/March 2025**

1 hour 30 minutes

3620062188

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 Rahul has obsessive-compulsive disorder (OCD) and constantly worries about his family's safety. To reduce these worries, he arranges his books by colour, newspapers in date order and food in his kitchen cupboards alphabetically. If any of the items are placed out of sequence, Rahul becomes very anxious and immediately puts them back in order.

Suggest how cognitive-behavioural therapy (CBT) could treat Rahul's OCD. [4]

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

(b) Explain **one** problem psychologists may have when investigating the psychodynamic explanation of fear-related disorders. [2]

3 Eesha has generalised anxiety disorder and her clinician wants to monitor her during therapy.

(a) Suggest how the Generalised Anxiety Disorder assessment (GAD-7) could be used to monitor Eesha during and after her therapy. [4]

(b) Explain **one** weakness of the GAD-7. [2]

4 **(a)** Describe the biochemical (dopamine hypothesis) explanation and the psychological (cognitive) explanation of schizophrenia. [6]

(b) Evaluate the biochemical (dopamine hypothesis) explanation and the psychological (cognitive) explanation of schizophrenia, including a discussion about reductionism versus holism.

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 restaurant has a noisy kitchen, which can be heard by the customers.

Suggest how the noise from the kitchen may affect perception of food by the customers. [4]

6 Research conducted has shown the effect of product placement in films on choice for both adults and children.

(a) Outline **one** explanation for why product placement in films affects choice. [2]

(b) Explain why it is important to follow ethical guidelines when using children in psychological research. [2]

7 **(a)** Malika is the marketing manager of a company that sells flowers. Most of the company's customers are over 50 years old. Malika wants to market the flowers to younger customers.

Suggest **two** ways that Malika could use Lauterborn's 4 Cs marketing mix model to attract younger customers. [4]

(b) Explain one weakness of Lauterborn's 4 Cs marketing mix model. [2]

8 **(a)** Describe the study by Robson et al. (2011) on consumers' responses to table spacing in restaurants. [6]

(b) Evaluate the study by Robson et al. (2011), including a discussion about self-reports.

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 Samay has been experiencing stress at work for many years. His doctor tells him that he is in the 'exhaustion' phase of the GAS model of stress.

(a) Suggest **two** physical effects of stress that Samay may be experiencing. [2]

(b) For **one** of the physical effects of stress you suggested in part **(a)**:

Suggest the effect this could have on Samay at work. [2]

10 **(a)** Outline what is meant by the idiographic approach, using an example from non-adherence to medical advice. [2]

(b) Explain **one** weakness of taking an idiographic approach to understanding non-adherence to medical advice. [2]

11 Dr Singh wants to encourage his patients to exercise regularly and runs a clinic to support them to attend swimming or running classes.

(a) Suggest how Dr Singh could use contracts to improve the adherence of his patients to regular exercise. [4]

(b) For your suggestion in part **(a)**:
Explain one practical problem with implementing your suggestion. [2]

12 **(a)** Describe:
- a study using fear arousal to improve health, and
- a study about providing information so people know how to improve their health. [6]

(b) Evaluate:
- a study using fear arousal to improve health, and
- a study about providing information so people know how to improve their health,

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 D: Organisational Psychology

Answer **all** questions.

13 Jaya is the manager of a book shop. She has received training about Blau and Boal's model. The sales staff show high job involvement and low organisational commitment.

(a) Suggest **one** reason why her sales staff show high job involvement. [2]

(b) Suggest **one** reason why her sales staff show low organisational commitment. [2]

14 **(a)** Outline **two** features of the job descriptive index (JDI). [2]

(b) Explain **one** practical application of the job descriptive index (JDI). [2]

15 Workers on the production line of a car factory are in conflict about the time of lunch breaks. All workers want to have lunch at 12 pm but the workers cannot all go at once. The manager decides to use Thomas-Kilmann's conflict-handling modes to reduce this conflict.

(a) Suggest how the manager could use **two** of Thomas-Kilmann's conflict-handling modes to reduce this conflict about lunch breaks. Your answer **must** be ethical. [4]

(b) For **one** of the modes to reduce conflict that you have suggested in part **(a)**:
Explain **one** weakness of this mode to reduce conflict. [2]

16 **(a)** Describe what psychologists investigating traditional and modern theories of leadership have discovered about:
- universalist theories of leadership, and
- Heifetz's six principles in meeting adaptive challenges. [6]

(b) Evaluate what psychologists investigating traditional and modern theories of leadership have discovered about:
- universalist theories of leadership, and
- Heifetz's six principles in meeting adaptive challenges,

including a discussion about nature versus nurture.

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

Section A: Clinical Psychology

1 The therapist would start by explaining OCD to Rahul, so he understands the link between his intrusive thought ("my family will come to harm") and his compulsion of arranging books by colour, newspapers by date and food alphabetically, which only reduces his anxiety for a short time. His symptoms could be measured with the Y-BOCS before, during and after therapy.

Rahul would be given homework to record his worries about his family, his ordering behaviour and how anxious he felt. In sessions the therapist would use this diary to challenge and restructure his thinking, replacing "something bad will happen unless my food is in alphabetical order" with "my family are safe, and the order of my cupboard has no effect on their safety". Using exposure and response prevention, Rahul would deliberately leave a book out of colour order and resist putting it back, using relaxation techniques until his anxiety falls. He learns that nothing bad happens, so the compulsion stops being reinforced and he can stop or reduce his ordering.

2(a) Determinism is the view that behaviour is caused by forces outside the person's control, such as unconscious drives, so the individual has little or no free will. For example, the psychodynamic explanation says a phobia is caused by the unconscious repressing a childhood conflict and displacing the fear onto a phobic object, as with Little Hans' fear of horses being displaced fear of his father.

2(b) The cause of the fear-related disorder is said to be an unconscious conflict from early childhood, so the patient cannot remember it or report it directly.

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	Psychologists must use techniques such as dream analysis or hypnosis to reach these memories, which produce subjective, qualitative data that depends on the analyst's interpretation and may be inaccurate, so the explanation is hard to test scientifically.
3(a)	The GAD-7 is a self-report questionnaire with 7 items, such as "feeling nervous, anxious or on edge", "not being able to stop or control worrying", "trouble relaxing" and "becoming easily annoyed or irritable". Eesha rates how often each has bothered her over the last two weeks from 0 (not at all) to 3 (nearly every day), giving a total out of 21. Her clinician could give her the GAD-7 before therapy for a baseline, then every few sessions during therapy to see whether symptoms such as trouble relaxing or irritability are happening less often. A score of 15 or more shows severe anxiety, so if her score stays this high the therapy may need to be changed or continued. After therapy, the clinician would want her score to be 9 or below (mild anxiety) before ending treatment, and could repeat the GAD-7 at follow-up to check her improvement lasts.
3(b)	The GAD-7 only collects quantitative data, so it gives no in-depth information about Eesha's anxiety. For example, she may score 3 on "becoming easily annoyed or irritable", but this does not explain what is annoying her, so the clinician will not know whether the cause of her irritability is changing from week to week.
4(a)	The dopamine hypothesis is a biochemical explanation which says schizophrenia is caused by an imbalance of the neurotransmitter dopamine. Excess dopamine activity, especially overactive D2 receptors in subcortical and limbic areas such as the mesolimbic pathway and striatum, is linked to positive symptoms. For example, excess dopamine in Broca's area is associated with auditory hallucinations. Too

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little dopamine activity in the prefrontal cortex is linked to negative and cognitive symptoms, such as flattened affect, avolition and poverty of speech.

The cognitive explanation (Frith, 1992) says the symptoms are caused by faulty thinking processes. Frith argues that a central monitoring system normally recognises that our inner speech is self-generated. In schizophrenia this monitoring fails, so the person believes their own thoughts come from an external source, producing auditory hallucinations and experiences such as thought insertion. Delusions, such as being controlled by aliens, then develop as a way of explaining these hallucinations. Frith also suggests patients have a poorly developed theory of mind, so they misread other people's intentions, leading to paranoid delusions. Because they cannot monitor their own mental state, they struggle to start actions or conversations without a prompt, explaining avolition and social withdrawal. Frith accepted that genes and brain processes contribute, but focused on the faulty cognitions. In support, patients judging whether items had been read aloud by themselves, an experimenter or a computer made more errors, and those with incoherent speech performed worst.

4(b)

The dopamine hypothesis is reductionist because it reduces a complex disorder to the level of one neurotransmitter, ignoring thoughts, family and social stressors. This makes it scientific and testable, but it cannot explain why not all patients improve on antipsychotics. The cognitive explanation is more holistic, because it considers how the patient experiences and interprets their own thoughts, and Frith accepts that biological factors may cause the faulty monitoring. However, it is still partly reductionist, as it focuses only on cognitive processes. Overall, the cognitive explanation offers the fuller account.

There is good supporting evidence for the dopamine hypothesis. Amphetamines, which increase dopamine, can produce psychotic symptoms in healthy people, and typical antipsychotics that block D2 receptors reduce positive symptoms. However,

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this is a cause and effect problem: the drugs working does not prove that excess dopamine causes the disorder, and atypical drugs such as clozapine also act on serotonin, suggesting other neurotransmitters matter.

Both explanations have practical applications. The dopamine hypothesis led to antipsychotic medication, which allows many patients to live in the community. The cognitive explanation supports CBT, which helps patients recognise that voices are their own thoughts, and Sensky et al. (2000) found CBT improved symptoms even in patients resistant to drugs.

Both explanations are deterministic. Dopamine imbalance is outside the patient's control, and Frith sees faulty self-monitoring as having a biological cause. However, the cognitive approach allows some free will, because patients can learn to bring their self-talk under control. On nature versus nurture, the dopamine hypothesis supports nature, as dopamine levels may be inherited, while cognitions can be shaped by experience.

Finally, both are nomothetic, giving general laws that apply to everyone with schizophrenia, which is useful for diagnosis and treatment but ignores individual differences in symptoms, such as why one patient hears voices and another does not. In conclusion, neither explanation alone is complete, and an interactionist approach combining biochemical vulnerability with faulty cognition is most convincing.

Section B: Consumer Psychology

5 The kitchen noise acts like the loud background white noise in Woods et al. (2011), where blindfolded participants rated foods while hearing no sound, quiet or loud noise. Customers would therefore rate the food as less sweet, so their desserts would seem less tasty, and as less salty, so savoury dishes would seem bland, with less intense flavour overall. However, they would perceive crunchy food, such as

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	chips or salad, as more crunchy. Woods also found that how much people liked the background noise was correlated with how much they liked the food, so customers who dislike the clatter from the kitchen would like their meal less.
6(a)	One explanation is mere exposure. Repeated exposure to a branded product in a film creates positive feelings towards it, even though viewers often do not consciously notice the brand. These unconscious positive feelings make the viewer more likely to choose that product later, for example a drink the main character enjoys.
6(b)	Children are vulnerable and are too young to understand what taking part in a study means, so they cannot give valid informed consent themselves. Therefore their parents or carers must give consent once the study is fully explained, and the children must still be protected from harm, for example by testing them in a familiar setting such as their school.
7(a)	First, Malika could use customer wants and needs. She could research what younger customers buy flowers for, such as gifts for friends or decorating a flat, and offer potted plants and eco-friendly, plastic-free bouquets, since younger people may have environmental concerns about cut flowers. Second, she could use convenience to buy. Younger customers prefer shopping online, so she could sell the flowers through a mobile-friendly website with same-day delivery, and advertise on social media such as Instagram with links that take them straight to the purchase page.
7(b)	It is difficult to test which part of the model was effective. If sales to younger customers rise, Malika cannot tell whether it was due to the convenience of buying online, the communication on social media, or an outside factor such as a

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competitor closing, so she does not know which C to invest in.

8(a) Robson et al. aimed to investigate how restaurant guests perceive specific distances between tables during different dining occasions, and how these perceptions affect their attitudes and preferences.

The sample was 1013 American adults (461 male, 537 female, 15 did not state gender), about 81% Caucasian, with a wide age range and a balance of rural, suburban and urban residents, recruited by volunteer sampling.

The study used a web-based questionnaire. Participants first gave demographic details, how often they ate out and whether they had worked in restaurants. They were randomly assigned to one of nine scenarios: tables 6, 12 or 24 inches apart, combined with a romantic meal, a meal with a friend or a business lunch. They then rated 32 statements on 7-point Likert-type scales about their emotional and behavioural responses, such as "sitting at this table, I am likely to be overheard", with stress measured by items from the Stress Arousal Checklist.

At 6 inches participants felt more crowded, less private and more dissatisfied, and were concerned about being overheard or disturbing others. The romantic meal at 6 inches produced the highest stress and discomfort and least sense of control, the friend scenario moderate stress, while the business lunch was only affected by lower comfort. Women reacted more negatively to close spacing than men. They concluded that diners have negative feelings about tightly spaced tables.

8(b) The study used self-reports, which have strengths. A questionnaire was the best way to find out what diners think and feel about table spacing. Because it was online, it was easy to complete and gained a large sample of over 1000 people, and the researcher was not present, which may have encouraged honest answers. Many statements were clear, such as being likely to be overheard, so were likely to produce valid responses.

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However, self-reports also have weaknesses. Some statements were hard to interpret, such as "I would have an exciting meal experience". With 32 statements, participants may have lost concentration and answered carelessly, lowering validity. Most importantly, what people say may not match their behaviour: a diner may still choose a crowded restaurant if the food is good and cheap.

The Likert scales gave quantitative data, so the nine conditions could be compared statistically. However, there was no qualitative data explaining why people felt stressed, and participants may have chosen middle scores to avoid seeming extreme.

Ecological validity is low because participants imagined a scenario rather than sitting at a real table, so their feelings may differ from a real meal. However, random allocation to the nine conditions increased internal validity.

On individual and situational explanations, the findings are mainly situational, as table distance and the type of meal affected feelings. However, women felt more stressed than men, suggesting individual differences.

The sample was American, and personal space norms vary between cultures, so diners in more collectivist cultures might be comfortable with closer tables.

Ethically, the study was good: participants volunteered, data was confidential and the questions were not upsetting.

The study is useful, as restaurants can space tables wider for romantic meals and seat business diners at closer tables. Overall it is a well-controlled, useful study, but its reliance on imagined self-report limits its validity.

Section C: Health Psychology

9(a) Samay may experience fatigue (lack of energy) and a weakened immune system, so he catches infections more often.

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9(b)	Because of fatigue, Samay may struggle to get up and arrive at work on time. Once there, his lack of energy and sleepiness may make it hard to concentrate on his tasks, so he makes more mistakes and his performance falls.
10(a)	The idiographic approach studies the uniqueness of an individual and their own subjective experience, rather than looking for general laws. For example, in rational non-adherence a patient weighs up the costs and benefits of treatment, and each patient has their own unique costs, such as side effects of a drug that affect them differently, so their reason for not taking it is personal to them.
10(b)	The idiographic approach cannot produce general laws about behaviour. Because every patient has unique reasons for not adhering, psychologists cannot create a general theory of non-adherence, so it is difficult to design one practical intervention, such as a reminder scheme, that would improve adherence for most patients.
11(a)	Dr Singh could first review each patient's current level of exercise with them and agree a realistic goal, for example attending at least two swimming or running classes per week. They would plan exactly which days and classes the patient will attend, and write this into a contract which both the patient and Dr Singh sign, so the patient feels committed. The contract could include a small reward, such as two free classes after completing ten. The patient would return to the clinic every two weeks to review their attendance against the contract with Dr Singh and set new targets.
11(b)	The patient may claim they are attending the classes when they are not. Dr Singh would not know what they are really doing, so he cannot help them stick to the contract, and the patient will not get the fitness and health improvements the

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contract was designed to produce.

12(a) Janis and Feshbach (1953) studied fear arousal using an independent groups design with 200 high school students (mean age 15). The experimental groups of 50 each heard a 15-minute lecture on dental hygiene. The strong fear group was told about painful consequences such as tooth decay, gum disease and even cancer, with disturbing slides of diseased mouths. The moderate fear group heard a similar lecture with milder pictures, and the minimal fear group heard a factual lecture about teeth and cavities with no frightening images. A control group of 50 heard a lecture about the human eye. Questionnaires measured emotional reactions and dental practices one week before, straight after and one week after the lecture. Strong fear produced the most worry, but minimal fear produced the greatest change in dental behaviour, a net change of 36% compared with 8% for strong fear.

Lewin et al. (1992) studied providing information. 176 patients who had recently had a heart attack were randomly allocated to either a self-help rehabilitation programme, the Heart Manual, or standard care plus a placebo package of information and informal counselling. A facilitator contacted both groups at 1, 3 and 6 weeks, checking the rehabilitation group's progress with the manual. Psychological adjustment was measured with the Hospital Anxiety and Depression Scale and the General Health Questionnaire at 6 weeks, 6 months and 12 months, and GPs reported contacts and readmissions. The rehabilitation group showed better psychological adjustment at one year, had significantly fewer GP contacts and fewer hospital readmissions in the first 6 months. The benefit was greatest for patients who were anxious or depressed at discharge.

12(b) Lewin et al. is a longitudinal study, following patients for 12 months. This is a strength, as it shows whether the information produced lasting change in

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adjustment and readmissions, not just a short-term effect. However, longitudinal studies are costly and time-consuming, and participants may drop out, so the remaining sample may be biased towards more motivated patients. In contrast, Janis and Feshbach is a snapshot study lasting just over a week, so it cannot tell us whether minimal fear changed tooth brushing in the long term, which limits its usefulness.

Both studies used good controls. Janis and Feshbach used a control group and standardised lectures, and Lewin et al. used random allocation and a placebo package, so changes can be attributed to the independent variable.

Janis and Feshbach relied on self-reports of dental behaviour, which are subjective and open to social desirability, as students may have claimed to brush more than they did. Lewin et al. had both subjective data from the anxiety and depression scales and objective data from GP records of contacts and readmissions, increasing validity.

On individual and situational explanations, both studies are situational, as they conclude the type of message or the manual caused change. However, individual factors such as motivation or the patient's health may also have affected behaviour.

Ethically, the strong fear group in Janis and Feshbach may have been caused psychological distress, and there is no record of consent from these 15-year-olds. Lewin et al. caused no harm, although the control group did not receive the manual.

On generalisability, Janis and Feshbach used American students, so findings may not apply to adults or other cultures, and cultures may differ in how they respond to fear or self-help. Lewin et al. only used heart attack patients.

Both have practical applications: health campaigns should use low levels of fear, and self-help manuals reduce health service costs. Overall Lewin et al. is stronger because it is longitudinal and uses objective data.

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	Section D: Organisational Psychology
13(a)	The sales staff identify strongly with their work and take pride in it, for example they love books and feel proud when they recommend a book a customer enjoys. So they put a lot of effort in, helping customers find or order books.
13(b)	The staff do not feel loyal to the book shop as an organisation. For example, when sales jobs at other shops are advertised with better pay, they frequently apply for them, so staff turnover at Jaya's shop is high.
14(a)	The JDI has 72 items. It measures five aspects of job satisfaction, including pay, opportunities for promotion, supervision, co-workers and the work itself, and each word is answered "yes", "no" or "?" (cannot decide).
14(b)	The JDI shows which specific aspect of the job workers are dissatisfied with. For example, if workers score low on opportunities for promotion but high on supervision and co-workers, the organisation can focus only on this area, such as providing training so workers gain the skills needed for promotion, improving job satisfaction.
15(a)	The manager could use compromise, where each side gives up part of what it wants. The workers would agree that everyone gets lunch at 12 pm on some days, and the manager draws up a fair rota so the 12 pm slot is shared equally among all workers on the production line. The manager could also use collaboration, which is assertive and cooperative. The manager would hold a meeting where workers work together on a solution that meets everyone's needs, for example agreeing to rotate lunch times weekly and

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	letting workers swap slots for personal reasons such as childcare.
15(b)	With compromise, someone must be responsible for making sure the 12 pm lunch break is fairly allocated to every worker. This is time-consuming and difficult to monitor, especially if workers swap shifts, so complaints of unfairness could restart the conflict.
16(a)	Universalist theories look for the characteristics and personal qualities that all great leaders share. The great person theory is a trait theory claiming that leaders are born, not made, with innate qualities such as intelligence, courage, confidence, persuasiveness and excellent communication skills. Charismatic leaders are charming, inspirational and good at public speaking, and are seen as visionaries who persuade followers to work hard to achieve their vision. Transformational leaders have a strong vision that often requires drastic change, and they motivate and inspire their workforce to achieve it, even when it means difficult, challenging work. Heifetz and Laurie (1997) argued that leaders must help their workforce meet adaptive challenges, problems with no clear solution, and adapt their style to the changing environment. The six principles are: get on the balcony, taking an overview of the whole organisation to see patterns of functional and dysfunctional behaviour while also moving back into day-to-day work; identify the adaptive challenge, recognising what needs to change; regulate distress, balancing the stress of change with keeping workers motivated and helping them tolerate uncertainty; maintain disciplined attention, listening to conflicting viewpoints and confronting issues rather than avoiding them; give the work back to the people, valuing workers' knowledge and letting them make decisions in their area of expertise; and protect voices of leadership from below, encouraging employees at all levels to raise concerns.

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16(b)

The great person theory supports nature, as it claims leaders are born with traits. Charismatic leadership could also be seen as nature, but it can be learned: Steve Jobs is said to have practised holding long silences and eye contact.

Transformational leaders may develop their vision through life experience, supporting nurture. Heifetz's principles imply leadership can be learned, supporting nurture. The universalist view is weakened because training improves leadership, suggesting nurture is important.

Heifetz's principles have strong practical application, giving managers clear guidance such as "get on the balcony" or "regulate distress". Universalist theories are less useful, because if leaders are born an organisation can only select them, not train them.

On individual and situational explanations, universalist theories are individual, focusing on a leader's unique traits, and ignore that a leader effective in one situation may fail in another. Heifetz is more situational, since leaders must adapt to the changing business environment, although some people may be better at this than others.

The great person theory is reductionist, reducing leadership to inborn traits and ignoring training and followers. Heifetz is more holistic, considering interpersonal skills, change and staff, but does not explain why some people adapt better.

Both are theoretical, so their findings come from supporting research. For example, Fuller et al. (1996) found charismatic leadership is related to effectiveness, but such research is correlational and cannot show cause. Heifetz's ideas come from case examples.

Universalist theories are also culturally biased, since traits valued in Western leaders, such as assertiveness, may not be valued in collectivist cultures.

Universalist theories are deterministic, suggesting people cannot choose to become leaders, while Heifetz allows free will. Overall, Heifetz is more useful.

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