PEARSON EDEXCEL INTERNATIONAL ADVANCED LEVEL PSYCHOLOGY

UNIT 4 - WPS04

Clinical psychology and psychological skills

EXEMPLARS WITH EXAMINER COMMENTARIES
June 2018 series

Introduction

Assessment information

Section A: Clinical psychology, totals 32 marks and comprises short-answer questions.

Section B: Clinical psychology, comprises one 16-mark extended open response question.

Section C: Psychological skills, totals 20 marks and comprises short-answer questions drawing on research methods from other topic areas (except Topics F and G).

Section D: Psychological skills, comprises one eight-mark extended open response question based on the analysis of a key question from other topic areas (except Topics F and G).

Section E: Psychological skills, comprises one 20-mark synoptic question based on issues and debates from other topic areas (except Topics F and G).

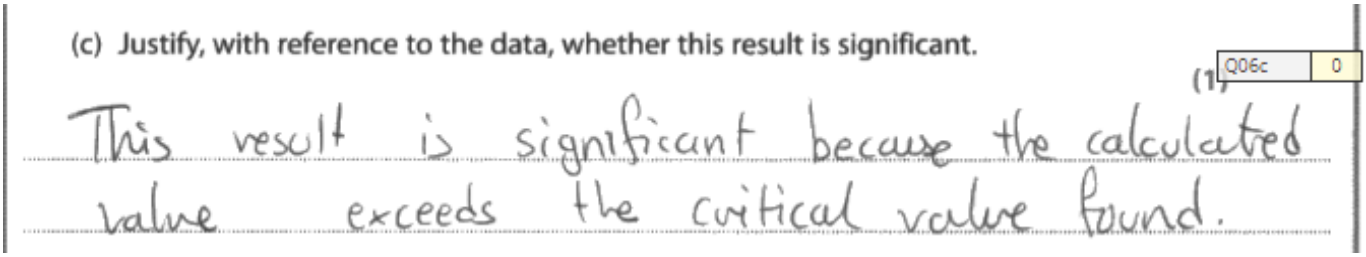
Exam duration: 2 hours.
Total marks for paper: 96 marks

Example 1 Mathematical Skills

June 2018 Question 6c

Justify, with reference to the data, whether this result is significant. (1)

This question required students to justify the significance of the result given in the scenario. There should be use of the data to make the justification, as indicated in the question.
A common error seen is where students omit the data in their responses and do not access the marks available.


(c) Justify, with reference to the data, whether this result is significant.

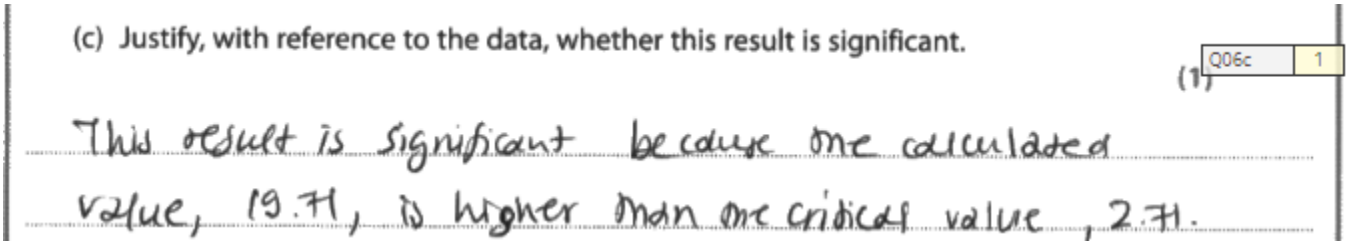
(1) Q06c 0

This result is significant because the calculated value exceeds the critical value found.

Examiner commentary

This candidate scores zero marks.

The justification they give does not have reference to the data they are presented with, and therefore the response is considered generic and does not meet the demands of the question.


(c) Justify, with reference to the data, whether this result is significant.

(1) Q06c 1

This result is significant because the calculated value, 19.71, is higher than the critical value, 2.71.

Examiner commentary

This candidate scores one mark.
The justification of whether the result is significant has been accurately presented with reference to their interpretations of the critical value and calculated value and is therefore creditable.

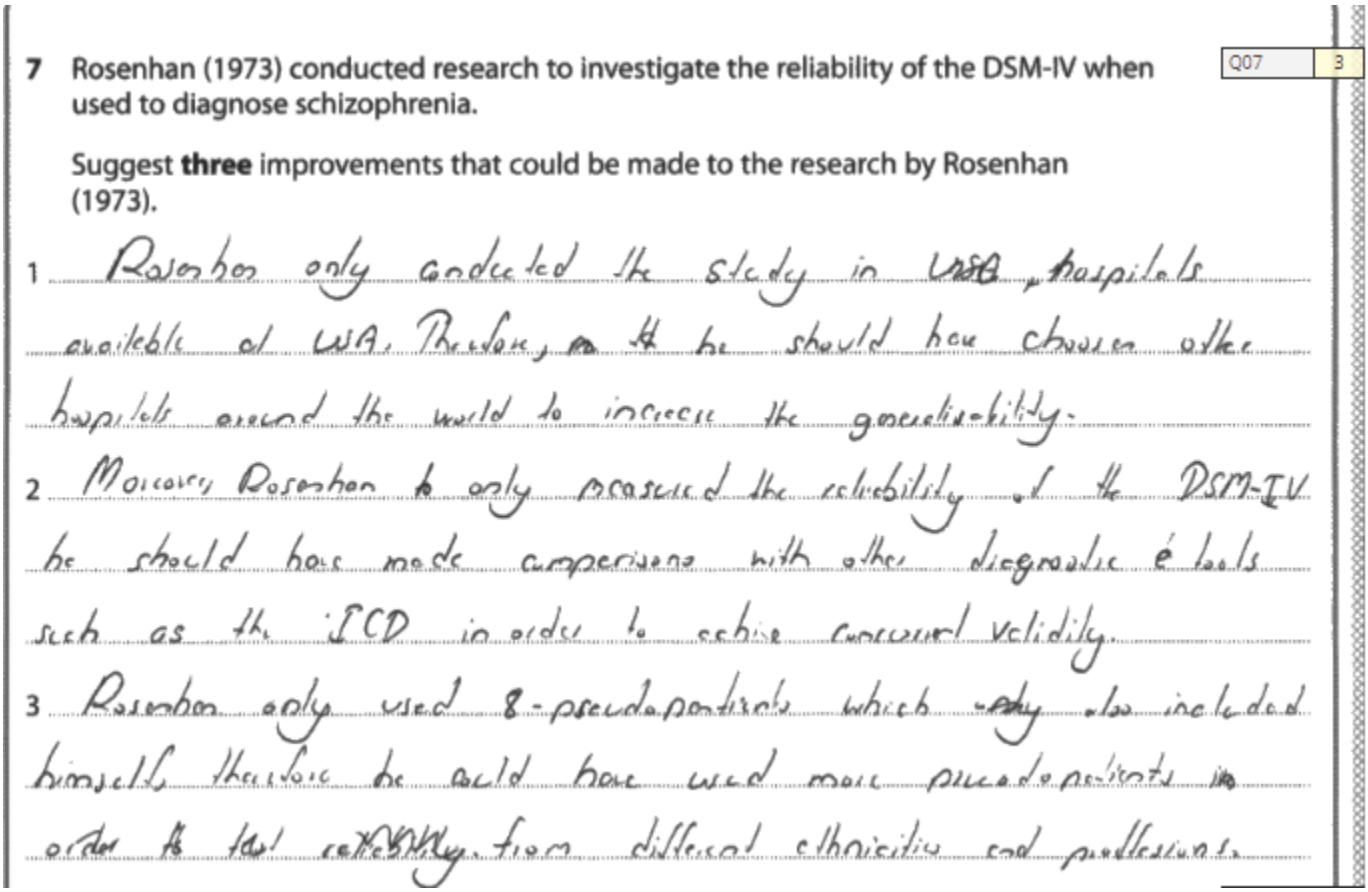
In mathematical questions of this nature, an interpretation of the data available or correct use of the results of a study are expected in responses to demonstrate students can interpret mathematical content and use this content to support their responses. In this case the data was to support a statement of significance, but this is also a requirement in other mathematically based questions, for example requiring data to support conclusions.

Example 2 Short Answer question

June 2018 Question 7

Rosenhan (1973) conducted research to investigate the reliability of the DSM-IV when used to diagnose schizophrenia. Suggest three improvements that could be made to the research by Rosenhan (1973). (3)

This question required students to give three distinct improvements to the study conducted by Rosenhan (1973). A common error seen is where students give weaknesses of the original study. A further common misconception is giving generic responses that do not necessarily improve the study itself. This has been seen across papers and series.



7 Rosenhan (1973) conducted research to investigate the reliability of the DSM-IV when used to diagnose schizophrenia. Q07 3

Suggest **three** improvements that could be made to the research by Rosenhan (1973).

1 Rosenhan only conducted the study in USA, hospitals available of USA. Therefore, he should have chosen other hospitals around the world to increase the generalisability.

2 Moreover, Rosenhan only measured the reliability of the DSM-IV he should have made comparisons with other diagnostic tools such as the ICD in order to achive concurrent validity.

3 Rosenhan only used 8-pseudopatients which only also included himself, therefore he could have used more pseudopatients in order to test reliability from different ethnicities and professions.

Examiner commentary

This candidate scores three marks.

The first mark is awarded for suggesting a more representative sample of hospitals could have been used. It is acceptable to improve the sample representativeness, but students should be careful not to suggest impractical ideas, such as visit every hospital in the USA or the world.
The second mark is awarded for improvements to the validity of the diagnosis process by making comparisons to ICD diagnosis to inform his judgements about the reliability and validity of diagnosis.
The third mark is awarded for improving the representativeness of the confederates used as pseudo-patients to include different ethnicities and professions, which is relevant given the cultural influences on diagnosis.

7 Rosenhan (1973) conducted research to investigate the reliability of the DSM-IV when used to diagnose schizophrenia. Q07 2

Suggest **three** improvements that could be made to the research by Rosenhan (1973).

1 Rosenhan should have informed the staff of hospitals beforehand about the ruse being set up to avoid deceiving the staff which would make the study unethical under BPS code of ethics (2009)

2 Rosenhan could have used a wider range of hospitals across different countries rather than just USA to increase generalisability.

3 Use a larger sample of female pseudopatients to increase applicability of findings to females with mental health disorders

Examiner commentary

This student scores two marks.

The first point is a good example of an improvement that has been suggested which would in real terms weaken the study. If hospital staff knew they were being observed, then they could have shown social desirability or demand characteristics and the data gathered would be a less valid representation of how staff treat patient.
The second mark is awarded for accessing a wider range of countries rather than just the USA.
The third mark is awarded for a sample of confederate pseudo-patients that included more females, as there can be differences in the diagnosis of mental health due to gender.

An improvement to a study or scenario can be asked in different forms, in this case three were required to be suggested without the need to exemplify them, however improvements could require explanations, where the improvement is identified and exemplified to show how or why it is an improvement.

The skill underpinning making improvements to studies or scenarios is one that embeds an understanding of research methods and the practical decisions that surround the choices of methods. Students sometimes suggest a complete change to the methodology, while an addition to the methodology would be acceptable, for example to triangulate data collection, a new methodology is not an improvement but rather a new piece of research, so these should be avoided.

Example 3 Application question

June 2018 Question 15

15 One key question for society is the influence of role models on risk-taking behaviour in adolescents.

Distefan et al. (1999) found that adolescents whose favourite movie stars were seen to smoke on and/or off screen, were more likely to smoke themselves than the adolescents whose favourite movie stars were non-smokers. This suggests that role models influence the risk-taking behaviour of smoking in adolescence.

Steinberg (2008) reviewed research that suggested that heightened risk-taking during adolescence is more likely to be 'biologically driven reward sensitivity' which takes place during puberty. Therefore risk-taking behaviour could be a developmental shift with an evolutionary origin.

Discuss the key question of whether role models can influence risk-taking behaviours in adolescents. You should use concepts, theories and/or research studied in your psychology course.

You **must** make reference to the context in your answer.

(8)

The key question asked in Section D of WPS04 is where students are required to draw on their understanding from across the course in order to respond to an unseen stimulus material structure around discussing a key question in society that psychology can provide answers to and/or solutions for. Students often struggle with this question as they tend to make a number of common and reoccurring errors when answering.

One of the main issues is students copying information from the scenario into their responses. This does not gain credit. The candidate should use the scenario as a 'springboard' to stimulate their use of a wider and more varied range of content from their learning in psychology.

The use of just one area of psychology is often limiting to students as it does not easily enable them to formulate a discussion about the key question and they often struggle to expand and develop their points sufficiently.

Students should remember to address the key question itself and use this as a focus for their answer, in this case adolescent risk-taking behaviours should be their main focus.

Finally, students are often drawn away from the taxonomy itself, providing evaluations that are not required in a 'discuss' question. Their aim for this question is to give knowledge and understanding of concepts, theories and/or research from across the course and then apply these to the key question given, using the information in the scenario to help them formulate ideas or discussion points.

The social learning theory explains whether or not the children can learn any aggressive behaviour from role models, through the process of attention, retention, reproduction and motivation. He said that the child must pay attention to the behaviour first, then form a mental representation of that behaviour in their mind for it to be repeated later on. After that comes reproduction which is the physical capability of someone to be able to reproduce the behaviour and lastly it is motivation, which is the will to be able to imitate the certain behaviour. Bandura demonstrated this in his social learning theory experiment of a bobo doll, where the children who had seen the male role model be positively reinforced for their actions, were more likely to imitate the behaviour. Distefan also demonstrated this that anyone who saw their favourite movie stars smoking were more likely to smoke also and this suggests that the role models do influence the behaviour. If a child or an adult sees any risk taking behaviour occurring, they are more likely to imitate it because they are going to be biologically driven as mentioned by Steinberg.

Examiner commentary

This student scores three marks.

They have been awarded level 3 for their AO1 knowledge and understanding, the information about social learning theory is accurate and demonstrates understanding of a relevant theory from their studies of psychology. There is however no application of this theory to the key question of risk-taking behaviour in adolescents nor any development of the stimulus material. The student also has not engaged with the discussion that role models may not influence this behaviour, as indicated through the stimulus information they were provided with.

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SLT

Steinberg (2008) reviewed research that suggested that heightened risk-taking during adolescence is more likely to be 'biologically driven reward sensitivity' which takes place during puberty. Therefore risk-taking behaviour could be a developmental shift with an evolutionary origin.

EC

Discuss the key question of whether role models can influence risk-taking behaviours in adolescents. You should use concepts, theories and/or research studied in your psychology course.

You **must** make reference to the context in your answer.

(8) Q15 1

Social learning theory suggests that individuals learn by observing other people and modelling their behaviour. There are 4 stages to SLT: attention, retention, reproduction and motivation. Attention is paid to others, around us, typically, role models who are individuals that we look up to and admire and we retain this observed behaviour.

In Distefanrt al (1999)'s case, adolescents, who observed their favourite movie stars smoking, who are their role models, and they retained this in their memory and later reproduced the observed behaviour. This suggested that role models do influence risk-taking behaviours.

Adolescents are motivated vicariously to repeat the smoking because it may reward them through appreciation of others

O

Bandura (1961) provides experimental evidence for SLT where he found that children copied aggressive behaviours of adult role models. So this shows that risk-taking behaviour is influenced by role models.

In Steinberg's (2008) case, operant conditioning suggests that we are more likely to undertake risky behaviours because it fulfills our biological need of thrill. ~~As taking part in risky behaviour, satisfies~~

We are likely to take part in more risk-taking behaviours because it rewards our biological need of thrill.

Examiner commentary

This student scores one mark.
They were awarded credit for relevant knowledge and understanding of social learning theory in the response. There is very limited application of this to the key question of risk taking behaviour in adolescents. The student has copied information from the stimulus material, but they have not fully attempted to apply their understanding from their studies of psychology to the information they have given.

The taxonomy of 'Discuss' does not require any conclusions to be made so deemed the most applicable for AO1 and AO2 questions. This Section D question (as with all 8-mark 'Discuss' questions) will always requires underpinning knowledge (AO1) and this will be combined with an equivalent emphasis of application (AO2). Where the question requires AO2 the wording of the question will signpost the link to the scenario/context and is indicated further using the 'Discuss' taxonomy.

Example 4 Extended Response question

June 2018 Question 10

Evaluate issues of validity and culture in the diagnosis of mental health disorders. (16)

This question is a levels-based question where students are required to present a balanced evaluation of validity and cultural issues in terms of mental health diagnosis.

Students should address both sides of an argument when evaluating, for example demonstrating that validity in diagnosis is and is not a concern, and that culture does and does not impact on diagnosis of mental health disorders.

10 Evaluate issues of validity and culture in the diagnosis of mental health disorders.

(16) Q10 11

There are three types of validity when diagnosing mental health disorders: a) Concurrent validity (the extent to which several studies produce the same results when re-tested) b) Predictive validity (the extent to which a diagnosis is indicative of future behaviour) c) Aetiological validity [a diagnosis being ~~are~~ made due to a known cause of a disorder, e.g. a person with an MZ twin with schizophrenia (genetics) would be more easily diagnosed with the disorder (as according to Gottesman, 1991 he has a 48% chance of developing schizophrenia) than a person with no ~~patients~~ known family history of the disorder that has a less than 1% of developing it]

Diagnosis of mental health disorders need to be valid as the entire course of treatment for a patient ~~does~~ is based on his/her accurate diagnosis. Rosenhan's 1973 study of 'Being Sane in Insane Places' demonstrated that even though there was high reliability in diagnosis, validity was pretty low as all 8 participants with absolutely no mental health issues were continuously mis-diagnosed. Ward et al (1962) found that out of all issues in the validity of diagnosis, a mis-diagnosis was 5% responsible to patient factors, 32.5% responsible to clinician factors and 62.5% ~~resp~~ due to an inadequacy of the classification system. However classification systems such as the DSM (now on it's 5th version) and the ICD (on it's tenth) are constantly revised to ensure that validity of diagnoses is high. Brown et al (2001) found that the DSM-IV was 'good-to-excellent' in terms of both reliability and validity

A lot of issues with the validity of diagnosis arise from the unstructured nature of clinical interviews, that allow for subjective interpretation from the part of the clinician ~~and~~ in terms of the observations he/she makes and the fact that much of the data that is necessary for diagnosis is dependent on the patient's willingness and capability to share them (mistrust / guilt / shame / memory issues of the patient all affect his diagnosis).

That is why there have been attempts in the psychological community to have objective standards ~~in order the~~ when defining abnormality ~~Rosenhan and Seligman (1989) stated [illegible]~~ One definition of abnormality that is now used is that of the 'Deviance from Social Norms' this defines 'abnormality' as a 'behaviour that violates accepted social morals, values and rules'. However practical this definition is, it has major issues ~~bound to~~ tied with the issue of ethical differences when diagnosing mental-health disorders. In terms of behaviour there are many differences between what is considered normal and what not not only between cultures but also within them. For example in the Yanomamö Indian tribe ~~aggression~~ the use of violence is a trait associated with leadership qualities, however the Pueblo Indians of the Southwestern States consider this type of behaviour a negative and even ostracise people that exhibit it. In an attempt to create a practical, standardised definition of abnormality to help with ~~accurate validity~~ validity in diagnosis Rosenhan and Seligman (1969) stated that abnormality was a synonym for 'failure to function adequately' and gave 4

criteria for what that meant, however many of which are affected by cultural context. For example the 'observer discomfort' criterion which states that 'abnormal behaviour can be classified as a behaviour that makes the person observing it uncomfortable' Thus is extremely subjective and is especially harmful to ethnic minorities whose behaviour might not necessarily be abnormal according to their culture but might make someone unfamiliar with it be. Another criterion that has cultural generalisability issues is 'vividness and unconventionality'. What is considered 'unconventional' drastically varies between cultures for example in certain areas of South America the ability to contact the dead is considered a virtue, whereas in North America it is considered absurd and 'abnormal behaviour'.

The very nature of 'abnormal behaviour' is socially constructed and as thus, tied to changes in norms and values (for example up until 1973, homosexuality was in the DSM under the name of 'sociopathic behaviour') which makes it difficult to establish validity in diagnosis especially with so many cultural issues. Finally, an important issue concerning culture and validity in diagnosis lies on western influence on what is considered normal Fernando, 1998 established that [redacted] notions of normality and abnormality globally were affected to great lengths by western norms

Examiner commentary

This student scores 11 marks.

Knowledge and understanding is demonstrated throughout the first paragraph detailing the underpinning knowledge of validity is accurate and demonstrates that the student is able to understand the issues of validity that should be considered when looking at diagnosis. The student continues and attempts to evaluate with their point about Gottesman, however this is disjointed and not fully relevant to the preceding points, or the subsequent content. The student begins to more fully engage with the evaluative skills as they begin to include Rosenhan and further on the study by Ward. This is continued with reference to the updated DSM and supporting evidence for validity by Brown.

On the second page, the student gives detailed understanding for the first paragraph, and they begin to evaluate the consequences of how mental health is defined in terms of validity and cultural norms, drawing on suitable examples to exemplify their points. The student continues this theme of definitions of mental health and the impact on diagnosis in terms of validity and culture throughout the third page. The response becomes overly focussed on these concepts, therefore does not develop much further in terms of ideas, concepts, theories or evidence for culture and or validity beyond those points.

Therefore, the response demonstrates accurate knowledge and understanding and give arguments that are developed using mostly coherent, although not always, chains of reasoning. There is an understanding of competing arguments, but the evaluation is imbalanced more towards the 'negative' issues of validity and culture rather than fully addressing the view that it also can be considered that there are no issues.

10 Evaluate issues of validity and culture in the diagnosis of mental health disorders.

(16) Q10

To begin with, validity and culture do play a role in the diagnosis of mental health disorders. Both can decrease the accuracy of diagnosis.

For example, culture, differ among the population. Different cultures have different beliefs and social norms. This could affect diagnosis of mental health disorder especially if the clinician doing the diagnosis and the client have different cultures, hence perceive things in a different way and have different perspectives. There are certain tribes who think that it is a blessing to hear voices, however, western cultures would perceive this as psychosis. Moreover, there are cultural specific disorders, that could not be diagnosed by a clinician of a different culture. Furthermore, ~~according~~ to Cooper et al, found differences between diagnosis ~~of~~ from British clinicians and American clinicians. Since British clinicians diagnosed people to be depressed ~~as~~ twice as much, and the American clinicians diagnosed them to be Schizophrenic ~~as~~ twice as much compared to the British ~~were~~ clinicians. This indicates how cultural differences do play a role in diagnosis, and that even when they are using the same diagnostic measure (DSM-5 of ICD-10), clinicians could come ~~up~~ to with different diagnosis, that are based on their culture, hence decreasing the reliability and validity of diagnosis. However Andrews et al, found 65% agreement between the

DSM-5 and the ICD-10, therefore highlighting the fact that diagnosis could be reliable, even among cultures.

Additionally, validity of diagnosis of mental health disorders could vary, for example diagnostic measures, like the ~~a~~ DSM-5 are culturally specific. So diagnosis of a patient of a different culture could ~~to~~ be invalid. However, Lee et al. investigated whether diagnosis of korean children with ADHD, using the DSM was valid. He found, that the diagnosis ~~for~~ using the DSM, and the responses from the questionnaires were the same, hence showing, that diagnosis of mental health disorders can be valid.

Overall culture ~~and~~ does affect the validity of diagnosis, since each culture is different, and some ~~disord~~ symptoms of disorders like hallucinations, could be considered normal for a culture, but for another culture it could be considered as Skizophrenia.

Examiner commentary

This student scores 5 marks.

The response begins well, with understanding of culture presented within the first paragraph and this is followed by a link to evidence by Cooper et al. about diagnosis. There is detailed use of Cooper et al. which demonstrates the student knows this particular source of evidence and how it can support their argument about culture, but they perhaps over emphasis this one element to the detriment of not including further evidence or points against the impact of culture. Equally, they only address culture in this one sense, and while they touch upon culture bound syndromes or individual experiences at the start, the influence of these is not fully evident and they do not engage with the broader range of cultural facets of diagnosis.
On the second page they begin a 'second essay' almost, thus their overall response is somewhat disjointed, and they do not fully engage with the potential cross-over between cultural issues and validity when it comes to mental heath diagnosis. There is a basic point about validity and then evidence from Lee to support their argument, but again there is limited balance here and the argument about valid mental health diagnosis has not been fully addressed.
Much of this student response is therefore only superficially addressing the question and present a single-sided perspective.

The extended response in clinical psychology requires students to place their emphasis on their evaluative skills, with an AO balance of AO1 (6 marks) and AO3 (10 marks). These indicate the expected weighting of an answer and the structures a student should take to meet the requirements of this essay at A Level.

A 16-mark question is a higher order mark tariff question. It is intended to stretch the high ability students and therefore have a greater emphasis on AO3. For the 16-mark questions AO1 is capped at 6 marks because the focus of an evaluative question is on AO3, with students drawing on AO1 to support responses. Successful responses will only require the smaller proportion of AO1 to support extensive evaluative points - this is reflected in levels and indicative content.

Often student responses are heavily weighted to knowledge and understanding, and improving the balance is a skill they could practice in terms of structuring coherent arguments that have perhaps two or three evaluative points centred around each element of their knowledge and understanding.

Levels based mark schemes

In any LBMS question candidates will need to draw upon underpinning knowledge and understanding (AO1) which may be then be used to apply to a context or scenario (AO2) and/or make judgements and reach conclusions (AO3).
AO proportions will be reflected in proportions of indicative content in a mark scheme.

The mark tariff will determine the amount of detail required of a candidate in order to address the question. In conjunction with this the command word used in the question will determine the emphasis necessary in terms of AO1, AO2 and AO3.

LBMS are broken down into levels where each level is represented by a descriptor that articulates what a candidate is required to demonstrate in their answer to achieve that level.

The requirement for and focus of AOs will be transparent for both students and markers as the taxonomies published in the specification establishes the requirements of a candidate's response mechanism and following rules will be applied to maintain a consistent and reliable focus.

Further information about levels based mark schemes can be found on the IAL Psychology page here.

Section A Clinical Psychology
WPS04 June 2018 Q10

Level	Mark	Descriptor
AO1 (6 marks), AO3 (10 marks) **Candidates must demonstrate a greater emphasis on evaluation/conclusion vs knowledge and understanding in their answer.** **Knowledge & understanding is capped at maximum 6 marks.**		
	0	No rewardable material.
Level 1	1-4 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) A conclusion may be presented but will be generic and the supporting evidence will be limited. Limited attempt to address the question. (AO3)
Level 2	5-8 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Candidates will produce statements with some development in the form of mostly accurate and relevant factual material, leading to a superficial conclusion being made. (AO3)
Level 3	9-12 Marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning leading to a conclusion being presented. Candidates will demonstrate a grasp of competing arguments, but evaluation may be imbalanced. (AO3)
Level 4	13-16 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical evaluation, containing logical chains of reasoning throughout. Demonstrates an awareness of competing arguments, presenting a balanced conclusion. (AO3)

Section D Psychological Skills
WPS04 June 2018 Q15

Level	Mark	Descriptor
AO1 (4 marks), AO2 (4 marks) **Candidates must demonstrate an equal emphasis between knowledge and understanding vs application in their answer.**		
	0	No rewardable material
Level 1	1–2 Marks	Demonstrates isolated elements of knowledge and understanding. (AO1) Provides little or no reference to relevant evidence from the context (scientific ideas, processes, techniques and procedures). (AO2)
Level 2	3–4 Marks	Demonstrates mostly accurate knowledge and understanding. (AO1) Discussion is partially developed but is imbalanced or superficial occasionally supported through the application of relevant evidence from the context (scientific ideas, processes, techniques and procedures). (AO2)
Level 3	5–6 Marks	Demonstrates accurate knowledge and understanding. (AO1) Arguments developed using mostly coherent chains of reasoning. Candidates will demonstrate a grasp of competing arguments, but discussion may be imbalanced or contain superficial material supported by applying relevant evidence from the context (scientific ideas, processes, techniques and procedures (AO2)
Level 4	7–8 Marks	Demonstrates accurate and thorough knowledge and understanding. (AO1) Displays a well-developed and logical balanced discussion, containing logical chains of reasoning. Demonstrates a thorough awareness of competing arguments supported throughout by sustained application of relevant evidence from the context (scientific ideas, processes, techniques or procedures). (AO2)