Cambridge Assessment International Education

Cambridge International AS & A Level

PSYCHOLOGY **9990/31**

Paper 3 Specialist Options: Approaches, Issues and Debates **October/November 2025**

1 hour 30 minutes

5680069136

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 Hugh has obsessive-compulsive disorder (OCD). Hugh's childhood was difficult. His mother had an obsession with germs, insisting on excessive cleanliness.

Suggest **two** different explanations of why Hugh has OCD. [4]

2 **(a)** Outline what is meant by 'cultural differences'. [2]

(b) Explain **one** reason why cultural differences could affect the diagnosis of an anxiety disorder. [2]

3 Habiba has a phobia of flying insects. She is afraid of the noise they make and is very scared if one lands on her. Habiba's therapist recommends that she is treated using systematic desensitisation.

(a) Suggest how Habiba's therapist can use systematic desensitisation to treat Habiba's phobia. [4]

(b) Explain **one** weakness of systematic desensitisation. [2]

4 **(a)** Describe what psychologists investigating the treatment and management of mood (affective) disorders have discovered about:
- MAOI anti-depressants, and
- Ellis's rational emotive behaviour therapy (REBT). [6]

(b) Evaluate what psychologists investigating the treatment and management of mood (affective) disorders have discovered about:
- MAOI anti-depressants, and
- Ellis's rational emotive behaviour therapy (REBT),

including a discussion of 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 Abdul wants to purchase a chair from a website. The website is designed so that comparisons between items are **not** easy to make.

Suggest **two** decision-making strategies Abdul is likely to use when purchasing his chair. [4]

6 **(a)** Outline what is meant by 'determinism', including an example from choice heuristics. [2]

(b) Explain **one** strength of using the determinism side of the determinism versus free-will debate to understand choice heuristics. [2]

7 Supermarket shoppers do **not** all behave in the same way. Shoppers can be categorised into five types based on their different spatial behaviour patterns. Zelda visits all of the aisles of the supermarket when she does her main shopping. However, Louis spends a short time in the supermarket and visits only a few aisles.

(a) **(i)** Identify which type of shopper spatial behaviour pattern would be **most** appropriate to describe:
- Zelda
- Louis. [2]

(ii) Frank is a different type of shopper from Zelda and Louis. He shows a different spatial behaviour pattern.

Suggest how Frank could behave in the supermarket. [2]

(b) Explain **one** problem that psychologists may have when investigating shoppers' spatial behaviour patterns. [2]

8 **(a)** Describe what psychologists have discovered about types of advertising and advertising techniques:
- the Yale model of communication, and
- a study about types of advertising media. [6]

(b) Evaluate what psychologists have discovered about types of advertising and advertising techniques:
- the Yale model of communication, and
- a study about types of advertising media,

including a discussion of objective and subjective data.

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

Section C: Health Psychology

Answer **all** questions.

9 A university student, Chloe, thinks that she has less chance of becoming ill than other students. She also thinks that she has more chance of living longer than other students. This suggests unrealistic optimism in Chloe's health beliefs.

Suggest **two** reasons why Chloe may have unrealistic optimism in her health beliefs. [4]

10 **(a)** Outline what is meant by the debate between individual and situational explanations. [2]

(b) Explain why **one** strategy for improving health has a situational explanation. [2]

11 Omar is in hospital with chest pain. His practitioner wants to investigate this by assessing Omar's pain.

(a) Suggest **two** different measures of pain that Omar's practitioner could use with him. [4]

(b) For **one** of the measures of pain you suggested in part **(a)**:

Explain **one** weakness of this measure of pain. [2]

12 **(a)** Describe what psychologists investigating practitioner diagnosis have discovered about:
- making a diagnosis (disclosure of information, false positive and false negative diagnosis), and
- presenting a diagnosis. [6]

(b) Evaluate what psychologists investigating practitioner diagnosis have discovered about:
- making a diagnosis (disclosure of information, false positive and false negative diagnosis), and
- presenting a diagnosis,

including a discussion of validity.

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 Celeste is a member of a newly formed school council. This is a group of student representatives who make decisions, such as what should be on the school menu and whether to have recycling bins or a new drinks machine.

Suggest the stages of group development that the school council could go through as they make decisions. [4]

14 **(a)** Outline what is meant by a 'nomothetic approach', including an example from a need theory of motivation at work. [2]

(b) Explain how a need theory of motivation at work could be investigated using an idiographic approach. [2]

15 Tatpara is the manager at a carpet factory. He is concerned about low production at his factory. Tatpara believes this may be due to a lack of motivation in the workers.

(a) Suggest **two** ways Tatpara could use extrinsic motivators with the carpet factory workers to increase production. [4]

(b) For **one** of your suggestions in part **(a)**:

Explain **one** strength of this suggestion, other than to increase production. [2]

16 **(a)** Describe what psychologists have discovered about temporal conditions of work environments:
- rapid rotation and slow rotation shiftwork, and
- a study about the effects of shiftwork on health and accidents. [6]

(b) Evaluate what psychologists have discovered about temporal conditions of work environments:
- rapid rotation and slow rotation shiftwork, and
- a study about the effects of shiftwork on health and accidents,

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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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 Behavioural (operant conditioning): as a child Hugh was probably praised by his mother whenever he washed or cleaned, so this positive reinforcement made cleaning more likely to be repeated. Washing also briefly relieves his anxiety about germs, so the compulsion is negatively reinforced and has become a habit.
Genetic: Hugh may have inherited a vulnerability to OCD from his mother, as her obsession with germs suggests she may have OCD herself. Lewis (1936) found that 37% of OCD patients had parents with OCD, and Monzani et al. (2014) found higher concordance for MZ twins (52%) than DZ twins (21%).

2(a) Culture is the shared set of beliefs, values, norms and practices of a group or society. Cultural differences are the ways these beliefs and norms vary between groups, so behaviour that is normal in one culture, such as hearing the voices of ancestors, may be seen as a symptom of a disorder in another.

2(b) Diagnosis depends on whether behaviour deviates from social norms. In some cultures it is the norm for women not to leave the home alone, so a clinician from a different culture might wrongly diagnose agoraphobia, when the avoidance of going outside is actually culturally expected and not caused by anxiety.

3(a) First the therapist teaches Habiba relaxation techniques, such as deep breathing and visualising a calm place. Together they build a fear hierarchy, from looking at

Question number	
	a picture of a fly at the bottom, to hearing a quiet recording of buzzing, up to a wasp flying near her and one landing on her sleeve at the top. Habiba is exposed to the lowest step while using her relaxation, as she cannot feel fear and relaxation at the same time (reciprocal inhibition). Once she is relaxed at one step she moves to the next, such as a louder buzzing sound, over several sessions until she stays relaxed when an insect lands on her.
3(b)	Systematic desensitisation needs several sessions with a trained therapist, so it is costly and needs a lot of commitment. Being exposed to the feared object is also distressing, so patients like Habiba may drop out before reaching the top of the hierarchy, meaning the phobia is not fully treated.
4(a)	MAOIs (monoamine oxidase inhibitors) were the first antidepressants, used since the 1950s. They inhibit the enzyme monoamine oxidase, which normally breaks down the neurotransmitters serotonin, noradrenaline and dopamine in the synapse. Because these neurotransmitters are not broken down, their levels stay higher in the brain, which improves mood. Evidence shows they are effective, but today they are usually given only when other antidepressants such as SSRIs have not worked. They have side effects such as headaches, drowsiness, insomnia and constipation, and they interact with other medicines and foods high in tyramine, such as some cheeses, red wine and fermented foods, which can cause a dangerous rise in blood pressure (hypertensive crisis). Ellis's REBT is based on stoicism: we are disturbed not by events but by our beliefs about them. It uses the ABC model: A is the activating event, B is the belief about the event, and C is the emotional and behavioural consequence. Ellis argued that constant irrational, negative beliefs, such as "I must be perfect", lead to depression. The therapist uses disputing, actively challenging the irrational beliefs, so the patient replaces them with rational, constructive beliefs and can

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choose how to think and feel about setbacks. REBT focuses on the present, not the past. A meta-analysis of 70 REBT studies by Lyons and Woods (1991) found that people receiving REBT improved significantly more than control groups.

4(b)

Reductionism versus holism: both treatments are reductionist. MAOIs reduce depression to levels of neurotransmitters, ignoring the person's thoughts, relationships and life events, so the cause may remain and the patient may relapse when the drug stops. However, MAOIs act on several neurotransmitters, not just one, which is less reductionist than an SSRI. REBT reduces depression to irrational beliefs, but it is more holistic as it recognises that activating events matter and it treats the whole person's way of thinking about life.

Application to everyday life: both are supported by evidence of effectiveness, MAOIs since the 1950s and REBT by Lyons and Woods (1991). MAOIs are relatively cheap and easy to take, but a strict diet without tyramine-rich foods and serious side effects lower adherence. REBT needs a trained therapist and regular sessions, so it is more expensive and harder to access. It is also confrontational, which may be hard for a depressed patient with low motivation and self-esteem to engage with.

Individual versus situational: both are individual explanations. However, the link between neurotransmitters and depression is correlational, as low serotonin may be a result of depression rather than its cause, and situational stressors such as bereavement or redundancy may cause depression however rationally a person thinks.

Determinism versus free will: MAOIs reflect biological determinism, as we have no control over neurotransmitters, whereas REBT allows free will, as the patient chooses to change their beliefs, giving a sense of control.

Generalisations: findings of effectiveness are averages, and there are individual differences, as side effects affect some people more and REBT suits only

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	motivated patients. Overall both treatments work, but because each is reductionist, a holistic approach combining a drug with REBT may be the most effective.
	Section B: Consumer Psychology
5	As comparisons are hard, Abdul is likely to use non-compensatory strategies. He may use the lexicographic strategy: he decides the most important attribute is the design of the chair, so he picks the chair with the most attractive design and does not consider other attributes such as price. He may use satisficing: his basic requirements are a sturdy, comfortable wooden chair under £100, so he buys the first chair he sees that meets these and stops searching, even if a better one exists.
6(a)	Determinism is the view that behaviour is caused by internal or external factors outside our control. For example, the anchoring heuristic means consumers are automatically influenced by the first piece of information, such as the first price seen, without choosing to be.
6(b)	Determinism allows predictions of consumer behaviour. The representativeness heuristic predicts that a new product packaged to look like a high-quality market leader, such as a well-known trainer brand, will be judged as high quality, so companies can use this to increase sales.
7(a)(i)	Zelda: explorer. Louis: raider.
7(a)(ii)	Frank is a specialist. He goes into the supermarket for a few specific items, such as wine, and heads straight to that aisle, spending a long time comparing the

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	bottles there, but he may buy only one or two items.
7(b)	Shoppers do not behave consistently: a person may be a raider in one store but an explorer in a familiar store, or on a different day. This means classifying a shopper from one CCTV-tracked trip may not be representative, so the findings lack validity.
8(a)	The Yale model of communication (Hovland and colleagues, 1953) says persuasion depends on five features. Source: a message is more persuasive from a credible source, such as an expert or a trustworthy, attractive person. Message: two-sided arguments are more effective than one-sided ones, and statistics can convince people. Channel: the medium (written, verbal, TV, social media) should suit the audience. Audience: younger people and less educated people are more easily persuaded. Effect: the most effective messages change attitudes and, beyond this, behaviour, for example buying the product. Ciceri et al. (2020) compared three types of advertising media using the same mock newspaper containing 25 static adverts: a website on a laptop, a printed paper edition, and a PDF on a tablet. 72 participants read the newspaper at their own pace while eye-tracking measured fixation on adverts and EEG measured their frustration. After a one-hour distraction task, a recognition task showed them 50 adverts (25 had been in the newspaper) and asked which they had seen. Fixation time on adverts was longest on the tablet and shortest on the website, and recognition was most accurate for the tablet and least for the website. EEG showed less frustration on the tablet and paper than on the website. Tablet and paper results did not differ significantly.
8(b)	Objective and subjective data: Ciceri et al. collected objective data from eye-tracking, EEG and the recognition task. This is a strength because the data

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are numerical, not open to researcher bias, and reliable, so the media can be compared fairly. However, inferring frustration from EEG activity may not be valid, and no subjective data were collected, so participants could not explain why website adverts irritated them. The Yale model has subjective elements, for example what counts as a "credible" source or a "young" audience differs between people, so it is hard to test objectively.

Application to everyday life: the Yale model gives advertisers clear guidance, such as using an expert as the source and choosing the channel for the target age group. Ciceri et al. suggest advertisers should place adverts in tablet and print editions rather than on websites, where they are ignored and irritating.

Validity: Ciceri et al. was a lab experiment with wearable eye-tracking and EEG, which could make reading unnatural and lower ecological validity, although the materials were like a real newspaper. It has high temporal validity as it uses modern media. The Yale model was developed in 1953 to understand wartime propaganda, so it may be less valid for social media influencers today.

Cultural differences: the Yale model was developed in the West, and features such as source credibility may differ between cultures, for example in collectivist cultures. Ciceri et al. also used one Western sample of 72, which limits generalisation. Overall both are useful for advertisers, but objective measures should be combined with subjective reports to fully explain advertising effects.

Section C: Health Psychology

9

Stereotypes: Chloe may think the people at risk of illness, such as heart attacks, are overweight middle-aged men. As a young female student she does not fit this stereotype, so she believes she is less at risk and ignores advice about diet and exercise (Weinstein, 1980).

Lack of personal experience: Chloe may never have had a serious illness, nor has

Question number	
	anyone close to her, so she thinks it will not happen to her. She may also believe the risk is controllable, for example "I walk to lectures, so I will live longer than other students".
10(a)	Individual explanations say behaviour is caused by internal, dispositional factors, such as personality or beliefs. Situational explanations say behaviour is caused by external, environmental factors, such as reinforcement or other people. The debate is about how far behaviour is caused by each.
10(b)	Fear arousal, such as photographs of mouth cancer on cigarette packets, is situational because it is an external source of influence, not controlled by the individual. Everyone receives the same message, and it assumes all smokers will react in the same way regardless of personality.
11(a)	The practitioner could use the McGill Pain Questionnaire. Omar would choose words from 20 groups of descriptors that describe his chest pain, such as "crushing" or "tight", covering sensory, affective and evaluative aspects. This gives a pain rating index, plus a present pain intensity score from 0 (no pain) to 5 (excruciating). The practitioner could use the UAB pain behaviour scale. A nurse observes Omar and rates ten target behaviours, such as verbal complaints, facial grimaces and mobility (for example whether he can walk), each as none, occasional or frequent (0, 0.5 or 1), giving a total pain behaviour score.
11(b)	The UAB scale only measures outward pain behaviours, not Omar's experience of pain. If Omar hides his pain, for example because he does not want to seem weak, he would score low even though his chest pain is severe, so the measure may lack validity.

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12(a)	Making a diagnosis: patients may not disclose information fully. Sarafino (2006) described how patients may be angry with or critical of the doctor, ignore what the doctor asks, or insist on unnecessary tests, which make diagnosis harder. Robinson and West (1992) found that patients at a sexual health clinic disclosed more information on a computerised interview than on a written questionnaire, and both gave more than when speaking to a doctor, so patients may hold back embarrassing information. Incomplete information can lead to errors. A false positive (Type 1 error) is when a healthy patient is diagnosed as ill, so they may receive unnecessary treatment. A false negative (Type 2 error) is when an ill patient is diagnosed as healthy, so they do not receive the treatment they need. Presenting a diagnosis: the traditional method is face to face, but this may not always be best. Cooke and Colver (2016) let 77 skin cancer patients choose how to receive their diagnosis after explaining the pros and cons: 48% chose a letter, 37% a phone call and 11% face to face. 94% of those who received it in their chosen way were happy. Karri et al. (2009) found 52% of skin cancer patients preferred a letter. Schofield et al. (2003) found no difference in satisfaction, anxiety or depression between diagnosis by phone or face to face, but satisfaction was higher when patients felt prepared, the word "cancer" was used and information was clear.
12(b)	Validity: the research has high ecological validity as it studies real patients in real clinics, such as the skin cancer patients in Cooke and Colver. Robinson and West controlled the method of gathering information, so differences in disclosure can be attributed to the method, giving good internal validity. However, population validity is limited, as the presenting research mainly used skin cancer patients, whose preferences may differ from patients with more serious cancers or other conditions. Self-reported satisfaction may also be affected by social desirability, lowering validity.

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	Application to everyday life: the research is highly useful, as almost everyone receives a diagnosis. Using a computerised interview could reduce false negatives for embarrassing conditions, and offering patients a choice of how to receive a diagnosis increases satisfaction. Individual versus situational: disclosure depends on individual factors, such as the patient's embarrassment or personality, and on situational factors, such as the method used and the doctor's style. Cultural differences: in some cultures disclosing sensitive information, especially to a doctor of the opposite gender, is difficult, so findings may not generalise across cultures. Determinism versus free will: the method of information-gathering appears to determine what is disclosed, and so the risk of a false positive or false negative. However, giving patients free choice over how a diagnosis is presented improves how they cope. Overall the research is valid and useful, although findings from skin cancer patients should be generalised with care.
	Section D: Organisational Psychology
13	Forming: at the first meetings the members do not know each other, so they are polite and formal and set rules, such as how votes will be taken. Storming: members such as Celeste start to disagree, for example over whether to spend money on recycling bins or a drinks machine, and may resist the leader. Norming: they accept each other's views and agree on norms. Performing: they work together in a trusting way, dividing roles so Celeste may survey students about the menu. Adjourning: at the end of the year they review their decisions and make recommendations for the next council.
14(a)	A nomothetic approach studies large groups to establish general laws that apply to

Question number	
	everyone. For example, Maslow's hierarchy of needs states that all workers must have physiological, safety and social needs met before they can be motivated by esteem needs.
14(b)	A psychologist could carry out a case study of one worker, using an unstructured interview with open questions and a daily diary of when they felt a need for achievement, affiliation or power (McClelland). This gives rich qualitative detail about that individual's unique motivation, rather than general laws.
15(a)	Performance-related pay: Tatpara could pay each worker more for each carpet produced above a target, so the workers who produce the most carpet earn the most. Bonus: Tatpara could pay every worker a one-off bonus if the factory meets a monthly production target, so workers are motivated to work together as a team to all receive the bonus.
15(b)	The team bonus is seen as fair, as everyone benefits if they all work hard together. This makes the carpet workers feel valued and part of a team, increasing their commitment, so they are more likely to stay at the factory, reducing staff turnover.
16(a)	Pheasant identified two ways of organising shiftwork. Rapid rotation means frequent shift changes, such as the metropolitan rota: two day shifts, two afternoon shifts, two night shifts, then two days off, or the continental rota with a longer cycle of 2 day, 2 twilight and 3 night shifts. Rapid rotation is difficult to adjust to, as circadian rhythms are constantly disrupted. Slow rotation means infrequent changes, such as working night shifts for several weeks before changing to day shifts, which lets circadian rhythms adapt and causes fewer health

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problems.

Gold et al. (1992) carried out a hospital-based questionnaire survey of 635 female nurses in Massachusetts, USA, about their shiftwork, sleep and accidents. Nurses who rotated shifts were compared with nurses who worked only day or evening shifts. Rotators had more sleep/wake disruption and nodded off at work more. They had twice the odds of nodding off while driving to or from work, and twice the odds of reporting an accident or error related to sleepiness. Gold et al. concluded that applying circadian principles to hospital work schedules could improve the health and safety of nurses and patients.

16(b) Quantitative and qualitative data: Gold et al. collected mainly quantitative data, such as the odds of nodding off or having accidents. This is a strength because rotators and non-rotators can be compared easily and objectively, for example showing twice the odds of accidents. However, quantitative data lack depth, so we do not know why the nurses felt sleepy or how shiftwork affected their lives. Qualitative interviews would give this detail but would be harder to compare.

Questionnaires: data were self-reported, so the nurses may have under-reported accidents or errors to avoid blame, or exaggerated sleepiness, lowering validity. However, questionnaires allowed a large sample of 635 nurses to be studied quickly.

Correlation: the link between rotating shifts and accidents is correlational, so other factors, such as having young children at home, may cause sleepiness.

Application to everyday life: employers can use the findings to change rapid rotation to slow rotation and reduce accidents, which is important where errors are dangerous, such as in hospitals.

Determinism: shiftwork effects seem biologically determined by circadian rhythms, although people choose shift jobs, and some, such as "night owls", cope better, so there are individual differences.

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Generalisability: Gold et al. studied only female nurses in one US state, so findings may not apply to male workers or other jobs. Overall the research is useful, but its quantitative, self-report data should be combined with qualitative and objective measures.

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PSYCHOLOGY **9990/32**

Paper 3 Specialist Options: Approaches, Issues and Debates **October/November 2025**

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 Halema has been having depressed moods. Her psychiatrist thinks Halema has either depressive disorder (unipolar) or bipolar disorder.

Suggest **two** differences that may be seen in Halema's behaviour that would help distinguish between depressive disorder (unipolar) and bipolar disorder. [4]

2 **(a)** Outline learned helplessness as an explanation of depressive disorder. [2]

(b) Explain how the learned helplessness explanation of depressive disorder is an individual explanation. [2]

3 Blake has schizophrenia. His psychiatrist suggests treating him with atypical antipsychotics rather than typical antipsychotics.

(a) Suggest **two** reasons why atypical antipsychotics could be a suitable treatment for Blake. [4]

(b) Explain **one** weakness of using antipsychotics to treat schizophrenia. [2]

4 **(a)** Describe the following treatments for anxiety disorders and fear-related disorders:
- cognitive-behavioural therapy (CBT), and
- applied tension focusing on treating blood/injection/injury phobia. [6]

(b) Evaluate the following treatments for anxiety disorders and fear-related disorders:
- cognitive-behavioural therapy (CBT), and
- applied tension focusing on treating blood/injection/injury phobia,

including a discussion of generalisations.

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 Clive is the manager of a shopping mall. He is aware of the pleasure-arousal-dominance (PAD) model. Clive wants to use a pleasant odour in the mall.

Suggest **two** effects this pleasant odour could have on shoppers. [4]

6 **(a)** Outline the nomothetic approach, including an example from the effect of sound on consumer behaviour. [2]

(b) Explain **one** strength of using a nomothetic approach in psychology. [2]

7 Nandi is a chef in a local restaurant. She is designing a menu and knows that food names can affect customers' menu item choice.

(a) Suggest how Nandi could use her knowledge about food names when designing a menu for her restaurant. [4]

(b) Explain **one** problem with carrying out research into the effect of food names on menu item choice. [2]

8 **(a)** Describe explanations and examples of compensatory, non-compensatory and partially compensatory strategies of consumer decision-making. [6]

(b) Evaluate explanations and examples of compensatory, non-compensatory and partially compensatory strategies of consumer decision-making, including a discussion of application to everyday life.

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

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Section C: Health Psychology

Answer **all** questions.

9 Dr Jones knows that some of his adult patients do not take their medication every day. He wants to improve daily adherence in his patients.

Suggest **two** ways that Dr Jones could use prompts to improve daily adherence to medication in his patients. [4]

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

(b) Explain why free-will is important for **one** way to manage stress. [2]

11 Lydia has recently started a new job. She is also helping a sick relative at home. Lydia is irritable, anxious and often very tired. Lydia thinks these symptoms may be due to stress.

(a) Suggest how the GAS model can explain the symptoms Lydia is experiencing. [4]

(b) Explain **one** weakness of the GAS model. [2]

12 **(a)** Describe the following types and theories of pain:
- types of pain: acute, chronic and phantom limb pain, and
- gate control theory of pain. [6]

(b) Evaluate the following types and theories of pain:
- types of pain: acute, chronic and phantom limb pain, and
- gate control theory of pain,

including a discussion of nature versus nurture.

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 A mobile phone company has a large number of workers in a noisy open plan office. They are moving to a new building with a different office layout. The new building has an office for each worker separated by internal walls.

Suggest **two** effects on the workers of working in the new building, compared to the open plan office. [4]

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

(b) Explain **one** strength of taking a holistic approach when investigating the effects of shiftwork on health and accidents. [2]

15 Ingrid is the headteacher in a large school. She would like to measure the job satisfaction of all the workers at the school, including teachers and other workers. She has decided to use the job descriptive index (JDI).

(a) Suggest **two** reasons why the JDI is an appropriate measure of job satisfaction of all the workers at Ingrid's school. [4]

(b) Explain **one** weakness of the JDI. [2]

16 **(a)** Describe the study by Claypoole and Szalma (2019) on concentration levels when being monitored using Electronic Performance Monitoring (EPM). [6]

(b) Evaluate the study by Claypoole and Szalma (2019), including a discussion of controls.

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

Answers for paper 9990/32

Section A: Clinical Psychology

1 If Halema has bipolar disorder, she will also have manic episodes where her mood is high: she is euphoric, very energetic and talkative, and needs little sleep, for at least a week. With depressive disorder she would never have manic episodes, only low mood.

With bipolar disorder Halema may have mixed episodes, where her mood switches rapidly between depression and mania. With depressive disorder her mood would stay consistently low for weeks, with poor concentration, guilt and sleep problems, without switching.

2(a) Learned helplessness (Seligman) says depression results from a perceived lack of control over situations. After repeated failure, a person learns that nothing they do makes things better, so they stop trying and become passive and depressed.

2(b) An individual explanation says the cause of behaviour lies within the person. Learned helplessness is individual because it is the person's own belief that they have no control that causes depression: two people in the same situation may differ, as one believes they can escape it and the other does not.

3(a) Atypical antipsychotics have fewer and less severe side effects than typical antipsychotics. Typicals often cause tardive dyskinesia, with sudden jerky movements of the face and body, which may make Blake stop taking his

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	medication, whereas with atypicals he is more likely to keep taking it. Atypical antipsychotics treat both positive and negative symptoms, whereas typicals mainly treat positive symptoms. If Blake has negative symptoms, such as flattened affect and lack of motivation, atypicals are more likely to reduce these, helping him to function day to day.
3(b)	Antipsychotics treat the symptoms but not the cause of schizophrenia. Patients often stop taking them when they feel well or because of side effects, and their positive symptoms, such as hallucinations, then return, leading to relapse.
4(a)	CBT for anxiety and fear-related disorders: the therapist and patient identify the faulty, irrational thoughts about the feared object, such as "all dogs bite", and the patient is taught to replace them with alternative, realistic thoughts, such as "most dogs do not bite". The patient is educated about how common their anxiety is, taught relaxation techniques, and given homework to practise new thoughts between sessions. CBT often includes gradual exposure through a fear hierarchy, with anxiety rated on the Subjective Units of Discomfort Scale (SUDS) from 0 to 100. Applied tension, developed by Öst, treats blood/injection/injury phobia, in which the person's blood pressure drops and they faint at the sight of blood or needles. The patient learns to tense the muscles of the arms, legs and body for about 10 to 15 seconds, which raises blood pressure and stops fainting, then practises this while exposed to blood-related stimuli. Chapman and DeLapp (2013) treated T, a man with blood/injection phobia, using CBT with applied tension. He was educated about phobias, created a fear hierarchy and rated each step on SUDS. Over about nine sessions he worked through the hierarchy without his SUDS becoming too high, ending with having blood taken (SUDS of 40, soon falling to nothing) with only minimal muscle tension. At 4, 10 and 12 months after treatment, T reported

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no fear of medical stimuli.

4(b) Generalisations: there is a lot of evidence that CBT is effective for a wide range of anxiety disorders, so it can be generalised. Applied tension, however, is designed for blood/injection/injury phobia, where fainting occurs, so it cannot be generalised to other phobias such as spiders, where blood pressure rises. Chapman and DeLapp is a single case study of T, so another patient may not respond as well, and the success cannot be attributed to CBT or applied tension alone as they were combined. However, blood phobia is fairly common and debilitating for people needing medical treatment, so the findings are still useful.

Case studies: the case study gave rich, detailed data about T using many measures, which is a strength, but the therapist's interpretation may be biased.

Self-reports: T's progress was measured using questionnaires such as the Beck Anxiety Inventory, Beck Depression Inventory and Blood-Injection Symptom Scale before and after treatment, allowing objective comparison, and SUDS was personalised to T. However, T may have exaggerated his improvement to please the therapist, lowering validity.

Longitudinal: T was followed up for 12 months, showing the treatment had lasting effects, a strength over drug treatments where symptoms return when drugs stop.

Nomothetic versus idiographic: the case study is idiographic, but the standardised questionnaires are based on norms from large samples, so they are nomothetic, giving a balanced approach.

Application: both therapies are cheap, have no side effects, and teach skills the patient can use on their own. Overall both are effective, but more research with larger samples is needed before generalising the combined treatment to everyone with blood/injection phobia.

Section B: Consumer Psychology

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5	The pleasant odour could increase pleasure and arousal, so shoppers spend longer in the mall than they would without the odour, visiting more shops and spending more money. Shoppers could perceive the mall environment and the products more positively. Chebat and Michon (2003) found a citrus odour in a mall led to a more positive perception of the environment and of product quality.
6(a)	The nomothetic approach studies large groups to establish general laws of behaviour. For example, North et al. (2003) found that playing classical music in a restaurant led to higher spending per head than pop music or no music, suggesting a general law about sound and spending.
6(b)	Because laws are based on large numbers of participants, they can be generalised and have high predictive value. For example, shop managers can predict that playing classical music will raise spending in their own stores, which makes psychology more scientific and useful.
7(a)	Nandi should use descriptive, evocative names rather than plain names. For example, instead of "seafood fillet" she could write "Succulent Italian Seafood Fillet". Customers rate descriptive names as more appealing and tastier, and expect to feel more satisfied, so they are more likely to order them. She should avoid confusing French names such as "consommé julienne", and instead use simple names showing fresh, seasonal ingredients, such as "fresh clear soup with spring vegetables". She could also use nostalgic names like "Grandma's homemade lasagne", which customers expect to taste good.
7(b)	If a repeated measures design is used, participants see both versions of the menu

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	item names, so they may guess the aim of the study. They may then change their ratings of the menu items to help the researcher, a demand characteristic, which lowers the validity of the findings.
8(a)	Compensatory strategies: a high value on one attribute compensates for a low value on another, for example the preferred car model compensates for high mileage. Richarme (2005) described the equal weight strategy, where all attributes are seen as equally important, and the weighted additive strategy, where some attributes, such as low mileage, are given more importance than others. Non-compensatory strategies: each attribute is evaluated separately and a weak attribute cannot be compensated, so a car with a good price, model and mileage is rejected if it is the wrong colour. Simon suggested three: satisficing, choosing the first product that meets basic requirements; elimination by aspects, setting a cut-off for the most important attribute, such as minimum capacity of a washing machine, then assessing the remaining items on the next attribute; and lexicographic, choosing the item that is best on the most important attribute, such as the biggest capacity, and only moving to the next attribute if there is a tie. Partially compensatory strategies lie in between. Majority of confirming dimensions compares two products on all attributes, keeps the better one and compares it with the next until one remains. Frequency of good and bad features counts how many attributes of each product exceed cut-off values, such as capacity, efficiency and price, and chooses the product with the most good features.
8(b)	Application to everyday life: knowing which strategy customers use has practical value. Jedetski et al. (2002) found that when a website makes comparisons easy, consumers use compensatory strategies, but when it is hard they use non-compensatory strategies. Companies selling expensive products could therefore design websites with comparison tables showing where models differ. However, it

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is hard to apply the strategies, as the same customer may use different strategies for different purchases, such as satisficing for cheap items and weighted additive for a car, and joint decisions, such as buying a family car, may not fit any strategy.

Reductionism versus holism: classifying decisions into strategies is reductionist. It makes decisions easier to study, but ignores emotions, impulse buying and the influence of other people, which are part of real shopping.

Determinism versus free will: the strategies are deterministic, allowing sellers to predict behaviour, but consumers can freely choose to change strategy, so predictions will not always be accurate.

Nomothetic versus idiographic: the strategies aim to be general laws, but individual consumers could be interviewed to explain their own choices, which would give a more valid picture of how they decide.

Cultural differences: in less affluent cultures there may be fewer products to choose from, so the complex compensatory strategies may not be used. Overall the strategies are useful descriptions with clear applications, but real decisions are more flexible than the categories suggest.

Section C: Health Psychology

9 Dr Jones could set up a text message service, so each patient receives a text every morning at 8am saying "Have you taken your medication today?", prompting them to take it at the same time each day.

He could put a sticker on each patient's medication box saying "Remember to take me with breakfast", with a picture of the sun, so patients are prompted whenever they see the box. Yokley and Glenwick (1984) found that prompts such as reminders increase adherence.

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10(a)	Determinism is the view that behaviour is caused by internal or external forces outside our control, such as genes or reinforcement. Free will is the view that behaviour is within our own personal control and we choose how to act.
10(b)	Biofeedback trains a person to control bodily stress responses, such as heart rate or muscle tension, using a signal like a beeping sound. Free will is important because the person must choose to respond to the feedback and actively relax their muscles or slow their breathing to slow the beeping.
11(a)	In the alarm reaction stage of Selye's GAS model, Lydia's new job triggers the release of adrenaline and cortisol, giving her extra energy, faster heart rate and breathing to cope with the demands. Because her stressors continue, as her job stays demanding and her relative remains sick, she enters the resistance stage, where her body stays on high alert, which explains her irritability. As this continues for too long she enters the exhaustion stage, where her resources are drained, explaining her constant tiredness and anxiety.
11(b)	The GAS model is reductionist, dividing stress into three fixed stages. Lydia may be in the alarm stage for her new job but in exhaustion from long-term caring, and the model does not explain how these interact, or why some people under the same stressors do not reach exhaustion.
12(a)	Acute pain comes on quickly and lasts a short time. It can be severe, is usually in a specific location with an identifiable source, such as a cut, and is fairly easy to treat with painkillers. Chronic pain lasts a long time (at least a month), often due to illness such as cancer or long-term back or joint pain. It is hard to treat and affects quality of life, mental health and relationships, and acute pain can become chronic if not treated. Phantom limb pain is when a person who has lost a limb

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still feels pain coming from it. It is very hard to treat, but mirror treatment (Ramachandran) can help: the remaining limb is put in a box with a mirror down the middle, so the patient sees two intact limbs and does movement exercises, which reduces phantom pain in some patients.

Gate control theory (Melzack and Wall, 1965) proposes a "gate" in the dorsal horn of the spinal cord that either blocks pain signals or lets them pass to the brain. Small nerve fibres carry pain signals and large nerve fibres carry touch and pressure. When there is more large fibre activity, the gate closes and less pain is felt, which is why rubbing an injury reduces pain. When small fibre activity dominates, the gate opens and pain is perceived. Signals from the brain, such as emotions and expectations, can also open or close the gate, so anxiety increases pain.

12(b) Nature versus nurture: acute and chronic pain are mainly nature, caused by physical damage or illness. Phantom limb pain has a nature basis in the brain's map of the body, but mirror treatment shows that learning and visual experience (nurture) can change it. Gate control theory is nature-based, explaining pain through nerve fibres, but it is a strength that it includes nurture, as emotions and expectations from past experiences open or close the gate, explaining why soldiers in battle may feel little pain.

Reductionism versus holism: gate control theory reduces pain to large and small fibre activity, but it is more holistic than specificity theory because it includes psychological factors.

Determinism versus free will: pain types are biologically determined, but patients can choose to use strategies like rubbing, distraction or mirror therapy, showing some free will.

Application to everyday life: gate control theory explains why TENS, massage and distraction work, and mirror treatment offers a cheap, drug-free treatment for

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	phantom limb pain. However, it works only for some patients. Generalisations: evidence for mirror treatment comes from case studies of a few patients, so it may not generalise to all amputees. The distinction between acute and chronic pain by duration is also a generalisation, as some pain falls in between. Overall, gate control theory is the most complete explanation, as it integrates nature and nurture.
	Section D: Organisational Psychology
13	The workers may feel more internally motivated and satisfied, because in their own office they have more privacy and autonomy and no longer feel constantly watched by others, and they can concentrate without the noise of the open plan office. Communication between workers may decrease, because they must leave their office and go to another person's office to talk, so they may feel less part of a team.
14(a)	Reductionism explains behaviour by breaking it down into its simplest component parts, such as biology. Holism explains behaviour by looking at the whole person and the context, as the whole is more than the sum of its parts.
14(b)	A holistic approach looks at the whole picture, not just one variable. A shift pattern may correlate with cardiovascular disease, but a holistic approach would also consider lifestyle, such as poor diet in shift workers, giving a more valid explanation of the cause.
15(a)	The JDI is easy to complete, as workers simply answer yes, no or ? (cannot decide) to short statements. This suits busy teachers and all school workers, including cleaners and caretakers who may have less education, so more will

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	complete it. The JDI measures five specific facets of job satisfaction: the work itself, pay, promotion, supervision and co-workers. Ingrid can see which areas staff are unhappy with, for example pay for support staff, and compare scores with standardised norms.
15(b)	The JDI uses forced-choice answers (yes, no, ?), so workers cannot explain why they are dissatisfied. This lacks qualitative detail, so Ingrid may not know what to change to improve satisfaction.
16(a)	Claypoole and Szalma (2019) aimed to see whether electronic performance monitoring (EPM) affects performance on a sustained attention (vigilance) task. In this lab experiment with an independent measures design, 106 student volunteers (65 female, 41 male) with a mean age of 20.57 from a US university took part for course credit and gave informed consent. They were randomly allocated to a control group with no monitoring, or an electronic presence condition, where a webcam on top of the screen and a video recorder 1 metre behind them would record their performance for later evaluation. After a demographics questionnaire, participants did a 24-minute vigilance task, pressing the space bar when a critical signal appeared: a pair of two-digit numbers with a difference of 0 or 1. Critical signals appeared randomly five times in each 6-minute block. The DVs were the proportion of correct detections, false alarms and response time. Vigilance decreased over the 24 minutes in both conditions. The EPM group had a higher proportion of correct detections (mean 0.69) than the control group (0.60), fewer false alarms, and faster median response times (767 ms compared to 802 ms). They concluded that electronic monitoring has similar effects to a human presence, improving vigilance.

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16(b)

Controls: the study was highly controlled. There was a control group with no monitoring, giving a baseline to compare with, and participants were randomly allocated, reducing participant variables. The procedure was standardised: the camera was always placed 1 metre behind, the task always lasted 24 minutes, and critical signals appeared randomly five times per block. This means the improvement can be attributed to EPM, giving high internal validity, and the study can be replicated to check reliability. However, these controls make the situation artificial, as real workers are monitored for weeks, not 24 minutes, lowering ecological validity.

Quantitative data: only quantitative data were collected, such as correct detections (0.69 compared to 0.60), allowing easy comparison. However, no qualitative data were collected, so we do not know how participants felt about being watched, for example whether they felt stressed.

Generalisability: the sample of 106 is large, but all were US students, who may respond differently to monitoring than experienced employees, and people in other cultures may react differently.

Ethics: participants gave informed consent, were anonymised and could withdraw, so the study was ethical.

Application to everyday life: EPM can improve performance in critical tasks needing long focus, such as monitoring systems for long-distance drivers. However, constant monitoring at work may reduce trust. Overall the study is well-controlled and reliable, but its artificial controls limit its application to real workplaces.

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PSYCHOLOGY **9990/33**

Paper 3 Specialist Options: Approaches, Issues and Debates **October/November 2025**

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 Hugh has obsessive-compulsive disorder (OCD). Hugh's childhood was difficult. His mother had an obsession with germs, insisting on excessive cleanliness.

Suggest **two** different explanations of why Hugh has OCD. [4]

2 **(a)** Outline what is meant by 'cultural differences'. [2]

(b) Explain **one** reason why cultural differences could affect the diagnosis of an anxiety disorder. [2]

3 Habiba has a phobia of flying insects. She is afraid of the noise they make and is very scared if one lands on her. Habiba's therapist recommends that she is treated using systematic desensitisation.

(a) Suggest how Habiba's therapist can use systematic desensitisation to treat Habiba's phobia. [4]

(b) Explain **one** weakness of systematic desensitisation. [2]

4 **(a)** Describe what psychologists investigating the treatment and management of mood (affective) disorders have discovered about:
- MAOI anti-depressants, and
- Ellis's rational emotive behaviour therapy (REBT). [6]

(b) Evaluate what psychologists investigating the treatment and management of mood (affective) disorders have discovered about:
- MAOI anti-depressants, and
- Ellis's rational emotive behaviour therapy (REBT),

including a discussion of 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 Abdul wants to purchase a chair from a website. The website is designed so that comparisons between items are **not** easy to make.

Suggest **two** decision-making strategies Abdul is likely to use when purchasing his chair. [4]

6 **(a)** Outline what is meant by 'determinism', including an example from choice heuristics. [2]

(b) Explain **one** strength of using the determinism side of the determinism versus free-will debate to understand choice heuristics. [2]

7 Supermarket shoppers do **not** all behave in the same way. Shoppers can be categorised into five types based on their different spatial behaviour patterns. Zelda visits all of the aisles of the supermarket when she does her main shopping. However, Louis spends a short time in the supermarket and visits only a few aisles.

(a) **(i)** Identify which type of shopper spatial behaviour pattern would be **most** appropriate to describe:
- Zelda
- Louis. [2]

(ii) Frank is a different type of shopper from Zelda and Louis. He shows a different spatial behaviour pattern.

Suggest how Frank could behave in the supermarket. [2]

(b) Explain **one** problem that psychologists may have when investigating shoppers' spatial behaviour patterns. [2]

8 **(a)** Describe what psychologists have discovered about types of advertising and advertising techniques:
- the Yale model of communication, and
- a study about types of advertising media. [6]

(b) Evaluate what psychologists have discovered about types of advertising and advertising techniques:
- the Yale model of communication, and
- a study about types of advertising media,

including a discussion of objective and subjective 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 A university student, Chloe, thinks that she has less chance of becoming ill than other students. She also thinks that she has more chance of living longer than other students. This suggests unrealistic optimism in Chloe's health beliefs.

Suggest **two** reasons why Chloe may have unrealistic optimism in her health beliefs. [4]

10 **(a)** Outline what is meant by the debate between individual and situational explanations. [2]

(b) Explain why **one** strategy for improving health has a situational explanation. [2]

11 Omar is in hospital with chest pain. His practitioner wants to investigate this by assessing Omar's pain.

(a) Suggest **two** different measures of pain that Omar's practitioner could use with him. [4]

(b) For **one** of the measures of pain you suggested in part **(a)**:

Explain **one** weakness of this measure of pain. [2]

12 **(a)** Describe what psychologists investigating practitioner diagnosis have discovered about:
- making a diagnosis (disclosure of information, false positive and false negative diagnosis), and
- presenting a diagnosis. [6]

(b) Evaluate what psychologists investigating practitioner diagnosis have discovered about:
- making a diagnosis (disclosure of information, false positive and false negative diagnosis), and
- presenting a diagnosis,

including a discussion of validity.

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 Celeste is a member of a newly formed school council. This is a group of student representatives who make decisions, such as what should be on the school menu and whether to have recycling bins or a new drinks machine.

Suggest the stages of group development that the school council could go through as they make decisions. [4]

14 **(a)** Outline what is meant by a 'nomothetic approach', including an example from a need theory of motivation at work. [2]

(b) Explain how a need theory of motivation at work could be investigated using an idiographic approach. [2]

15 Tatpara is the manager at a carpet factory. He is concerned about low production at his factory. Tatpara believes this may be due to a lack of motivation in the workers.

(a) Suggest **two** ways Tatpara could use extrinsic motivators with the carpet factory workers to increase production. [4]

(b) For **one** of your suggestions in part **(a)**:

Explain **one** strength of this suggestion, other than to increase production. [2]

16 **(a)** Describe what psychologists have discovered about temporal conditions of work environments:
- rapid rotation and slow rotation shiftwork, and
- a study about the effects of shiftwork on health and accidents. [6]

(b) Evaluate what psychologists have discovered about temporal conditions of work environments:
- rapid rotation and slow rotation shiftwork, and
- a study about the effects of shiftwork on health and accidents,

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

Question number

Answers for paper 9990/33

Section A: Clinical Psychology

1 Behavioural (operant conditioning): as a child Hugh was probably praised by his mother whenever he washed or cleaned, so this positive reinforcement made cleaning more likely to be repeated. Washing also briefly relieves his anxiety about germs, so the compulsion is negatively reinforced and has become a habit.
Genetic: Hugh may have inherited a vulnerability to OCD from his mother, as her obsession with germs suggests she may have OCD herself. Lewis (1936) found that 37% of OCD patients had parents with OCD, and Monzani et al. (2014) found higher concordance for MZ twins (52%) than DZ twins (21%).

2(a) Culture is the shared set of beliefs, values, norms and practices of a group or society. Cultural differences are the ways these beliefs and norms vary between groups, so behaviour that is normal in one culture, such as hearing the voices of ancestors, may be seen as a symptom of a disorder in another.

2(b) Diagnosis depends on whether behaviour deviates from social norms. In some cultures it is the norm for women not to leave the home alone, so a clinician from a different culture might wrongly diagnose agoraphobia, when the avoidance of going outside is actually culturally expected and not caused by anxiety.

3(a) First the therapist teaches Habiba relaxation techniques, such as deep breathing and visualising a calm place. Together they build a fear hierarchy, from looking at

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	a picture of a fly at the bottom, to hearing a quiet recording of buzzing, up to a wasp flying near her and one landing on her sleeve at the top. Habiba is exposed to the lowest step while using her relaxation, as she cannot feel fear and relaxation at the same time (reciprocal inhibition). Once she is relaxed at one step she moves to the next, such as a louder buzzing sound, over several sessions until she stays relaxed when an insect lands on her.
3(b)	Systematic desensitisation needs several sessions with a trained therapist, so it is costly and needs a lot of commitment. Being exposed to the feared object is also distressing, so patients like Habiba may drop out before reaching the top of the hierarchy, meaning the phobia is not fully treated.
4(a)	MAOIs (monoamine oxidase inhibitors) were the first antidepressants, used since the 1950s. They inhibit the enzyme monoamine oxidase, which normally breaks down the neurotransmitters serotonin, noradrenaline and dopamine in the synapse. Because these neurotransmitters are not broken down, their levels stay higher in the brain, which improves mood. Evidence shows they are effective, but today they are usually given only when other antidepressants such as SSRIs have not worked. They have side effects such as headaches, drowsiness, insomnia and constipation, and they interact with other medicines and foods high in tyramine, such as some cheeses, red wine and fermented foods, which can cause a dangerous rise in blood pressure (hypertensive crisis). Ellis's REBT is based on stoicism: we are disturbed not by events but by our beliefs about them. It uses the ABC model: A is the activating event, B is the belief about the event, and C is the emotional and behavioural consequence. Ellis argued that constant irrational, negative beliefs, such as "I must be perfect", lead to depression. The therapist uses disputing, actively challenging the irrational beliefs, so the patient replaces them with rational, constructive beliefs and can

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choose how to think and feel about setbacks. REBT focuses on the present, not the past. A meta-analysis of 70 REBT studies by Lyons and Woods (1991) found that people receiving REBT improved significantly more than control groups.

4(b)

Reductionism versus holism: both treatments are reductionist. MAOIs reduce depression to levels of neurotransmitters, ignoring the person's thoughts, relationships and life events, so the cause may remain and the patient may relapse when the drug stops. However, MAOIs act on several neurotransmitters, not just one, which is less reductionist than an SSRI. REBT reduces depression to irrational beliefs, but it is more holistic as it recognises that activating events matter and it treats the whole person's way of thinking about life.

Application to everyday life: both are supported by evidence of effectiveness, MAOIs since the 1950s and REBT by Lyons and Woods (1991). MAOIs are relatively cheap and easy to take, but a strict diet without tyramine-rich foods and serious side effects lower adherence. REBT needs a trained therapist and regular sessions, so it is more expensive and harder to access. It is also confrontational, which may be hard for a depressed patient with low motivation and self-esteem to engage with.

Individual versus situational: both are individual explanations. However, the link between neurotransmitters and depression is correlational, as low serotonin may be a result of depression rather than its cause, and situational stressors such as bereavement or redundancy may cause depression however rationally a person thinks.

Determinism versus free will: MAOIs reflect biological determinism, as we have no control over neurotransmitters, whereas REBT allows free will, as the patient chooses to change their beliefs, giving a sense of control.

Generalisations: findings of effectiveness are averages, and there are individual differences, as side effects affect some people more and REBT suits only

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	motivated patients. Overall both treatments work, but because each is reductionist, a holistic approach combining a drug with REBT may be the most effective.
	Section B: Consumer Psychology
5	As comparisons are hard, Abdul is likely to use non-compensatory strategies. He may use the lexicographic strategy: he decides the most important attribute is the design of the chair, so he picks the chair with the most attractive design and does not consider other attributes such as price. He may use satisficing: his basic requirements are a sturdy, comfortable wooden chair under £100, so he buys the first chair he sees that meets these and stops searching, even if a better one exists.
6(a)	Determinism is the view that behaviour is caused by internal or external factors outside our control. For example, the anchoring heuristic means consumers are automatically influenced by the first piece of information, such as the first price seen, without choosing to be.
6(b)	Determinism allows predictions of consumer behaviour. The representativeness heuristic predicts that a new product packaged to look like a high-quality market leader, such as a well-known trainer brand, will be judged as high quality, so companies can use this to increase sales.
7(a)(i)	Zelda: explorer. Louis: raider.
7(a)(ii)	Frank is a specialist. He goes into the supermarket for a few specific items, such as wine, and heads straight to that aisle, spending a long time comparing the

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	bottles there, but he may buy only one or two items.
7(b)	Shoppers do not behave consistently: a person may be a raider in one store but an explorer in a familiar store, or on a different day. This means classifying a shopper from one CCTV-tracked trip may not be representative, so the findings lack validity.
8(a)	The Yale model of communication (Hovland and colleagues, 1953) says persuasion depends on five features. Source: a message is more persuasive from a credible source, such as an expert or a trustworthy, attractive person. Message: two-sided arguments are more effective than one-sided ones, and statistics can convince people. Channel: the medium (written, verbal, TV, social media) should suit the audience. Audience: younger people and less educated people are more easily persuaded. Effect: the most effective messages change attitudes and, beyond this, behaviour, for example buying the product. Ciceri et al. (2020) compared three types of advertising media using the same mock newspaper containing 25 static adverts: a website on a laptop, a printed paper edition, and a PDF on a tablet. 72 participants read the newspaper at their own pace while eye-tracking measured fixation on adverts and EEG measured their frustration. After a one-hour distraction task, a recognition task showed them 50 adverts (25 had been in the newspaper) and asked which they had seen. Fixation time on adverts was longest on the tablet and shortest on the website, and recognition was most accurate for the tablet and least for the website. EEG showed less frustration on the tablet and paper than on the website. Tablet and paper results did not differ significantly.
8(b)	Objective and subjective data: Ciceri et al. collected objective data from eye-tracking, EEG and the recognition task. This is a strength because the data

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are numerical, not open to researcher bias, and reliable, so the media can be compared fairly. However, inferring frustration from EEG activity may not be valid, and no subjective data were collected, so participants could not explain why website adverts irritated them. The Yale model has subjective elements, for example what counts as a "credible" source or a "young" audience differs between people, so it is hard to test objectively.

Application to everyday life: the Yale model gives advertisers clear guidance, such as using an expert as the source and choosing the channel for the target age group. Ciceri et al. suggest advertisers should place adverts in tablet and print editions rather than on websites, where they are ignored and irritating.

Validity: Ciceri et al. was a lab experiment with wearable eye-tracking and EEG, which could make reading unnatural and lower ecological validity, although the materials were like a real newspaper. It has high temporal validity as it uses modern media. The Yale model was developed in 1953 to understand wartime propaganda, so it may be less valid for social media influencers today.

Cultural differences: the Yale model was developed in the West, and features such as source credibility may differ between cultures, for example in collectivist cultures. Ciceri et al. also used one Western sample of 72, which limits generalisation. Overall both are useful for advertisers, but objective measures should be combined with subjective reports to fully explain advertising effects.

Section C: Health Psychology

9 Stereotypes: Chloe may think the people at risk of illness, such as heart attacks, are overweight middle-aged men. As a young female student she does not fit this stereotype, so she believes she is less at risk and ignores advice about diet and exercise (Weinstein, 1980).

Lack of personal experience: Chloe may never have had a serious illness, nor has

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	anyone close to her, so she thinks it will not happen to her. She may also believe the risk is controllable, for example "I walk to lectures, so I will live longer than other students".
10(a)	Individual explanations say behaviour is caused by internal, dispositional factors, such as personality or beliefs. Situational explanations say behaviour is caused by external, environmental factors, such as reinforcement or other people. The debate is about how far behaviour is caused by each.
10(b)	Fear arousal, such as photographs of mouth cancer on cigarette packets, is situational because it is an external source of influence, not controlled by the individual. Everyone receives the same message, and it assumes all smokers will react in the same way regardless of personality.
11(a)	The practitioner could use the McGill Pain Questionnaire. Omar would choose words from 20 groups of descriptors that describe his chest pain, such as "crushing" or "tight", covering sensory, affective and evaluative aspects. This gives a pain rating index, plus a present pain intensity score from 0 (no pain) to 5 (excruciating). The practitioner could use the UAB pain behaviour scale. A nurse observes Omar and rates ten target behaviours, such as verbal complaints, facial grimaces and mobility (for example whether he can walk), each as none, occasional or frequent (0, 0.5 or 1), giving a total pain behaviour score.
11(b)	The UAB scale only measures outward pain behaviours, not Omar's experience of pain. If Omar hides his pain, for example because he does not want to seem weak, he would score low even though his chest pain is severe, so the measure may lack validity.

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12(a)	Making a diagnosis: patients may not disclose information fully. Sarafino (2006) described how patients may be angry with or critical of the doctor, ignore what the doctor asks, or insist on unnecessary tests, which make diagnosis harder. Robinson and West (1992) found that patients at a sexual health clinic disclosed more information on a computerised interview than on a written questionnaire, and both gave more than when speaking to a doctor, so patients may hold back embarrassing information. Incomplete information can lead to errors. A false positive (Type 1 error) is when a healthy patient is diagnosed as ill, so they may receive unnecessary treatment. A false negative (Type 2 error) is when an ill patient is diagnosed as healthy, so they do not receive the treatment they need. Presenting a diagnosis: the traditional method is face to face, but this may not always be best. Cooke and Colver (2016) let 77 skin cancer patients choose how to receive their diagnosis after explaining the pros and cons: 48% chose a letter, 37% a phone call and 11% face to face. 94% of those who received it in their chosen way were happy. Karri et al. (2009) found 52% of skin cancer patients preferred a letter. Schofield et al. (2003) found no difference in satisfaction, anxiety or depression between diagnosis by phone or face to face, but satisfaction was higher when patients felt prepared, the word "cancer" was used and information was clear.
12(b)	Validity: the research has high ecological validity as it studies real patients in real clinics, such as the skin cancer patients in Cooke and Colver. Robinson and West controlled the method of gathering information, so differences in disclosure can be attributed to the method, giving good internal validity. However, population validity is limited, as the presenting research mainly used skin cancer patients, whose preferences may differ from patients with more serious cancers or other conditions. Self-reported satisfaction may also be affected by social desirability, lowering validity.

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	Application to everyday life: the research is highly useful, as almost everyone receives a diagnosis. Using a computerised interview could reduce false negatives for embarrassing conditions, and offering patients a choice of how to receive a diagnosis increases satisfaction. Individual versus situational: disclosure depends on individual factors, such as the patient's embarrassment or personality, and on situational factors, such as the method used and the doctor's style. Cultural differences: in some cultures disclosing sensitive information, especially to a doctor of the opposite gender, is difficult, so findings may not generalise across cultures. Determinism versus free will: the method of information-gathering appears to determine what is disclosed, and so the risk of a false positive or false negative. However, giving patients free choice over how a diagnosis is presented improves how they cope. Overall the research is valid and useful, although findings from skin cancer patients should be generalised with care.
	Section D: Organisational Psychology
13	Forming: at the first meetings the members do not know each other, so they are polite and formal and set rules, such as how votes will be taken. Storming: members such as Celeste start to disagree, for example over whether to spend money on recycling bins or a drinks machine, and may resist the leader. Norming: they accept each other's views and agree on norms. Performing: they work together in a trusting way, dividing roles so Celeste may survey students about the menu. Adjourning: at the end of the year they review their decisions and make recommendations for the next council.
14(a)	A nomothetic approach studies large groups to establish general laws that apply to

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	everyone. For example, Maslow's hierarchy of needs states that all workers must have physiological, safety and social needs met before they can be motivated by esteem needs.
14(b)	A psychologist could carry out a case study of one worker, using an unstructured interview with open questions and a daily diary of when they felt a need for achievement, affiliation or power (McClelland). This gives rich qualitative detail about that individual's unique motivation, rather than general laws.
15(a)	Performance-related pay: Tatpara could pay each worker more for each carpet produced above a target, so the workers who produce the most carpet earn the most. Bonus: Tatpara could pay every worker a one-off bonus if the factory meets a monthly production target, so workers are motivated to work together as a team to all receive the bonus.
15(b)	The team bonus is seen as fair, as everyone benefits if they all work hard together. This makes the carpet workers feel valued and part of a team, increasing their commitment, so they are more likely to stay at the factory, reducing staff turnover.
16(a)	Pheasant identified two ways of organising shiftwork. Rapid rotation means frequent shift changes, such as the metropolitan rota: two day shifts, two afternoon shifts, two night shifts, then two days off, or the continental rota with a longer cycle of 2 day, 2 twilight and 3 night shifts. Rapid rotation is difficult to adjust to, as circadian rhythms are constantly disrupted. Slow rotation means infrequent changes, such as working night shifts for several weeks before changing to day shifts, which lets circadian rhythms adapt and causes fewer health

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problems.

Gold et al. (1992) carried out a hospital-based questionnaire survey of 635 female nurses in Massachusetts, USA, about their shiftwork, sleep and accidents. Nurses who rotated shifts were compared with nurses who worked only day or evening shifts. Rotators had more sleep/wake disruption and nodded off at work more. They had twice the odds of nodding off while driving to or from work, and twice the odds of reporting an accident or error related to sleepiness. Gold et al. concluded that applying circadian principles to hospital work schedules could improve the health and safety of nurses and patients.

16(b) Quantitative and qualitative data: Gold et al. collected mainly quantitative data, such as the odds of nodding off or having accidents. This is a strength because rotators and non-rotators can be compared easily and objectively, for example showing twice the odds of accidents. However, quantitative data lack depth, so we do not know why the nurses felt sleepy or how shiftwork affected their lives. Qualitative interviews would give this detail but would be harder to compare.

Questionnaires: data were self-reported, so the nurses may have under-reported accidents or errors to avoid blame, or exaggerated sleepiness, lowering validity. However, questionnaires allowed a large sample of 635 nurses to be studied quickly.

Correlation: the link between rotating shifts and accidents is correlational, so other factors, such as having young children at home, may cause sleepiness.

Application to everyday life: employers can use the findings to change rapid rotation to slow rotation and reduce accidents, which is important where errors are dangerous, such as in hospitals.

Determinism: shiftwork effects seem biologically determined by circadian rhythms, although people choose shift jobs, and some, such as "night owls", cope better, so there are individual differences.

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Generalisability: Gold et al. studied only female nurses in one US state, so findings may not apply to male workers or other jobs. Overall the research is useful, but its quantitative, self-report data should be combined with qualitative and objective measures.