Cambridge Assessment International Education

Cambridge International AS & A Level

PSYCHOLOGY **9990/31**

Paper 3 Specialist Options: Approaches, Issues and Debates **October/November 2024**

1 hour 30 minutes

5932204496

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 Jude has a phobia of some foods. This affects his everyday life because he is anxious when other people are eating these foods near him.

Suggest how systematic desensitisation could treat Jude's phobia. [4]

2 **(a)** Outline the reductionism side of the reductionism versus holism debate. [2]

(b) Explain how the biochemical explanation of schizophrenia is reductionist. [2]

3 Aisha finds she has trouble relaxing. She visits her doctor, who suggests using the Generalised Anxiety Disorder assessment (GAD-7).

(a) Suggest **two** reasons why the doctor wants to use the GAD-7 with Aisha. [4]

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

4 **(a)** Describe the study by Lovell et al. (2006) on treatment of obsessive-compulsive disorder (OCD) using telephone administered cognitive-behavioural therapy (CBT). [6]

(b) Evaluate the study by Lovell et al., including a discussion of reliability.

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 An online grocery retailer currently uses a grid layout in its virtual store.

Suggest **two** effects on customers if the store changes to a freeform layout in its virtual store. [4]

6 **(a)** Outline **one** example of how psychologists can use children in psychological research when investigating the topic of brand awareness and recognition. [2]

(b) Explain **one** strength of using children in psychological research when investigating the topic of brand awareness and recognition. [2]

7 Priya is the new manager of a restaurant. She believes that the introduction of background music at the restaurant will improve the atmosphere.

(a) Suggest **two** features of the background music that Priya should choose to improve the atmosphere in her restaurant. [4]

(b) Explain **one** problem of introducing background music in her restaurant. [2]

8 **(a)** Describe what psychologists have discovered about consumer behaviour and personal space:
- personal space at restaurant tables (including Hall's four zones), and
- overload, arousal and behaviour constraint. [6]

(b) Evaluate what psychologists have discovered about consumer behaviour and personal space:
- personal space at restaurant tables (including Hall's four zones), and
- overload, arousal and behaviour constraint,

including a discussion of cultural differences.

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 teacher sees one class of 11-year-olds eating too much unhealthy food. She wants to promote healthy eating.

Suggest how the teacher could decrease the amount of unhealthy food eaten by the children in this class. [4]

10 **(a)** Outline what is meant by free-will, including an example from positive psychology. [2]

(b) Explain **one** reason why positive psychology can be considered to be deterministic. [2]

11 Nadim has been feeling stressed at work but feels relaxed at home. His practitioner is concerned about the effect of this stress on Nadim.

(a) Suggest how his practitioner could compare Nadim's stress at home and at work, using **two** different biological measures. [4]

(b) For **one** of the measures of stress you suggested in part **(a)**:
Explain **one** weakness of this measure of stress. [2]

12 **(a)** Describe explanations of why patients do not adhere to medical advice (rational non-adherence and Health Belief Model). [6]

(b) Evaluate explanations of why patients do not adhere to medical advice (rational non-adherence and Health Belief Model), including a discussion of applications to everyday life.

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 Koffi is the manager of an important project. The project is demanding and the team members have never worked together. Koffi knows about Forsyth's cognitive limitations and errors.

Suggest **two** cognitive limitations/errors that could cause problems for the team members. [4]

14 **(a)** Outline what is meant by social loafing at work. [2]

(b) Explain **one** practical application that could reduce social loafing at work. [2]

15 In a cake factory there are different jobs:
- Factory workers put the finished cakes into boxes.
- Factory supervisors check that the factory workers put the cakes into boxes correctly.
- The factory manager of the whole factory is in charge of the factory supervisors.

(a) For each of the jobs below, identify **one** of Kelley's five followership styles that would help them to be effective in their work. Include a reason for each answer. You must **not** choose the same followership style for both jobs.

(i) A factory worker. [2]

(ii) A factory supervisor. [2]

(b) Explain **one** weakness of Kelley's followership styles. [2]

16 **(a)** Describe what psychologists have discovered about measuring job satisfaction:
- the job descriptive index (JDI), and
- Walton's quality of working life (QWL). [6]

(b) Evaluate what psychologists have discovered about measuring job satisfaction:
- the job descriptive index (JDI), and
- Walton's quality of working life (QWL),

including a discussion of psychometrics.

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 First, Jude and the therapist build a fear hierarchy of food situations, rating each one for fear. For example, if his phobia is of fatty foods, the lowest step could be sitting in a restaurant where other diners are eating but not near him, a middle step could be someone at his table having a plate of fatty food, and the top step could be fatty food on his own plate while eating with others. The therapist then teaches Jude relaxation techniques such as deep breathing and muscle relaxation. Because of reciprocal inhibition, he cannot feel anxious and relaxed at the same time, so he is exposed to the lowest step while relaxing until he feels no fear, then moves gradually up the hierarchy over a number of sessions until he can cope with the most feared food situation calmly.

2(a) Reductionism is the view that complex behaviour or psychological phenomena can be explained by breaking them down into smaller, simpler component parts or the most basic level of explanation, such as genes, neurotransmitters or stimulus-response links.

2(b) The biochemical explanation says schizophrenia is caused by an imbalance of the neurotransmitter dopamine, such as excess dopamine activity in the mid-brain. This is reductionist because it explains a complex disorder using a single chemical, and does not include other processes such as faulty cognition or family influences.

Question number	
3(a)	First, the GAD-7 is a screening test for generalised anxiety disorder, and trouble relaxing is one of its seven items. So the doctor can find out whether Aisha's difficulty relaxing is part of wider anxiety, and if her score is high (the maximum is 21) she can be referred to a specialist for further assessment and therapy. Second, it is quick and simple, so it will not make Aisha more anxious. She only rates seven items, such as feeling nervous or on edge and not being able to stop worrying, from 0 (not at all) to 3 (nearly every day) for the last two weeks, which takes only a few minutes in the appointment.
3(b)	One weakness is that it only measures how often symptoms occur, not how severe they are. Aisha may find one item, such as being unable to relax, far more disabling in her daily life than the others, but this is not shown by the score, so it cannot capture her full experience of anxiety or give a full diagnosis.
4(a)	Lovell et al. aimed to compare the effectiveness of cognitive-behavioural therapy (exposure and response prevention) for OCD delivered by telephone with the same therapy given face to face. It was a randomised controlled non-inferiority trial using an independent groups design. The participants were 72 out-patients with OCD, aged 16 to 65, from two psychology out-patient departments in the UK. All scored at least 16 on the Yale-Brown Obsessive Compulsive Scale (Y-BOCS). They were randomly allocated to two groups. Both received 10 weekly sessions of exposure and response prevention. The face-to-face group had ten one-hour sessions. The telephone group had a one-hour face-to-face session at the start and at the end, and eight 30-minute sessions by telephone in between. The measures were the Y-BOCS, the Beck Depression Inventory and a client satisfaction questionnaire. Patients were assessed twice before treatment (four weeks apart), after treatment, and at one, three and six month follow-ups. Before

Question number

treatment there was no significant difference between the groups.

Both groups showed a similar large reduction in OCD symptoms that lasted to six months. The difference in Y-BOCS scores between the treatments at six months was only −0.55, and satisfaction was high for both. Lovell et al. concluded that telephone CBT is as effective as face-to-face CBT for OCD.

4(b) A strength is reliability. The same standardised measures (Y-BOCS, Beck Depression Inventory and satisfaction questionnaire) were used with every patient at fixed points: twice before treatment, after it and at one, three and six months. Assessing twice before treatment showed symptoms were stable, so the change can be put down to the therapy. Both groups received the same exposure and response prevention, with the same therapists in each hospital, so the procedure was consistent and could be replicated. However, therapists cannot deliver sessions identically every time, which lowers reliability slightly.

A second strength is validity. Random allocation and no significant difference between groups before treatment mean the type of delivery was the only systematic difference. The data were quantitative, so the groups could be compared statistically, and the six-month follow-up shows lasting change. However, the Y-BOCS and satisfaction scores are self-report, so patients may show social desirability bias, and quantitative scores do not explain why the therapy helped.

The study has strong application to everyday life. Telephone sessions were only 30 minutes yet as effective, so services can treat more patients at lower cost, and people in remote areas or who are too anxious to leave home can get help.

The study supports a situational explanation, as the setting of therapy did not affect outcome, but individual differences such as motivation and the relationship with the therapist still matter.

A weakness is generalisation. The sample of 72 came from two UK hospitals, an individualistic culture where CBT is common. In collectivist cultures, a therapy

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focused on individual thoughts may be less accepted, and the stigma of OCD may affect willingness to take part.

Overall, the study is reliable, controlled and useful, although its sample limits how widely it applies.

Section B: Consumer Psychology

5 First, customers may find the virtual store more useful for finding items on their shopping list. In the grid layout they have to move through a hierarchy, from product category to subcategory to the product, but in the freeform layout they can reach products at once through a search engine or items displayed on every page, so their online grocery shop is quicker (Vrechopoulos et al., 2004).

Second, customers may spend longer in the online store. Vrechopoulos et al. found freeform layouts were more entertaining but also harder to use than grid layouts, so shoppers would browse more of the grocery pages and be engaged for longer, which could mean they buy extra items and spend more.

6(a) Psychologists can show young children brand logos and ask them to match each logo to the product it goes with. For example, Fischer et al. (1991) asked children aged 3 to 6 to place logo cards on pictures of products on a game board, to see which brands they recognised, with consent from parents and the school.

6(b) A strength is that children are less affected by demand characteristics than adults, so they give honest responses about which logos they recognise. This gives useful findings, for example that many young children recognised Old Joe the camel from cigarette adverts, which shows advertisers and governments that adult products should not be branded in child-appealing ways.

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7(a)	One feature is the genre of the music. North et al. (2003) found that customers spent more in a restaurant when classical music was played than when pop music or no music was played. So if Priya chooses a classical soundtrack, it should create an upmarket atmosphere and customers may order more food and drink. A second feature is the volume. The music should be quiet enough to stay in the background so diners can talk easily at their tables. This makes the atmosphere relaxed and pleasant, so customers stay longer and are more likely to return to Priya's restaurant.
7(b)	One problem is that the music may not suit her existing customers' taste. If regular diners dislike the genre, the new atmosphere may annoy them, so they may spend less time and money in the restaurant or stop coming, and Priya would lose sales.
8(a)	Hall described four zones of personal space. Intimate space, from touching up to about 46 cm, is for close relationships, such as a couple. Personal space, from about 46 cm to 1.2 m, is for family and close friends. Social space, from about 1.2 m to 3.7 m, is for acquaintances and business. Public space, from 3.7 m to over 8 m, is for public speaking. In a restaurant, diners expect strangers at nearby tables to stay out of their intimate and personal zones. Personal space has functions. Overload: when people are too close we must process extra information such as their conversation and smell, with little control, which causes stress. Arousal: invasion of space increases arousal, which may be positive at a celebration but negative during an intimate meal next to strangers. Behaviour constraint: when seated close to others we cannot move away, so we feel a loss of control, discomfort and even anger. Robson et al. (2011) carried out an online survey of over 1000 Americans. Participants imagined a romantic meal, a meal with a friend or a business lunch at

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	tables 6, 12 or 24 inches apart, and rated 32 statements about their emotions and behaviour. At 6 inches they felt more crowded, less private and less satisfied, especially in the romantic scenario. Women reported more stress and discomfort than men, while men reported more arousal.
8(b)	A key issue is cultural differences. Hall accepted that the exact distances of the zones vary between cultures, although he argued the zones themselves exist everywhere. Robson et al. only studied Americans, an individualistic culture. In India, for example, it is more common for people to sit closer together when eating, so 12 inches may feel comfortable there, although with business contacts more distance may still be needed. So the findings cannot be applied to restaurants worldwide, and restaurant designers would need local research. Robson et al. collected quantitative data from rating statements, which allowed statistical comparison of table distances, scenarios and gender. However, there were no qualitative data, so we do not know why participants felt uncomfortable, which lowers validity. Ecological validity is low, as participants imagined a scenario online instead of sitting in a real restaurant, so their real behaviour, such as leaving early, may differ. However, the large sample of over 1000 makes the findings more generalisable within the USA. The research is ethical, since an online survey avoided making participants actually sit uncomfortably close to strangers, but this is also why realism is lost. The research is mainly situational, as table distance is the cause, but individual differences such as gender, personality and confidence also affect how much overload, arousal and constraint people feel, as Robson et al.'s gender differences showed. The research is useful, as restaurants can balance the number of tables against customer comfort, for example by giving romantic diners more space.

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	Overall, the ideas are useful but limited by culture and imagined scenarios.
	Section C: Health Psychology
9	The teacher could run a healthy swaps project with this class. Each child keeps a simple food diary for a week of what they eat at school and home, then in class they identify the unhealthy foods, such as crisps, sweets and fries, and suggest healthy alternatives, such as fruit or vegetables instead of fries. Every time a child brings a healthy snack instead of an unhealthy one, they get a sticker on a class chart, and a certificate for every 10 stickers, which rewards eating less unhealthy food. The teacher could also write to the parents to explain the project so that the children are supported at home, and the class could turn their swaps into a leaflet.
10(a)	Free will is the idea that people are able to choose their own behaviour and are not controlled by internal or external forces. In positive psychology, a person can freely choose to set a long-term goal, such as getting fitter, and break it into weekly targets to increase their well-being.
10(b)	Positive psychology claims that if people use its interventions, such as identifying their character strengths or keeping a gratitude diary, they will become happier, so happiness is determined by the intervention and not by free choice. For example, in Shoshani and Steinmetz's school programme, the intervention determined that students' well-being improved.
11(a)	First, the practitioner could ask Nadim to wear a heart rate monitor, such as a smart watch, during several work days and evenings at home. Because stress activates the sympathetic nervous system, his heart rate would be expected to be higher at work than at home.

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	Second, Nadim could provide saliva samples at set times both at work and at home, which are tested for cortisol. Cortisol is released in stressful situations, so if he is stressed at work, his salivary cortisol should be higher at work than at home.
11(b)	Heart rate can be high for reasons other than stress, such as walking around at work, drinking coffee or poor fitness. So a higher heart rate at work may not show Nadim is stressed, and it does not identify the source of his stress.
12(a)	Rational non-adherence is when a patient makes a reasoned decision not to follow medical advice after a cost-benefit analysis, because adhering seems too costly. Factors include side effects, how severe the illness is, cost, how often the medicine must be taken, and restrictions such as alcohol. Bulpitt (1994) argued that patients focus on the risks of medication and rarely consider the benefits: drugs for high blood pressure reduced strokes by 40% but some patients stopped because of side effects. Laba et al. (2012) used an online survey of 161 Australian participants. Participants were given hypothetical choices about continuing two medications for long-term conditions, with attributes varied, such as side effects, chance of death, dose frequency, alcohol restrictions and monthly cost. Monthly cost mattered most for those without health insurance, people were more willing to continue a medicine taken once a day than four times a day, and current side effects mattered more than future harm, so decisions were rational trade-offs. The Health Belief Model (Becker and Rosenstock) says people decide rationally whether to take a health action. Perceived threat depends on perceived susceptibility and perceived severity of the illness, and is affected by modifying factors such as age, culture and education and by cues to action such as symptoms or a media campaign. The person weighs perceived benefits against perceived barriers, such as cost or side effects, and self-efficacy also matters.

Question number

Non-adherence occurs when threat or benefits seem low or barriers high.

12(b) A key strength is application to everyday life. If patients do not adhere because of cost or side effects, health services can make medicines cheaper, develop drugs with fewer side effects or simplify doses, for example once a day rather than four times, as Laba et al. showed this increases willingness to continue. The Health Belief Model can be used to design campaigns that raise perceived severity or give cues to action, and to train practitioners to ask about barriers. However, because of individual differences, one way of improving adherence will not work for everyone.

Both explanations are reductionist, breaking decisions into costs and benefits or a set of perceptions. This allows factors to be varied and tested, as in Laba et al., but people are not always rational, and emotions or habits such as forgetting are ignored, so a more holistic view may explain real patients better.

They are nomothetic, aiming for general laws about adherence, which is useful for health services, but may not fit an individual patient.

The Health Belief Model includes situational factors such as cues to action and education, and individual factors such as self-efficacy, so it is fairly comprehensive.

There are problems with generalisation. Laba et al. used 161 Australians, and both explanations are based on Western medicine, ignoring cultures where traditional medicine and trust in practitioners differ, or where insurance is unavailable. The survey used hypothetical choices, so it lacks ecological validity.

Overall, both are useful for improving adherence, but they overestimate how rational patients are.

Section D: Organisational Psychology

13 One error is a sin of omission, such as base rate bias, where relevant information

Question number	
	is overlooked. Because the project is demanding, the team members may rush to finish and ignore important features that need to be considered, such as risks or deadlines for some parts. A second is confirmation bias, where the group seeks information that confirms rather than contradicts its beliefs. As the team members have never worked together, they may agree with each other to avoid conflict and check their progress only with opinions from inside the team, rather than asking an outsider to check objectively, so mistakes are missed.
14(a)	Social loafing is when individuals reduce the effort they put into a task when working as part of a group at work, compared to the effort they make when working alone.
14(b)	The manager could make each worker's contribution identifiable, for example by giving each person a named task and reviewing it individually, together with a team bonus if the whole group finishes on time. As individual effort is seen and rewarded, workers are less likely to hide in the group, so loafing is reduced.
15(a)i	A sheep (passive and dependent) would be effective. Putting cakes into boxes is a simple, repetitive task that is checked by the supervisor, so the worker does not need to question decisions or think independently, and can just follow instructions.
15(a)ii	An effective follower (active and independent) would help. The supervisor must check the workers' boxing without constant direction from the manager, so needs to think critically, solve problems such as errors in packing independently, and actively pass on new initiatives to the workers.
15(b)	One weakness is that Kelley does not explain whether followership styles are

Question number

innate or learned, or whether they come from the person or the role. So it is unclear whether a worker's style can be changed through training, which makes it hard for managers to assign people to roles.

16(a) The Job Descriptive Index (JDI) is a self-report questionnaire that measures job satisfaction on five dimensions: the work itself, supervision, pay, promotion opportunities and co-workers. For each dimension the worker is given short words or phrases, for example for pay, 'income adequate for normal expenses' or 'less than I deserve'. They write Y for yes, N for no or ? if they cannot decide, to show whether each describes their job. Each answer is scored, so a total can be calculated for each dimension, and scores are compared with standardised norms from large samples, which are regularly updated.

Walton (1974) proposed that quality of working life (QWL) depends on eight conditions: fair and adequate pay; safe and healthy working conditions; opportunities to use and develop skills; opportunity for career growth and security; social integration in the workplace; constitutionalism, meaning rights, policies and procedures; the total life space, meaning a balance between work and life outside; and social relevance of the work. The QWL evaluation scale is a questionnaire using Likert scales to measure how employees feel about each condition, their job, colleagues and company. This helps the organisation respond to employees' needs and shows how these feelings affect growth and profitability.

16(b) A key issue is psychometrics. Both the JDI and the QWL scale are psychometric tests that produce quantitative scores, so satisfaction can be compared between workers, departments or over time and analysed statistically. The JDI is standardised against norms from large samples, so it is reliable and has good population validity. They are scored differently: the JDI uses yes, no and ?, which is quick, while the QWL uses Likert scales, which give a more sensitive measure

Question number

but can produce acquiescence bias. Some QWL items also use complex language, which may reduce validity if workers misunderstand them.

Both are self-reports, so workers may give socially desirable answers or worry that criticising their supervisor could affect their job. Anonymous completion would help, as more honest answers increase validity.

Both have high face validity, as the items are clearly about pay, colleagues and conditions. However, with no qualitative data, they cannot explain why a worker is dissatisfied, so managers may not know what to change.

They are reductionist, breaking job satisfaction into five or eight dimensions, which makes it measurable, although the QWL is more holistic, as it includes life outside work and social relevance.

They are nomothetic, assessing individuals mainly on situational features of the workplace.

Both are useful in everyday life: organisations can identify problems, such as unfair pay, and act on them to improve motivation and reduce staff turnover.

Overall, both are reliable, practical measures, but adding interviews would give a more valid picture.

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PSYCHOLOGY **9990/32**

Paper 3 Specialist Options: Approaches, Issues and Debates **October/November 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 Manjit has been diagnosed with schizophrenia. Her psychiatrist thinks all mental disorders have a biological cause.

Suggest how the psychiatrist could help Manjit to understand a biological cause of schizophrenia. [4]

2 **(a)** Outline the idiographic versus nomothetic debate. [2]

(b) Explain **one** strength of using an idiographic approach to diagnosing schizophrenia. [2]

3 Leo's parents are worried about his recent behaviour. His mother thinks that he may have obsessive-compulsive disorder (OCD). Leo's father says 'I do not agree. Leo has not been washing his hands all the time.'

(a) Suggest **two** reasons why Leo's mother may think he has OCD. [4]

(b) Explain **one** reason why an interview with Leo may **not** help to diagnose him with OCD. [2]

4 **(a)** Describe the psychological explanations of impulse control disorders:
- behavioural: positive reinforcement, and
- cognitive: Miller's feeling-state theory. [6]

(b) Evaluate the psychological explanations of impulse control disorders:
- behavioural: positive reinforcement, and
- cognitive: Miller's feeling-state theory,

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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Section B: Consumer Psychology

Answer **all** questions.

5 A mobile phone manufacturer wants to advertise a new phone. Advertisers propose creating an advertisement that is similar in design to advertisements for competitors' similar phones. This may interfere with consumers' memory.

Suggest how consumers' memory for details of the new phone may be affected by this proposed advertisement. [4]

6 **(a)** Outline the reductionism versus holism debate. [2]

(b) Explain **one** reason why a competitor-focused sales technique can be considered reductionist. [2]

7 Mariyah's car has broken down and she needs to buy a new car.

(a) Describe **two** stages Mariyah would go through in buying a new car, using the Engel Kollat Blackwell model of buyer decision-making. [4]

(b) Explain **one** strength of the Engel Kollat Blackwell model of buyer decision-making. [2]

8 **(a)** Describe what psychologists have discovered about retail atmospherics:
- model of effects of ambience: Mehrabian and Russell's pleasure-arousal-dominance (PAD) model, and
- the effects of odour on shopper pleasure-arousal-dominance. [6]

(b) Evaluate what psychologists have discovered about retail atmospherics:
- model of effects of ambience: Mehrabian and Russell's pleasure-arousal-dominance (PAD) model, and
- the effects of odour on shopper pleasure-arousal-dominance,

including a discussion of quantitative and qualitative data.

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 Camilla's father is told by his doctor that he needs to take pills every day. Camilla does not know if her father is adhering to his doctor's advice.

Suggest **two** ways in which Camilla could check whether her father has been taking his pills every day. [4]

10 **(a)** There are two practitioner styles: doctor-centred (directed) and patient-centred (sharing). Outline **one** of these practitioner styles in relation to an individual explanation. [2]

(b) Outline **one** weakness of an individual explanation, using an example from practitioner styles. [2]

11 Hanif visits his doctor and reports that he has pains in his chest. When his doctor examines him, she notices that Hanif has a number of abdominal scars from previous surgery. The doctor cannot find anything physically wrong with Hanif and she thinks that Hanif may have Munchausen syndrome.

(a) Suggest why the doctor may think that Hanif has Munchausen syndrome. [4]

(b) Explain **one** weakness of the diagnostic features of Munchausen syndrome. [2]

12 **(a)** Describe psychological measures of stress:
- a test of Friedman and Rosenman's Type A personality, and
- Holmes and Rahe's life events questionnaire. [6]

(b) Evaluate psychological measures of stress:
- a test of Friedman and Rosenman's Type A personality, and
- Holmes and Rahe's life events questionnaire,

including a discussion about questionnaires.

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 Ulrich manages an office where there is some conflict between the workers. Ulrich has read that a more stereotypically feminine leadership style may help him to manage his workers better.

Suggest how Ulrich could change his leadership style to one that is more stereotypically feminine. [4]

14 **(a)** Outline what is meant by intrinsic motivators at work. [2]

(b) Explain why intrinsic motivators at work can differ between cultures. [2]

15 Tayyibah is the manager of a small factory making fabric. Tayyibah has noticed that her workers do not seem to be motivated, although they receive good wages. She thinks that using Maslow's hierarchy of needs could help.

(a) Suggest **two** ways in which Tayyibah could use Maslow's hierarchy of needs to motivate her workers. [4]

(b) Explain **one** weakness of Maslow's hierarchy of needs. [2]

16 **(a)** Describe what psychologists have discovered about group development and decision-making:
- stages of group development, and
- Belbin's nine team roles. [6]

(b) Evaluate what psychologists have discovered about group development and decision-making:
- stages of group development, and
- Belbin's nine team roles,

including a discussion about application to everyday life.

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 The psychiatrist could explain that schizophrenia has a genetic component, so Manjit may have inherited genes that make her vulnerable. Gottesman and Shields found that twin studies always show higher concordance for identical than non-identical twins (58% compared with 12% in their own study), and that adopted children of a parent with schizophrenia are more likely to develop it. The psychiatrist could also explain the dopamine hypothesis: Manjit may have too much dopamine activity in the mid-brain, causing positive symptoms such as hallucinations, and too little in the prefrontal cortex, linked to negative symptoms. To help her understand, the psychiatrist could point out that antipsychotic drugs which block dopamine reduce symptoms for most patients.

2(a) The debate is about whether psychology should study the unique experience of an individual, often using qualitative data from case studies (idiographic), or establish general laws that apply to all people using quantitative data and psychometrics (nomothetic).

2(b) An idiographic approach can use an unstructured interview to explore the patient's own experience of symptoms, such as what their hallucinations or delusions are like and how negative symptoms affect their life. This gives deeper insight than a symptom count, so the clinician can reach a more accurate diagnosis of schizophrenia.

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3(a)	First, Leo may have told his mother about obsessions, which are persistent, intrusive and unwanted thoughts, images or urges that cause anxiety. For example, he may keep worrying that his parents will come to harm, even though he tries to push the thought away. Second, she may have seen other compulsions, as hand washing is not the only one. To reduce the anxiety Leo may repeatedly check that doors are locked, arrange objects in his room in a rigid order, or count in his head. This takes more than an hour a day and he spends time alone in his room, which causes distress and impairs his family life.
3(b)	Leo may feel embarrassed or ashamed about his intrusive thoughts and repetitive behaviours, or find them hard to put into words, especially if his parents are present. So in the interview he may hide or play down his obsessions and compulsions, and the clinician cannot tell whether he meets the criteria for OCD.
4(a)	The behavioural explanation uses operant conditioning: a behaviour that is followed by a reward is more likely to be repeated. In gambling, the reward is winning money and the excitement of the win; in kleptomania or pyromania, the reward is the thrill or relief of stealing or setting a fire. Gambling is explained by partial reinforcement on a variable ratio schedule: the gambler is rewarded only some of the time and cannot predict when, so they keep going because the next bet might win. This makes the behaviour very resistant to extinction, as losses are expected before a win. Miller's feeling-state theory says that impulse control disorders develop when an intense positive feeling, such as euphoria or a sense of power, becomes linked with a specific behaviour, such as gambling or stealing. This link forms a state-dependent memory called a feeling-state, made up of the emotions, thoughts

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and physiological arousal of the event, for example the excitement of a big win. When the feeling-state is triggered, the person feels a compulsive urge to repeat the behaviour. This is especially likely in people with negative beliefs about themselves, such as 'I am a failure', because the behaviour gives a feeling that overcomes the negative belief. The feeling-state can be targeted by Miller's ICD Protocol.

4(b) A key issue is nature versus nurture. Both explanations are on the nurture side. In the behavioural explanation the disorder is learned through rewards in the environment, and in feeling-state theory it is formed through the person's experience of the behaviour, such as a big win. The strength of this is that if the cause is learned, the environment can be changed, for example by limiting maximum payouts on gambling websites, and the behaviour can be unlearned. However, both ignore nature. Not everyone who wins becomes a compulsive gambler, so genetic or biochemical factors, such as differences in dopamine reward systems, may make some people more vulnerable, suggesting an interactionist view is better.

Both are reductionist. Positive reinforcement reduces the disorder to stimulus-response links and ignores thoughts, while feeling-state theory focuses on one memory link. Neither considers the person's background or how factors interact.

The behavioural explanation is deterministic, as the person is controlled by past rewards, although people can choose to avoid casinos or fires. Feeling-state theory is less deterministic, as the feeling-state can be processed in therapy.

The behavioural explanation is situational, while feeling-state theory is more individual, as the negative self-belief is personal.

Both have applications: rewarding alternative behaviours, and treating the feeling-state with Miller's protocol, which helped John, a compulsive gambler.

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	However, evidence for feeling-state theory comes mainly from case studies, so it is hard to generalise, and positive reinforcement explains gambling better than kleptomania. Overall, both are useful but would be improved by including biological factors.
	Section B: Consumer Psychology
5	Because the advert is very similar to competitors' adverts for similar phones, interference is likely. Interference is greatest when memories are similar and formed close together in time. With proactive interference, consumers' older memories of the competitors' adverts would disrupt the new memory, so they may forget details such as the new phone's name or features, or confuse it with a rival brand (Burke and Srull, 1988). With retroactive interference, the new advert may also blur older memories, so consumers cannot compare features properly. Either way, the advert would be less effective and sales may fall.
6(a)	Reductionism is explaining behaviour by breaking it down into small, simple units, such as one variable. Holism is considering behaviour as a whole, taking into account all of a person's influences, such as biological, cognitive and social factors, to understand them better.
6(b)	A competitor-focused technique sells the product mainly by comparing it with competitors, such as offering the best price. This is reductionist because it reduces the sale to one factor, ignoring the product's quality and the customer's individual needs and feelings.
7(a)	Problem recognition: Mariyah realises there is a gap between her actual state and desired state, as her car has broken down and she needs one to travel, so she

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recognises she must buy a new car.

Evaluation of alternatives: after searching garages and websites, Mariyah compares the cars on features important to her, such as price within her budget, mileage, size, fuel economy and the brand's reputation for reliability, and this leads her to choose the most suitable car.

7(b) One strength is that the model is comprehensive. It includes all the stages from problem recognition to post-purchase behaviour and many factors that affect the decision, such as budget and needs, so it explains important, expensive purchases like a car well.

8(a) Mehrabian and Russell's PAD model says that physical environments influence behaviour through their emotional impact, so emotion is a mediating factor between environmental cues, such as music or smell, and behaviour. All emotional responses can be measured on three dimensions. Pleasure-displeasure is how pleasant a person feels, for example joy compared with anger. Arousal-nonarousal is how energised or stimulated they feel, for example excitement compared with boredom. Dominance-submissiveness is how in control they feel; anger is dominant but fear is submissive. The emotional state leads to approach behaviour, such as staying longer, exploring and spending more, or avoidance behaviour, such as leaving the store.

Chebat and Michon (2003) tested the effect of odour on shoppers in a field experiment in a shopping mall in Canada. In the control week no scent was used, and in the second week a pleasant citrus scent was released in the main corridor. Shoppers completed a self-administered questionnaire, given by marketing students who wore no perfume, about their perception of the mall environment, product quality, and the pleasure and arousal they felt. With the scent, shoppers had more favourable perceptions of the shopping environment and product quality. However,

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the results supported a cognition-arousal model more than PAD, as the scent seemed to work through shoppers' perceptions rather than only their mood.

8(b) A key issue is quantitative and qualitative data. The PAD model measures emotions as numbers on each of its three dimensions, and Chebat and Michon collected quantitative ratings of product quality, the environment, pleasure and arousal. This allowed the scent and no-scent conditions to be compared statistically and conclusions drawn objectively. However, there were no qualitative data, so shoppers could not explain in their own words how the citrus smell made them feel or why, which reduces validity. Interviews would give richer data about the emotional process the PAD model proposes.

Chebat and Michon used questionnaires, so a large sample could be collected quickly, and data are reliable. However, self-report may be affected by demand characteristics and social desirability.

Ecological validity is high, as it was a field experiment with real shoppers in a real mall. However, there was less control: the weeks may have differed in weather or promotions, so extraneous variables may explain the results.

The research has useful applications, as stores can use pleasant scents to improve perceptions and increase spending. However, it suggests the PAD model is not fully supported, so retailers may need to consider shoppers' cognition too.

There are cultural issues. The study was in Canada, and which scents are pleasant varies between cultures, as does how emotions such as anger are viewed, so findings may not apply to open-air markets elsewhere.

The PAD model is reductionist, reducing all emotions to three dimensions, but this makes them measurable.

Overall, the research is useful but would be more valid with qualitative data.

Section C: Health Psychology

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9	First, Camilla could use pill counting. She counts the pills in her father's bottle at the start of the week and again a few days later. If the number left matches one pill taken each day, it suggests he is adhering, although he could remove pills without taking them. Second, she could fit a medication dispenser such as a TrackCap to the pill bottle. It records the date and time each time the bottle is opened, so she can check that it has been opened once every day.
10(a)	A doctor-centred (directing) style is where the doctor makes decisions and asks closed questions with little input from the patient. As an individual explanation, this style comes from the doctor's own personality and professional expertise, the belief that 'the doctor knows best', rather than from the situation.
10(b)	If practitioner style is due to the doctor's personality, it is fixed and inflexible. A doctor with a directing style may not adapt to patients who want to share decisions, so these patients feel they are not being listened to and have no input into their treatment.
11(a)	The doctor may notice several features of Munchausen syndrome. An essential feature is pathological lying about symptoms: Hanif reports chest pains but the doctor can find nothing physically wrong, so the symptoms may be feigned. A second essential feature is recurrent illness, and his many abdominal scars suggest a history of repeated illness and surgery. Multiple scars, usually abdominal, and multiple hospitalisations are also supporting features. Hanif has also presented himself willingly for examination, showing equanimity for diagnostic procedures and treatment, and being male is another supporting feature.

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11(b)	One weakness is that the features overlap with malingering. For example, multiple hospitalisations and seeking attention from doctors are features of both, so the doctor may misdiagnose Hanif, especially as patients with Munchausen syndrome lie, so accurate information is hard to obtain.
12(a)	Friedman and Rosenman proposed that stress depends on personality. Type A people are competitive, impatient, hostile and high achieving with a sense of time urgency, so they experience more events as stressful than Type B people, who are relaxed and non-competitive. There is no single standardised test of Type A. One is the structured interview (SI), in which the interviewer asks questions and also deliberately interrupts or speaks slowly to observe the person's emotional, verbal and non-verbal responses, such as speaking fast or showing irritation. Another is the Jenkins Activity Survey, a questionnaire with forced-choice items covering speed and impatience, job involvement and hard-driving competitiveness. Others include the Framingham Type A scale and the Bortner short rating scale. Holmes and Rahe's life events questionnaire is the Social Readjustment Rating Scale (SRRS). It lists 43 life events that require readjustment, such as death of a spouse (the highest, 100), divorce, marriage (50) and loss of job. The person ticks which events have happened to them in the past 12 months. Each event has a score in life change units, and these are added up. The higher the total, the higher the stress, and those scoring 300 or more are more susceptible to illness.
12(b)	A key issue is questionnaires. Both the SRRS and Type A tests, such as the Jenkins Activity Survey, are self-administered questionnaires, so they are quick and cheap to give to large numbers of people and produce quantitative scores that can be compared. As they can be completed privately, people may be more honest than in an interview. However, they are open to social desirability: people may not admit life events such as trouble with the law, or may underreport impatience. With the

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SRRS, people may also not recall accurately events from the past year.

Both are psychometric measures, so they are reductionist, turning stress or personality into a number and missing the qualitative experience. The SRRS gives objective scores, but the same event, such as losing a job, may be very stressful for one person and a relief for another, which lowers validity. Type A tests ask subjective questions, and forced-choice items can lack validity.

Reliability differs. The SRRS is standardised, so it is reliable, but there are many versions of Type A tests, so it is hard to establish reliability across them.

Validity is also questioned because stress may come more from daily hassles than major life events, which the SRRS ignores.

Both have applications: doctors can identify people at risk of stress-related illness and recommend stress management. However, the SRRS was developed in the USA and some events, such as a mortgage, may not generalise to other cultures.

Overall, both are useful screening tools, but should be combined with other measures.

Section D: Organisational Psychology

13 Cuadrado et al. (2008) identified stereotypically feminine leadership styles as democratic, relationship-oriented and individualised consideration. First, Ulrich could move from an autocratic to a democratic style, by meeting his workers as a group and asking them how the conflict could be handled, so they feel they have a say in decisions and more ownership of their work. Second, he could move from a task-oriented to a relationship-oriented style, focusing on the relationships between the workers that are causing the conflict rather than only on the work. He could also show individualised consideration by meeting each worker to listen to their concerns. Resolving the conflict should mean the work gets done better.

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14(a)	Intrinsic motivators at work are non-monetary rewards that give the worker an internal sense of satisfaction, such as praise, respect, recognition, empowerment and a sense of belonging.
14(b)	Cultures value different things. In individualistic cultures such as the USA, workers may be motivated more by individual praise and recognition, but in collectivist cultures such as China, individual praise can seem immodest, so a sense of belonging and contributing to the group is more motivating.
15(a)	First, Tayyibah could meet belonging needs. As wages already meet basic needs, she could provide a room where workers can eat lunch and relax together during breaks and arrange team events, so they feel part of a group, which allows them to then focus on esteem needs. Second, she could meet esteem needs by regularly giving positive feedback to workers whose fabric is high quality, and an 'employee of the month' award. This increases their status and self-esteem, and motivates them to progress towards self-actualisation, such as training to design new fabrics.
15(b)	One weakness is that it is culturally biased. The hierarchy, with self-actualisation at the top, reflects individualistic Western values, so in collectivist cultures belonging to the group may be more important than personal achievement, and the order of needs may not apply.
16(a)	Tuckman and Jensen described five stages of group development. In forming, members are strangers who get to know each other, and ground rules and the task are established. In storming, conflict occurs as members compete for their place in the group, and may challenge the leader. In norming, members feel part of the team, cohesion develops and each person's role is clear. In performing, the group

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has a clear purpose and focuses on achieving its shared goal. In adjourning, the group disbands after completing the task, or reviews its progress and recognises each member's contribution.

Belbin (1981) identified nine team roles. The plant is a creative problem solver, and the resource investigator explores opportunities and contacts outside the team. The coordinator is a good chairperson who clarifies goals, the shaper is dynamic and thrives on pressure, and the monitor evaluator is a strategic thinker who judges options. The team worker is cooperative and avoids friction, the implementer turns ideas into practical action, the completer finisher finds errors and finishes on time, and the specialist provides expert knowledge and skills. Belbin argued effective teams need a balance of these roles.

16(b) A key issue is application to everyday life. Tuckman's stages help managers and staff understand that conflict in the storming stage is a normal part of group development, so employees are less worried by it and leaders can use strategies such as coaching or supporting at each stage. Belbin's roles can be used to build teams with a balance of skills, for example making sure there is a completer finisher. However, Tuckman and Jensen admitted that there is little empirical evidence from real organisations, so some applications may not work in practice.

There are problems with generalisation. Tuckman's stages were developed for small groups meeting face to face, so they may not apply to large groups or remote teams. Belbin does not say whether all nine roles are needed, yet many teams have fewer than nine members.

Tuckman's theory is fairly holistic, as it considers how a group develops over time, but it is reductionist in assuming every group passes through the same stages; some groups form quickly to deal with a problem.

Both are nomothetic, giving general rules for all teams and ignoring the uniqueness of each group.

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The stages are situational, as they belong to the group, while Belbin's roles are individual, reflecting personal preferences, although a persuasive individual may affect the stage a group reaches.

Neither says how long a group stays in each stage, and the theories may lack temporal validity.

Overall, both are useful frameworks but need more research support.

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PSYCHOLOGY **9990/33**

Paper 3 Specialist Options: Approaches, Issues and Debates **October/November 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 Jude has a phobia of some foods. This affects his everyday life because he is anxious when other people are eating these foods near him.

Suggest how systematic desensitisation could treat Jude's phobia. [4]

2 **(a)** Outline the reductionism side of the reductionism versus holism debate. [2]

(b) Explain how the biochemical explanation of schizophrenia is reductionist. [2]

3 Aisha finds she has trouble relaxing. She visits her doctor, who suggests using the Generalised Anxiety Disorder assessment (GAD-7).

(a) Suggest **two** reasons why the doctor wants to use the GAD-7 with Aisha. [4]

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

4 **(a)** Describe the study by Lovell et al. (2006) on treatment of obsessive-compulsive disorder (OCD) using telephone administered cognitive-behavioural therapy (CBT). [6]

(b) Evaluate the study by Lovell et al., including a discussion of reliability.

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 An online grocery retailer currently uses a grid layout in its virtual store.

Suggest **two** effects on customers if the store changes to a freeform layout in its virtual store. [4]

6 **(a)** Outline **one** example of how psychologists can use children in psychological research when investigating the topic of brand awareness and recognition. [2]

(b) Explain **one** strength of using children in psychological research when investigating the topic of brand awareness and recognition. [2]

7 Priya is the new manager of a restaurant. She believes that the introduction of background music at the restaurant will improve the atmosphere.

(a) Suggest **two** features of the background music that Priya should choose to improve the atmosphere in her restaurant. [4]

(b) Explain **one** problem of introducing background music in her restaurant. [2]

8 **(a)** Describe what psychologists have discovered about consumer behaviour and personal space:
- personal space at restaurant tables (including Hall's four zones), and
- overload, arousal and behaviour constraint. [6]

(b) Evaluate what psychologists have discovered about consumer behaviour and personal space:
- personal space at restaurant tables (including Hall's four zones), and
- overload, arousal and behaviour constraint,

including a discussion of cultural differences.

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 teacher sees one class of 11-year-olds eating too much unhealthy food. She wants to promote healthy eating.

Suggest how the teacher could decrease the amount of unhealthy food eaten by the children in this class. [4]

10 **(a)** Outline what is meant by free-will, including an example from positive psychology. [2]

(b) Explain **one** reason why positive psychology can be considered to be deterministic. [2]

11 Nadim has been feeling stressed at work but feels relaxed at home. His practitioner is concerned about the effect of this stress on Nadim.

(a) Suggest how his practitioner could compare Nadim's stress at home and at work, using **two** different biological measures. [4]

(b) For **one** of the measures of stress you suggested in part **(a)**:
Explain **one** weakness of this measure of stress. [2]

12 **(a)** Describe explanations of why patients do not adhere to medical advice (rational non-adherence and Health Belief Model). [6]

(b) Evaluate explanations of why patients do not adhere to medical advice (rational non-adherence and Health Belief Model), including a discussion of applications to everyday life.

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 Koffi is the manager of an important project. The project is demanding and the team members have never worked together. Koffi knows about Forsyth's cognitive limitations and errors.

Suggest **two** cognitive limitations/errors that could cause problems for the team members. [4]

14 **(a)** Outline what is meant by social loafing at work. [2]

(b) Explain **one** practical application that could reduce social loafing at work. [2]

15 In a cake factory there are different jobs:
- Factory workers put the finished cakes into boxes.
- Factory supervisors check that the factory workers put the cakes into boxes correctly.
- The factory manager of the whole factory is in charge of the factory supervisors.

(a) For each of the jobs below, identify **one** of Kelley's five followership styles that would help them to be effective in their work. Include a reason for each answer. You must **not** choose the same followership style for both jobs.

(i) A factory worker. [2]

(ii) A factory supervisor. [2]

(b) Explain **one** weakness of Kelley's followership styles. [2]

16 **(a)** Describe what psychologists have discovered about measuring job satisfaction:
- the job descriptive index (JDI), and
- Walton's quality of working life (QWL). [6]

(b) Evaluate what psychologists have discovered about measuring job satisfaction:
- the job descriptive index (JDI), and
- Walton's quality of working life (QWL),

including a discussion of psychometrics.

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

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

Question number

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Section A: Clinical Psychology

1 First, Jude and the therapist build a fear hierarchy of food situations, rating each one for fear. For example, if his phobia is of fatty foods, the lowest step could be sitting in a restaurant where other diners are eating but not near him, a middle step could be someone at his table having a plate of fatty food, and the top step could be fatty food on his own plate while eating with others. The therapist then teaches Jude relaxation techniques such as deep breathing and muscle relaxation. Because of reciprocal inhibition, he cannot feel anxious and relaxed at the same time, so he is exposed to the lowest step while relaxing until he feels no fear, then moves gradually up the hierarchy over a number of sessions until he can cope with the most feared food situation calmly.

2(a) Reductionism is the view that complex behaviour or psychological phenomena can be explained by breaking them down into smaller, simpler component parts or the most basic level of explanation, such as genes, neurotransmitters or stimulus-response links.

2(b) The biochemical explanation says schizophrenia is caused by an imbalance of the neurotransmitter dopamine, such as excess dopamine activity in the mid-brain. This is reductionist because it explains a complex disorder using a single chemical, and does not include other processes such as faulty cognition or family influences.

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3(a)	First, the GAD-7 is a screening test for generalised anxiety disorder, and trouble relaxing is one of its seven items. So the doctor can find out whether Aisha's difficulty relaxing is part of wider anxiety, and if her score is high (the maximum is 21) she can be referred to a specialist for further assessment and therapy. Second, it is quick and simple, so it will not make Aisha more anxious. She only rates seven items, such as feeling nervous or on edge and not being able to stop worrying, from 0 (not at all) to 3 (nearly every day) for the last two weeks, which takes only a few minutes in the appointment.
3(b)	One weakness is that it only measures how often symptoms occur, not how severe they are. Aisha may find one item, such as being unable to relax, far more disabling in her daily life than the others, but this is not shown by the score, so it cannot capture her full experience of anxiety or give a full diagnosis.
4(a)	Lovell et al. aimed to compare the effectiveness of cognitive-behavioural therapy (exposure and response prevention) for OCD delivered by telephone with the same therapy given face to face. It was a randomised controlled non-inferiority trial using an independent groups design. The participants were 72 out-patients with OCD, aged 16 to 65, from two psychology out-patient departments in the UK. All scored at least 16 on the Yale-Brown Obsessive Compulsive Scale (Y-BOCS). They were randomly allocated to two groups. Both received 10 weekly sessions of exposure and response prevention. The face-to-face group had ten one-hour sessions. The telephone group had a one-hour face-to-face session at the start and at the end, and eight 30-minute sessions by telephone in between. The measures were the Y-BOCS, the Beck Depression Inventory and a client satisfaction questionnaire. Patients were assessed twice before treatment (four weeks apart), after treatment, and at one, three and six month follow-ups. Before

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treatment there was no significant difference between the groups.

Both groups showed a similar large reduction in OCD symptoms that lasted to six months. The difference in Y-BOCS scores between the treatments at six months was only −0.55, and satisfaction was high for both. Lovell et al. concluded that telephone CBT is as effective as face-to-face CBT for OCD.

4(b) A strength is reliability. The same standardised measures (Y-BOCS, Beck Depression Inventory and satisfaction questionnaire) were used with every patient at fixed points: twice before treatment, after it and at one, three and six months. Assessing twice before treatment showed symptoms were stable, so the change can be put down to the therapy. Both groups received the same exposure and response prevention, with the same therapists in each hospital, so the procedure was consistent and could be replicated. However, therapists cannot deliver sessions identically every time, which lowers reliability slightly.

A second strength is validity. Random allocation and no significant difference between groups before treatment mean the type of delivery was the only systematic difference. The data were quantitative, so the groups could be compared statistically, and the six-month follow-up shows lasting change. However, the Y-BOCS and satisfaction scores are self-report, so patients may show social desirability bias, and quantitative scores do not explain why the therapy helped.

The study has strong application to everyday life. Telephone sessions were only 30 minutes yet as effective, so services can treat more patients at lower cost, and people in remote areas or who are too anxious to leave home can get help.

The study supports a situational explanation, as the setting of therapy did not affect outcome, but individual differences such as motivation and the relationship with the therapist still matter.

A weakness is generalisation. The sample of 72 came from two UK hospitals, an individualistic culture where CBT is common. In collectivist cultures, a therapy

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focused on individual thoughts may be less accepted, and the stigma of OCD may affect willingness to take part.

Overall, the study is reliable, controlled and useful, although its sample limits how widely it applies.

Section B: Consumer Psychology

5 First, customers may find the virtual store more useful for finding items on their shopping list. In the grid layout they have to move through a hierarchy, from product category to subcategory to the product, but in the freeform layout they can reach products at once through a search engine or items displayed on every page, so their online grocery shop is quicker (Vrechopoulos et al., 2004).

Second, customers may spend longer in the online store. Vrechopoulos et al. found freeform layouts were more entertaining but also harder to use than grid layouts, so shoppers would browse more of the grocery pages and be engaged for longer, which could mean they buy extra items and spend more.

6(a) Psychologists can show young children brand logos and ask them to match each logo to the product it goes with. For example, Fischer et al. (1991) asked children aged 3 to 6 to place logo cards on pictures of products on a game board, to see which brands they recognised, with consent from parents and the school.

6(b) A strength is that children are less affected by demand characteristics than adults, so they give honest responses about which logos they recognise. This gives useful findings, for example that many young children recognised Old Joe the camel from cigarette adverts, which shows advertisers and governments that adult products should not be branded in child-appealing ways.

Question number	
7(a)	One feature is the genre of the music. North et al. (2003) found that customers spent more in a restaurant when classical music was played than when pop music or no music was played. So if Priya chooses a classical soundtrack, it should create an upmarket atmosphere and customers may order more food and drink. A second feature is the volume. The music should be quiet enough to stay in the background so diners can talk easily at their tables. This makes the atmosphere relaxed and pleasant, so customers stay longer and are more likely to return to Priya's restaurant.
7(b)	One problem is that the music may not suit her existing customers' taste. If regular diners dislike the genre, the new atmosphere may annoy them, so they may spend less time and money in the restaurant or stop coming, and Priya would lose sales.
8(a)	Hall described four zones of personal space. Intimate space, from touching up to about 46 cm, is for close relationships, such as a couple. Personal space, from about 46 cm to 1.2 m, is for family and close friends. Social space, from about 1.2 m to 3.7 m, is for acquaintances and business. Public space, from 3.7 m to over 8 m, is for public speaking. In a restaurant, diners expect strangers at nearby tables to stay out of their intimate and personal zones. Personal space has functions. Overload: when people are too close we must process extra information such as their conversation and smell, with little control, which causes stress. Arousal: invasion of space increases arousal, which may be positive at a celebration but negative during an intimate meal next to strangers. Behaviour constraint: when seated close to others we cannot move away, so we feel a loss of control, discomfort and even anger. Robson et al. (2011) carried out an online survey of over 1000 Americans. Participants imagined a romantic meal, a meal with a friend or a business lunch at

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	tables 6, 12 or 24 inches apart, and rated 32 statements about their emotions and behaviour. At 6 inches they felt more crowded, less private and less satisfied, especially in the romantic scenario. Women reported more stress and discomfort than men, while men reported more arousal.
8(b)	A key issue is cultural differences. Hall accepted that the exact distances of the zones vary between cultures, although he argued the zones themselves exist everywhere. Robson et al. only studied Americans, an individualistic culture. In India, for example, it is more common for people to sit closer together when eating, so 12 inches may feel comfortable there, although with business contacts more distance may still be needed. So the findings cannot be applied to restaurants worldwide, and restaurant designers would need local research. Robson et al. collected quantitative data from rating statements, which allowed statistical comparison of table distances, scenarios and gender. However, there were no qualitative data, so we do not know why participants felt uncomfortable, which lowers validity. Ecological validity is low, as participants imagined a scenario online instead of sitting in a real restaurant, so their real behaviour, such as leaving early, may differ. However, the large sample of over 1000 makes the findings more generalisable within the USA. The research is ethical, since an online survey avoided making participants actually sit uncomfortably close to strangers, but this is also why realism is lost. The research is mainly situational, as table distance is the cause, but individual differences such as gender, personality and confidence also affect how much overload, arousal and constraint people feel, as Robson et al.'s gender differences showed. The research is useful, as restaurants can balance the number of tables against customer comfort, for example by giving romantic diners more space.

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	Overall, the ideas are useful but limited by culture and imagined scenarios.
	Section C: Health Psychology
9	The teacher could run a healthy swaps project with this class. Each child keeps a simple food diary for a week of what they eat at school and home, then in class they identify the unhealthy foods, such as crisps, sweets and fries, and suggest healthy alternatives, such as fruit or vegetables instead of fries. Every time a child brings a healthy snack instead of an unhealthy one, they get a sticker on a class chart, and a certificate for every 10 stickers, which rewards eating less unhealthy food. The teacher could also write to the parents to explain the project so that the children are supported at home, and the class could turn their swaps into a leaflet.
10(a)	Free will is the idea that people are able to choose their own behaviour and are not controlled by internal or external forces. In positive psychology, a person can freely choose to set a long-term goal, such as getting fitter, and break it into weekly targets to increase their well-being.
10(b)	Positive psychology claims that if people use its interventions, such as identifying their character strengths or keeping a gratitude diary, they will become happier, so happiness is determined by the intervention and not by free choice. For example, in Shoshani and Steinmetz's school programme, the intervention determined that students' well-being improved.
11(a)	First, the practitioner could ask Nadim to wear a heart rate monitor, such as a smart watch, during several work days and evenings at home. Because stress activates the sympathetic nervous system, his heart rate would be expected to be higher at work than at home.

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	Second, Nadim could provide saliva samples at set times both at work and at home, which are tested for cortisol. Cortisol is released in stressful situations, so if he is stressed at work, his salivary cortisol should be higher at work than at home.
11(b)	Heart rate can be high for reasons other than stress, such as walking around at work, drinking coffee or poor fitness. So a higher heart rate at work may not show Nadim is stressed, and it does not identify the source of his stress.
12(a)	Rational non-adherence is when a patient makes a reasoned decision not to follow medical advice after a cost-benefit analysis, because adhering seems too costly. Factors include side effects, how severe the illness is, cost, how often the medicine must be taken, and restrictions such as alcohol. Bulpitt (1994) argued that patients focus on the risks of medication and rarely consider the benefits: drugs for high blood pressure reduced strokes by 40% but some patients stopped because of side effects. Laba et al. (2012) used an online survey of 161 Australian participants. Participants were given hypothetical choices about continuing two medications for long-term conditions, with attributes varied, such as side effects, chance of death, dose frequency, alcohol restrictions and monthly cost. Monthly cost mattered most for those without health insurance, people were more willing to continue a medicine taken once a day than four times a day, and current side effects mattered more than future harm, so decisions were rational trade-offs. The Health Belief Model (Becker and Rosenstock) says people decide rationally whether to take a health action. Perceived threat depends on perceived susceptibility and perceived severity of the illness, and is affected by modifying factors such as age, culture and education and by cues to action such as symptoms or a media campaign. The person weighs perceived benefits against perceived barriers, such as cost or side effects, and self-efficacy also matters.

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	Non-adherence occurs when threat or benefits seem low or barriers high.
12(b)	A key strength is application to everyday life. If patients do not adhere because of cost or side effects, health services can make medicines cheaper, develop drugs with fewer side effects or simplify doses, for example once a day rather than four times, as Laba et al. showed this increases willingness to continue. The Health Belief Model can be used to design campaigns that raise perceived severity or give cues to action, and to train practitioners to ask about barriers. However, because of individual differences, one way of improving adherence will not work for everyone. Both explanations are reductionist, breaking decisions into costs and benefits or a set of perceptions. This allows factors to be varied and tested, as in Laba et al., but people are not always rational, and emotions or habits such as forgetting are ignored, so a more holistic view may explain real patients better. They are nomothetic, aiming for general laws about adherence, which is useful for health services, but may not fit an individual patient. The Health Belief Model includes situational factors such as cues to action and education, and individual factors such as self-efficacy, so it is fairly comprehensive. There are problems with generalisation. Laba et al. used 161 Australians, and both explanations are based on Western medicine, ignoring cultures where traditional medicine and trust in practitioners differ, or where insurance is unavailable. The survey used hypothetical choices, so it lacks ecological validity. Overall, both are useful for improving adherence, but they overestimate how rational patients are.
	Section D: Organisational Psychology
13	One error is a sin of omission, such as base rate bias, where relevant information

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	is overlooked. Because the project is demanding, the team members may rush to finish and ignore important features that need to be considered, such as risks or deadlines for some parts. A second is confirmation bias, where the group seeks information that confirms rather than contradicts its beliefs. As the team members have never worked together, they may agree with each other to avoid conflict and check their progress only with opinions from inside the team, rather than asking an outsider to check objectively, so mistakes are missed.
14(a)	Social loafing is when individuals reduce the effort they put into a task when working as part of a group at work, compared to the effort they make when working alone.
14(b)	The manager could make each worker's contribution identifiable, for example by giving each person a named task and reviewing it individually, together with a team bonus if the whole group finishes on time. As individual effort is seen and rewarded, workers are less likely to hide in the group, so loafing is reduced.
15(a)i	A sheep (passive and dependent) would be effective. Putting cakes into boxes is a simple, repetitive task that is checked by the supervisor, so the worker does not need to question decisions or think independently, and can just follow instructions.
15(a)ii	An effective follower (active and independent) would help. The supervisor must check the workers' boxing without constant direction from the manager, so needs to think critically, solve problems such as errors in packing independently, and actively pass on new initiatives to the workers.
15(b)	One weakness is that Kelley does not explain whether followership styles are

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innate or learned, or whether they come from the person or the role. So it is unclear whether a worker's style can be changed through training, which makes it hard for managers to assign people to roles.

16(a) The Job Descriptive Index (JDI) is a self-report questionnaire that measures job satisfaction on five dimensions: the work itself, supervision, pay, promotion opportunities and co-workers. For each dimension the worker is given short words or phrases, for example for pay, 'income adequate for normal expenses' or 'less than I deserve'. They write Y for yes, N for no or ? if they cannot decide, to show whether each describes their job. Each answer is scored, so a total can be calculated for each dimension, and scores are compared with standardised norms from large samples, which are regularly updated.

Walton (1974) proposed that quality of working life (QWL) depends on eight conditions: fair and adequate pay; safe and healthy working conditions; opportunities to use and develop skills; opportunity for career growth and security; social integration in the workplace; constitutionalism, meaning rights, policies and procedures; the total life space, meaning a balance between work and life outside; and social relevance of the work. The QWL evaluation scale is a questionnaire using Likert scales to measure how employees feel about each condition, their job, colleagues and company. This helps the organisation respond to employees' needs and shows how these feelings affect growth and profitability.

16(b) A key issue is psychometrics. Both the JDI and the QWL scale are psychometric tests that produce quantitative scores, so satisfaction can be compared between workers, departments or over time and analysed statistically. The JDI is standardised against norms from large samples, so it is reliable and has good population validity. They are scored differently: the JDI uses yes, no and ?, which is quick, while the QWL uses Likert scales, which give a more sensitive measure

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but can produce acquiescence bias. Some QWL items also use complex language, which may reduce validity if workers misunderstand them.

Both are self-reports, so workers may give socially desirable answers or worry that criticising their supervisor could affect their job. Anonymous completion would help, as more honest answers increase validity.

Both have high face validity, as the items are clearly about pay, colleagues and conditions. However, with no qualitative data, they cannot explain why a worker is dissatisfied, so managers may not know what to change.

They are reductionist, breaking job satisfaction into five or eight dimensions, which makes it measurable, although the QWL is more holistic, as it includes life outside work and social relevance.

They are nomothetic, assessing individuals mainly on situational features of the workplace.

Both are useful in everyday life: organisations can identify problems, such as unfair pay, and act on them to improve motivation and reduce staff turnover.

Overall, both are reliable, practical measures, but adding interviews would give a more valid picture.