Topical Past Paper Questions Worksheets

AS & A Level Psychology (9990) Paper 3

Exam Series: Feb/Mar 2018 – Oct/Nov 2022

Format Type B:
Each question is followed by its answer scheme

Introduction

Each Topical Past Paper Questions Workbook contains a comprehensive collection of hundreds of questions and corresponding answer schemes, presented in worksheet format. The questions are carefully arranged according to their respective chapters and topics, which align with the latest IGCSE or AS/A Level subject content. Here are the key features of these resources:

1. The workbook covers a wide range of topics, which are organized according to the latest syllabus content for Cambridge IGCSE or AS/A Level exams.
2. Each topic includes numerous questions, allowing students to practice and reinforce their understanding of key concepts and skills.
3. The questions are accompanied by detailed answer schemes, which provide clear explanations and guidance for students to improve their performance.
4. The workbook's format is user-friendly, with worksheets that are easy to read and navigate.
5. This workbook is an ideal resource for students who want to familiarize themselves with the types of questions that may appear in their exams and to develop their problem-solving and analytical skills.

Overall, Topical Past Paper Questions Workbooks are a valuable tool for students preparing for IGCSE or AS/A Level exams, providing them with the opportunity to practice and refine their knowledge and skills in a structured and comprehensive manner. To provide a clearer description of this book's specifications, here are some key details:

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Chapter 1

Psychology and abnormality

1.1 Schizophrenic and psychotic disorders

1. 9990_m22_qp_32 Q: 1

(a) Outline **one** way that Freeman (2008) used virtual reality to assess the symptoms of schizophrenia. [2]

(b) Describe the study by Sensky (2000) that used cognitive-behavioural therapy (CBT) as a treatment for schizophrenia. [4]

(c) Explain **two** strengths of the study by Sensky. [6]

Answer:

Question	Answer	Marks
(a)	**Outline one way that Freeman (2008) used virtual reality to assess the symptoms of schizophrenia.** Award 1 mark for a basic outline of the term/concept. Award 2 marks for a detailed outline of the term/concept. A library scene / 5-minute train ride on the London underground between two stations was used as the setting for the virtual reality. (1) During the virtual reality the clinician noted down the comments made by the patient (1) and whether these were positive, neutral or paranoid. (1) Other appropriate responses should also be credited.	2
(b)	**Describe the study by Sensky (2000) that used cognitive-behavioural therapy (CBT) as a treatment for schizophrenia.** Award 1–2 marks for a basic answer with some understanding of the topic area. Award 3–4 marks for a detailed answer with clear understanding of the topic area. Study – 90 patients (1) in a randomised controlled design were given either cognitive-behaviour therapy or befriending sessions. (1) Patients were assessed by blind raters at baseline, after treatment (up to 9 months) and at a follow-up evaluation. (1) Patients received an average of 19 treatment sessions over 9 months (1) There were no significant differences between the two groups after treatment. (1) The patients who had received cognitive-behaviour therapy showed greater improvement on all measures at the 9-month follow up compared to the befriending patients. (1) Other appropriate responses should also be credited.	4

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Question	Answer	Marks
(c)	**Explain two strengths of the study by Sensky.** Likely strengths include – • Generalisability (90 patients aged 16-60 from four different cities in the UK) • Practical application as those receiving CBT improved the most at the follow-up assessment. • Good validity as a follow-up assessment done after 9 months to assess the longer term effectiveness of both treatments. • Good validity as it was a randomised control trial and the participants did not choose which treatment group to be in. • Good reliability as the patients were assessed by an experienced clinician who was blind to which treatment the patient had received. • Good ethics as the patients improved and also informed consent was obtained from them at the start of the study. • Quantitative data was collected using three rating scales. This enabled statistical comparisons to be made between the CBT and befriending groups. • Good validity as three measures were taken to assess improvements (Comprehensive Psychiatric Rating Scale, the Scale for Assessment of Negative Symptoms and a depression rating scale) Mark according to the levels of response criteria below: Level 3 (5–6 marks) • Candidates will show a clear understanding of the question and will explain two strengths. • Candidates will provide a good explanation with clear detail. Level 2 (3–4 marks) • Candidates will show an understanding of the question and will explain one appropriate strength in detail or two appropriate strengths in less detail. Level 1 (1–2 marks) • Candidates will show a basic understanding of the question and will attempt an explanation of a strength. They could include two strengths, both but just as an attempt. • Candidates will provide a limited explanation. Level 0 (0 marks) No response worthy of credit. Other appropriate responses should also be credited.	6

2. 9990_w22_qp_32 Q: 2

(a) Describe treatments and management of schizophrenia and delusional disorder (biochemical, ECT, token economy, CBT). [8]

(b) Evaluate treatments and management of schizophrenia and delusional disorder (biochemical, ECT, token economy, CBT), including a discussion of ethics. [10]

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Answer:

Question	Answer	Marks
(a)	**Describe treatments and management of schizophrenia and delusional disorder (biochemical, ECT, token economy, CBT).** Treatment and management of schizophrenia and delusional disorder, including the following: • biochemical (antipsychotics and atypical antipsychotics) • electro-convulsive therapy • token economy (Paul and Lentz, 1977) • cognitive-behavioural therapy (Sensky, 2000) **Biochemical (antipsychotics and atypical antipsychotics)** Chlorpromazine and other antipsychotics block dopamine and serotonin receptors in the (cortical and limbic regions) brain. Reduces agitation and hostility in the patient. After 2+ weeks reduces positive symptoms. **Electro-convulsive therapy** A general anaesthetic and a drug that relaxes muscles is given. Electrodes are placed on the scalp and a finely controlled electric current through those electrodes for a very short time. This will cause a brief seizure in the brain. The seizure is what treats the symptoms. Can be performed unilaterally or bilaterally. Often 12 weeks of treatment done 2x per week. One theory is affects post-synaptic responses to CNS transmitters. Often used effectively for acute episodes of psychosis and for catatonic symptoms. **Token economy (Paul and Lentz, 1977)** Aim was to investigate the effectiveness of operant conditioning by reinforcing appropriate behaviour with schizophrenic patient. Set up token economy system in hospital ward. 84 patients given tokens as reward when behaved appropriately. Could be exchanged for luxury items. Study lasted around 4.5 years. Independent measures design where half of patients received milieu therapy (therapeutic community), traditional hospital treatment and token economy. Behaviour monitored through observations, interviews and standardised questionnaires. Results – positive and negative symptoms were significantly reduced 11% of patients needed drug treatment, compared to 100% of the control group. Being able to live independently – 97% token economy group, 71% milieu therapy and 46% traditional hospital treatment group. Conclusion – operant conditioning is an effective means of treating people with chronic schizophrenia. **Cognitive-behavioural therapy (Sensky, 2000)** To compare cognitive behavioural therapy (CBT) with non-specific befriending interventions for patients with schizophrenia. A randomised controlled design: • Patients were allocated to one of two groups: a cognitive behavioural therapy group and a non-specific befriending control group • 90 patients. 57 from clinics in Newcastle, Cleveland and Durham and 33 from London. They had diagnoses of schizophrenia that had not responded to medication. Aged 16–60 years • Patients were allocated to one of two groups • Both interventions were delivered by two experienced nurses who received regular supervision	**8**

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Question	Answer	Marks
(a)	• Patients were assessed by blind raters at baseline after treatment (lasting up to 9 months) at a 9-month follow-up evaluation • Assessed on measures including the Comprehensive Psychiatric Rating Scale, the Scale for Assessment of Negative Symptoms, plus a depression rating scale • Patients continued to receive routine care throughout the study. The patients received a mean of 19 individual treatment sessions over 9 months Both interventions resulted in significant reductions in positive and negative symptoms and depression. After treatment there was no significant difference between the two groups. At the nine-month follow-up evaluation, patients who had received cognitive therapy showed greater improvements on all measures. They had improved, while the befriending group had lost some of the benefits. Mark according to the levels of response descriptors in Table A. Other appropriate responses should also be credited.	

Question	Answer	Marks
(b)	**Evaluate treatments and management of schizophrenia and delusional disorder (biochemical, ECT, token economy, CBT), including a discussion of ethics.** A range of issues could be used for evaluation here. These include: • **Named issue – Ethics:** Some treatments can be forced on a patient with schizophrenia such as biochemical and ECT if they are committed to a hospital. You cannot force anyone to participate in cognitive and behavioural treatments so they could be considered more ethical. Difficult to be sure that a psychotic individual has given fully informed consent to any treatment. Potential risk of physical harm from treatment with ECT and (to a lesser extent) drug therapies. However, ethical issues of consent and withdrawal could be balanced against benefit to the individual in helping manage their symptoms. • Determinism • Nature versus nurture • Appropriateness • Usefulness/effectiveness • Reductionism • Cost • Psychological approaches • Evaluation of studies on effectiveness Mark according to the levels of response descriptors in Table B. Other appropriate responses should also be credited.	**10**

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3. 9990_w21_qp_31 Q: 1

(a) Outline **one** cognitive explanation of schizophrenia and delusional disorder. [2]

(b) Describe the procedure in the study by Sensky et al. (2000) of cognitive-behavioural therapy (CBT) for schizophrenia. [4]

(c) Explain **one** similarity and **one** difference between CBT and biochemical treatments for schizophrenia/delusional disorder. [6]

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Answer:

Question	Answer	Marks
(a)	**Outline <u>one</u> cognitive explanation of schizophrenia and delusional disorder.** Award 1 mark for a basic explanation of the term/concept. Award 2 marks for a detailed explanation of the term/concept. For example: Frith describes schizophrenia as an 'abnormality of self-monitoring' as patients fail to recognise that the hallucination of hearing voices is actually the schizophrenic's own inner voice but they believe it to be someone else's. (2) The delusions (inner speech) may not be recognised as being self-generated. (1) Other appropriate responses should also be credited.	**2**
(b)	**Describe the procedure in the study by Sensky et al. (2000) of cognitive-behavioural therapy (CBT) for schizophrenia.** Award 1–2 marks for a basic answer with some understanding of the topic area. Award 3–4 marks for a detailed answer with clear understanding of the topic area. For example: Participants were referred by clinicians and eligibility confirmed by researchers using clinical interview. (1) 90 patients, 16-60 from 5 different venues – 2 West London, 1 Durham, 1 Cleveland, 1 Newcastle. CBT 46, Befriending 44. 67% CBT male, 50% male in befriending (2 marks max.) Patients were randomly assigned to a treatment and further assessments carried out approximately 9 months later, after intervention had completed and again at 9-month follow-up. (2) Antipsychotic medications were maintained. (1) Patients received individual treatment of CBT or befriending (this intervention was designed to give similar amount of therapist contact as CBT with an aim to be empathic and nondirective, focusing on neutral topics) (2) Done by experienced psychiatric nurses with each patient receiving at least 45 minutes of therapy per week. (1) After approximately 2 months, session frequency could be reduced, with the aim of completing therapy within 9 months. (1) Interviews were audiotaped. (1) Assessors were blind to patient's assigned group. (1) The Comprehensive Psychiatric Rating Scale (CPRS), Montgomery-Asberg Depression Rating Scale and the Scale for Assessment of Negative Symptoms (SANS) were all used to measure outcomes together with patients completing a 10-item questionnaire to elicit their satisfaction. (2 marks max for assessments given)	**4**

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Question	Answer	Marks
(c)	**Explain one similarity and one difference between CBT and biochemical treatments for schizophrenia/delusional disorder.** Likely similarities will be • Both have good evidence for success e.g. Lindstrom et al, 1999 drug trials and Sensky • Both require intervention from a therapist so adding to time, expense and commitment Likely differences will be • CBT based on cognitive approach, biochemical on biological approach • CBT is more active. Drug therapy is passive treatment. • CBT not suited for patients who find it difficult to engage in therapy (lack of motivation, intellect etc.) • Drug therapy has side effects Mark according to the levels of response criteria below: Level 3 (5–6 marks) • Candidates will show a clear understanding of the question and will explain an appropriate similarity and an appropriate difference. • Candidates will provide a good explanation with clear detail. Level 2 (3–4 marks) • Candidates will show an understanding of the question and will explain an appropriate similarity/difference in detail or both a similarity and a difference in less detail. • Candidates will provide a good explanation. Level 1 (1–2 marks) • Candidates will show a basic understanding of the question and will attempt a similarity and/or difference. This could include both but just as an attempt. • Candidates will provide a limited explanation. Level 0 (0 marks) No response worthy of credit. Other appropriate responses should also be credited.	**6**

4. 9990_w21_qp_32 Q: 2

(a) Describe characteristics and assessment of schizophrenia spectrum and psychotic disorders. [8]

(b) Evaluate characteristics and assessment of schizophrenia spectrum and psychotic disorders, including a discussion of validity. [10]

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Answer:

Question	Answer	Marks
(a)	**Describe characteristics and assessment of schizophrenia spectrum and psychotic disorders.** Including the following: • Definitions, examples and case studies of schizophrenia and psychotic disorders • Schizophrenia and delusional disorder • Symptom assessment using virtual reality (Freeman, 2008) **Definitions, examples and case studies** DSM-V defines schizophrenic spectrum and psychotic disorders as sharing one or more of the following: Positive symptoms include – beliefs not based in reality / delusions – hallucinations – sensory experiences of things that do not exist – disorganised thoughts/speech – catatonic behaviour – Negative symptoms such as – loss of speech (alogia) – loss of motivation (avolition) – diminished facial/emotion expression – social/emotional withdrawal Examples – these could include substance or medication-induced psychotic disorder, schizotypical (personality) disorder, schizoaffective disorder, and catatonia associated with another mental disorder or condition. DSM-V – two (or more) symptoms for at least one month. At least one of the symptoms must be delusions, hallucinations or disorganised thoughts/ speech. Case studies could include individuals who have been studied in detail. **Schizophrenia and delusional disorder** Schizophrenia is diagnosed when individual shows at least *two* of the following: delusions, hallucinations disorganised speech, disorganised or catatonic behaviour, and flattened affect for at least one month. The individual must show occupational or social functioning that has declined and these symptoms cannot be explained by another medical factor. Delusional disorder is characterised by persistent delusions but whose other behaviours are 'normal'. There is an absence of the other psychotic symptoms of schizophrenia such as hallucinations, disorganised speech or negative symptoms. Some types of delusional disorder are grandiose (belief that they have a (non-existent) unrecognised high status or great skill), persecutory (being conspired against or pursued by those intending to harm), and erotomaniac (belief someone is in love with them). To receive a diagnosis of delusional disorder symptoms must have been experienced for at least one month and be unrelated to physiological effects of substance use.	**8**

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Question	Answer	Marks
(a)	**Symptom assessment using VR (Freeman, 2008)** Prior to study, participants completed measures on intellectual functioning (Wechsler Abbreviated Scale of Intelligence) and trait paranoia (Green et al. Paranoid Thoughts Scale (GPTS) Part B) followed by numerous measures on factors in cognitive model of paranoia. Simulator-sickness questionnaire was given before and after the simulation. Virtual reality environment was a 4 min journey on a London underground train populated by computer generated 'neutral' avatars/characters. The avatars breathed and also looked in a variety of directions. There was background tube noise and low-level snippets of conversation. State social paranoia scale was given after the simulation ended as well as qualitative data collected about the participant's experiences. 200 nonclinical members of the general population were used who made comments ranging from positive to neutral to paranoid 'Lady sitting down laughed at me when I walked past'. This shows an unambiguous demonstration of paranoid thinking in the general public. Mark according to the levels of response descriptors in Table A. Other appropriate responses should also be credited.	

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Question	Answer	Marks
(b)	**Evaluate characteristics and assessment of schizophrenia spectrum and psychotic disorders, including a discussion of validity.** A range of issues could be used for evaluation here. These include: • **Named issue – validity of definitions/diagnosis –** schizophrenia spectrum and psychotic disorders include a variety of different symptoms and no one key symptom is needed for diagnosis. DSM-V and ICD-10 do not ask for the same criteria or longevity of symptoms. Two individuals with very different symptoms could both be diagnosed as schizophrenic. The reliance on self-report measures of a psychotic individual (by definition) may be invalid within a psychotic state. Co-morbidity could also call validity into question in terms of symptom overlap with another condition such as depression. **Validity of case studies –** this is good because they are in detail and often take place over a long period of time. The validity could be low as not generalisable and the data might be subjective. **Validity of Freeman study –** Good as a number of measures of were taken to assess level of paranoid thinking, social and cognitive traits and emotional distress to compare the results on the virtual reality to. Also good as rather than just interviewing a patient about their symptoms the practitioner can witness the patient in a lifelike environment. However, the ecological validity of the study is not good as it is a simulated environment. On the other hand, it does give some insight into the behaviour of a schizophrenic patient in a much more realistic setting than just asking the patient to describe their symptoms since the practitioner last had an appointment with them. • Reliability • Usefulness • Reductionist • Co-morbidity • Gender bias • Cultural bias Mark according to the levels of response descriptors in Table B. Other appropriate responses should also be credited.	**10**

5. 9990_w20_qp_31 Q: 2

(a) Describe explanations of schizophrenia and delusional disorder. [8]

(b) Evaluate explanations of schizophrenia and delusional disorder, including a discussion of the individual versus situational debate. [10]

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Answer:

Question	Answer	Marks
(a)	**Describe explanations of schizophrenia and delusional disorder.** Explanations of schizophrenia and delusional disorder, including the following: • genetic (Gottesman and Shields, 1972) • biochemical (dopamine hypothesis) • cognitive (Frith, 1992) **Genetic (Gottesman and Shields, 1972)** Schizophrenia appears to have a genetic cause as shown by Gottesman and Shields in their review article of studies of adoption, siblings and twins with schizophrenia. All adoption studies found an increased incidence of schizophrenia in adopted children with a schizophrenic biological parent. Biological siblings of children with schizophrenia showed a much higher percentage of schizophrenia. All twin studies found a higher concordance rate for schizophrenia in monozygotic (MZ) than dizygotic (DZ) twins. In Gottesman and Shield's own study the rate was 58% for identical twins, and 12% for non-identical twins. Conclusion – there is obviously a heavy genetic input into the onset of schizophrenia. **Biochemical (dopamine hypothesis)** The dopamine hypothesis of schizophrenia states that symptoms may be caused by an excess of dopamine in the mid-brain and a reduction in dopamine in the prefrontal cortex. The dopamine hypothesis of schizophrenia suggests that a high level of activity of dopamine D2 receptor neurotransmission in subcortical and limbic brain regions contributes to positive symptoms of schizophrenia, whereas negative and cognitive symptoms of the disorder can be attributed to heightened activity of dopamine D1 receptor neurotransmission in the prefrontal cortex. **Cognitive (Frith, 1992)** The symptoms of schizophrenia are due to faulty thinking processes. The patient fails to recognise through a central monitoring system that the thoughts they are having are self-created (such as our inner voice) and instead believe these are caused by external factors. The delusions may be a way of explaining the hallucinations. There may be a cognitive impairment of patients with schizophrenia which could explain some of the symptoms such as speech poverty and disorganised thoughts. The patients may also have a less developed theory of mind and find it difficult to understand the actions of others and so may develop delusions as a way of understanding other people's behaviours. Mark according to the levels of response descriptors in **Table A**. Other appropriate responses should also be credited.	**8**

Question	Answer	Marks
(b)	**Evaluate explanations of schizophrenia and delusional disorder, including a discussion of the individual versus situational debate.** A range of issues could be used for evaluation here. These include: • **Named issue – individual versus situational debate** – all explanations listed appear to give an individual explanation although it could be argued that because concordance rate of SZ in MZ twins is not 100% an environmental component must be involved. Similarly, the cognitive explanation could involve situational explanations in that type self-talk and could be influenced by upbringing and culture. • Reductionism • Nature versus nurture • Comparisons of different explanations • Application of psychology to everyday life (with reference to explanations) • Deterministic nature of the explanations • Evidence to support the explanations Mark according to the levels of response descriptors in **Table B**. Other appropriate responses should also be credited.	**10**

6. 9990_w20_qp_32 Q: 1

(a) Outline **two** characteristics of schizophrenia. [2]

(b) Describe token economy (Paul and Lentz, 1977) as a treatment for schizophrenia and delusional disorder. [4]

(c) Discuss the ethics of using token economies as a treatment for schizophrenia and delusional disorder. [6]

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Answer:

Question	Answer	Marks
(a)	**Outline <u>two</u> characteristics of schizophrenia.** Award **1** mark for each characteristic For example: Positive symptoms – delusions, hallucinations, disorganised speech. Negative symptoms – flattened affect, avolition, poverty of speech, and social withdrawal. Other appropriate responses should also be credited.	**2**
(b)	**Describe token economy (Paul and Lentz, 1977) as a treatment for schizophrenia and delusional disorder.** Award **1–2** marks for a basic answer with some understanding of the topic area. Award **3–4** marks for a detailed answer with clear understanding of the topic area. For example: Based around operant conditioning **(1)**. Patients with schizophrenia (usually in institutional care) are rewarded with tokens for instances of desirable behaviours **(1)** such as making beds, taking medication, self-care, engaging socially, and attending therapy sessions **(1)**. The tokens can be exchanged for luxury items such as cigarettes, TV use, sweets, or clothing **(1)**. In some instances, tokens can be removed for behaviours considered undesirable like angry outbursts **(1)**. Other appropriate responses should also be credited.	**4**

Question	Answer	Marks
(c)	**Discuss the ethics of using token economies as a treatment for schizophrenia and delusional disorder.** Likely ethical issues will be: • Use of vulnerable patients who may not be capable of giving informed consent; • Inability to withdraw from the scheme without loss of privileges; • Psychological harm as patient may feel that they are being judged adversely for merely suffering with an abnormality over which they have little control; • Briefing as patients can be made fully aware of why they are engaging in the program and how it will help them; • No deception is being used; Mark according to the levels of response criteria below: **Level 3 (5–6 marks)** • Candidates will show a clear understanding of the question and will discuss at least 2 appropriate ethical issues (positive or negative); • Candidates will provide a good explanation with clear detail; **Level 2 (3–4 marks)** • Candidates will show an understanding of the question and will explain appropriate ethical issues (at least 2) in less detail; • Candidates will provide a good explanation; **Level 1 (1–2 marks)** • Candidates will show a basic understanding of the question and will attempt to explain ethical issues. There could be a brief explanation of one ethical issue; • Candidates will provide a limited explanation; **Level 0 (0 marks)** No response worthy of credit. Other appropriate responses should also be credited.	**6**

7. 9990_w19_qp_31 Q: 1

(a) Explain what is meant by 'schizophrenia'. [2]

(b) Describe the genetic explanation of schizophrenia, as outlined by Gottesman and Shields (1972). [4]

(c) Explain **one** similarity and **one** difference between cognitive and genetic explanations of schizophrenia. [6]

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Answer:

Question	Answer	Marks
(a)	**Explain what is meant by 'schizophrenia'.** Award 1 mark for a basic explanation of the term/concept. Award 2 marks for a detailed explanation of the term/concept. For example: Schizophrenia is a mental health disorder that involves positive and negative symptoms (1). Positive symptoms include things such as hallucinations and delusions (1). Negative symptoms might include speech poverty and flattening of mood (1). It is a break from reality where the person experiences symptoms such as hallucinations and delusions (1). Hallucinations are a positive symptom of schizophrenia (1). Types of schizophrenia are no longer on the syllabus, but can be credited, only up to a maximum of 1 mark if this is all that is given (e.g. simple, paranoid, catatonia, delusional disorder, etc.) Other appropriate responses should also be credited.	**2**
(b)	**Describe the genetic explanation of schizophrenia, as outlined by Gottesman and Shields (1972).** Award 1–2 marks for a basic answer with some understanding of the topic area. Award 3–4 marks for a detailed answer with clear understanding of the topic area. For example: Schizophrenia appears to have a genetic cause as shown by Gottesman and Shields in their review of studies of adoption, siblings and twins with schizophrenia (1). All adoption studies found an increased incidence of schizophrenia in adopted children with a schizophrenic biological parent (1). Biological siblings of children with schizophrenia showed a much higher percentage of schizophrenia (1). All twin studies found a higher concordance rate for schizophrenia in monozygotic (MZ) than dizygotic (DZ) twins (1). In Gottesman and Shield's own study the rate was 58% for identical twins, and 12% for non-identical twins (1). There is a heavy genetic input into the onset of schizophrenia (1). Other appropriate responses should also be credited.	**4**

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Question	Answer	Marks
(c)	**Explain one similarity and one difference between cognitive and genetic explanations of schizophrenia.** Comparison will be for the cognitive explanation as outlined by Frith (1992) and the genetic explanation as outlined by Gottesman and Shields (1972). **Similarities** Both Gottesman and Frith believe that there is a **biological basis** for schizophrenia. Gottesman focusses on genetics and Frith also believes that genetics plays a part in the development of schizophrenia. Gottesman found a high concordance rate between MZ twins. Frith suggests that brain structure and biochemical processes also influence the development of the disorder. This shows that both explanations suggest a biological basis for the disorder. Both suggest **nature** is important in the development of schizophrenia – Gottesman suggests schizophrenia has a strong genetic cause and Frith suggests that schizophrenia cognitive difficulties are linked to genetics, brain structure and biochemical processes. Offer an **individual** explanation of schizophrenia. Gottesman suggests that one's individual genetic make-up causes schizophrenia and not environmental factors. Frith suggests it is the person's individual faulty mental processing (likely caused by biological factors) that lead to the development of the disorder and not environmental or social factors. Both explanations are backed up by **experiments**. Gottesman and Shields did many studies on twins and families to prove the genetic explanation of schizophrenia. Frith did a lab study where schizophrenic participants were unable to identify whether items that had been read aloud were done by a computer, the experimenter or themselves which shows the attention difficulties patients with schizophrenia have. **Differences** Frith also brings in a **cognitive** explanation of why the symptoms occur which is not done by Gottesman and Shields. Gottesman and Shields focus on the genetic cause of the disorder. Frith adds to this explanation by explaining the symptoms of the disorder due to faulty mental processing. Genetic explanation is **more reductionist** than the cognitive explanation. Gottesman and Shields just focus on the genetic cause of the disorder and do not consider other biological processes or cognitive explanations. Frith considers both biological causes and how these could lead to cognitive deficits such as faulty mental processing.	**6**

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Question	Answer	Marks
(c)	Mark according to the levels of response criteria below: Level 3 (5–6 marks) • Candidates will show a clear understanding of the question and will include one similarity and one difference. • Candidates will provide a good explanation with clear detail. Level 2 (3–4 marks) • Candidates will show an understanding of the question and will include one appropriate similarity in detail or one appropriate difference in detail. OR one similarity and one difference in less detail. • Candidates will provide a good explanation. Level 1 (1–2 marks) • Candidates will show a basic understanding of the question and will attempt a similarity and/or difference. This could include both but just as an attempt. • Candidates will provide a limited explanation. Level 0 (0 marks) No response worthy of credit. Other appropriate responses should also be credited.	

8. 9990_w19_qp_32 Q: 1

(a) Explain what is meant by 'schizophrenia'. [2]

(b) Describe the genetic explanation of schizophrenia, as outlined by Gottesman and Shields (1972). [4]

(c) Explain **one** similarity and **one** difference between cognitive and genetic explanations of schizophrenia. [6]

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Answer:

Question	Answer	Marks
(a)	**Explain what is meant by 'schizophrenia'.** Award 1 mark for a basic explanation of the term/concept. Award 2 marks for a detailed explanation of the term/concept. For example: Schizophrenia is a mental health disorder that involves positive and negative symptoms (1). Positive symptoms include things such as hallucinations and delusions (1). Negative symptoms might include speech poverty and flattening of mood (1). It is a break from reality where the person experiences symptoms such as hallucinations and delusions (1). Hallucinations are a positive symptom of schizophrenia (1). Types of schizophrenia are no longer on the syllabus, but can be credited, only up to a maximum of 1 mark if this is all that is given (e.g. simple, paranoid, catatonia, delusional disorder, etc.) Other appropriate responses should also be credited.	**2**
(b)	**Describe the genetic explanation of schizophrenia, as outlined by Gottesman and Shields (1972).** Award 1–2 marks for a basic answer with some understanding of the topic area. Award 3–4 marks for a detailed answer with clear understanding of the topic area. For example: Schizophrenia appears to have a genetic cause as shown by Gottesman and Shields in their review of studies of adoption, siblings and twins with schizophrenia (1). All adoption studies found an increased incidence of schizophrenia in adopted children with a schizophrenic biological parent (1). Biological siblings of children with schizophrenia showed a much higher percentage of schizophrenia (1). All twin studies found a higher concordance rate for schizophrenia in monozygotic (MZ) than dizygotic (DZ) twins (1). In Gottesman and Shield's own study the rate was 58% for identical twins, and 12% for non-identical twins (1). There is a heavy genetic input into the onset of schizophrenia (1). Other appropriate responses should also be credited.	**4**

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Question	Answer	Marks
(c)	**Explain one similarity and one difference between cognitive and genetic explanations of schizophrenia.** Comparison will be for the cognitive explanation as outlined by Frith (1992) and the genetic explanation as outlined by Gottesman and Shields (1972). **Similarities** Both Gottesman and Frith believe that there is a **biological basis** for schizophrenia. Gottesman focusses on genetics and Frith also believes that genetics plays a part in the development of schizophrenia. Gottesman found a high concordance rate between MZ twins. Frith suggests that brain structure and biochemical processes also influence the development of the disorder. This shows that both explanations suggest a biological basis for the disorder. Both suggest **nature** is important in the development of schizophrenia – Gottesman suggests schizophrenia has a strong genetic cause and Frith suggests that schizophrenia cognitive difficulties are linked to genetics, brain structure and biochemical processes. Offer an **individual** explanation of schizophrenia. Gottesman suggests that one's individual genetic make-up causes schizophrenia and not environmental factors. Frith suggests it is the person's individual faulty mental processing (likely caused by biological factors) that lead to the development of the disorder and not environmental or social factors. Both explanations are backed up by **experiments**. Gottesman and Shields did many studies on twins and families to prove the genetic explanation of schizophrenia. Frith did a lab study where schizophrenic participants were unable to identify whether items that had been read aloud were done by a computer, the experimenter or themselves which shows the attention difficulties patients with schizophrenia have. **Differences** Frith also brings in a **cognitive** explanation of why the symptoms occur which is not done by Gottesman and Shields. Gottesman and Shields focus on the genetic cause of the disorder. Frith adds to this explanation by explaining the symptoms of the disorder due to faulty mental processing. Genetic explanation is **more reductionist** than the cognitive explanation. Gottesman and Shields just focus on the genetic cause of the disorder and do not consider other biological processes or cognitive explanations. Frith considers both biological causes and how these could lead to cognitive deficits such as faulty mental processing.	**6**

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Question	Answer	Marks
(c)	Mark according to the levels of response criteria below: Level 3 (5–6 marks) • Candidates will show a clear understanding of the question and will include one similarity and one difference. • Candidates will provide a good explanation with clear detail. Level 2 (3–4 marks) • Candidates will show an understanding of the question and will include one appropriate similarity in detail or one appropriate difference in detail. OR one similarity and one difference in less detail. • Candidates will provide a good explanation. Level 1 (1–2 marks) • Candidates will show a basic understanding of the question and will attempt a similarity and/or difference. This could include both but just as an attempt. • Candidates will provide a limited explanation. Level 0 (0 marks) No response worthy of credit. Other appropriate responses should also be credited.	

9. 9990_s18_qp_31 Q: 2

(a) Describe the treatment and management of schizophrenia and delusional disorder. [8]

(b) Evaluate the treatment and management of schizophrenia and delusional disorder, including a discussion of determinism. [10]

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