2.1 Sociocultural approach and the options

Name: _____ Class: _____ Date: _____ **Total: 28 marks**

KEY WORDS conformity • bystander effect

Sociocultural approach and the options

Objective

Explain the individual-and-the-group findings (identity, conformity, obedience), cultural dimensions and acculturation, and apply the options kits – abnormal, developmental, health, relationships – with accurately named studies (core approach 3 with the options).

1 Key knowledge and worked examples

Sociocultural + options toolkit. SIT: categorisation, identification, comparison; Tajfel's minimal groups. Conformity (Asch ≈75% at least once, ≈37% of trials; an ally collapses it); obedience (Milgram 26/40 = 65%). Hofstede's dimensions (never for individuals); enculturation; Berry's four acculturation strategies, integration healthiest. Abnormal: Rosenhan's 8 pseudopatients, 12 hospitals, 7–52 days; depression's three-level etiology; CBT vs SSRIs. Developmental: Rutter's orphans; Sally–Anne at ~4; Marcia's statuses; metacognition. Health: Whitehall II gradient; Kiecolt–Glaser caregivers; health-belief model. Relationships: Walster's dance; Sherif's superordinate goals; Darley–Latané 85%/31%.

2 Practice

2.1 State the three processes of social identity theory and outline what Tajfel's minimal group study found. [3]

2.2 Outline Asch's (1951) findings with the two percentages, and one factor that reduces conformity. [4]

2.3 Distinguish conformity from obedience, naming the source of pressure in each. [2]

2.4 Name Berry's four acculturation strategies and state which shows the best average mental-health outcomes. [2]

2.5 Outline Steele and Aronson's (1995) stereotype-threat finding and the comparison it rests on. [4]

3 Exam-style questions

3.1 *(Essay excerpt style, abnormal option.)* Using Rosenhan (1973), discuss the validity and reliability of psychiatric diagnosis. State the procedure, two findings, and what they imply about labels. [6]

3.2 *(Option application, relationships.)* Darley and Latané's seizure study found 85% helped alone against 31% with four others. Explain diffusion of responsibility and evaluate whether "apathy" explains the result. [4]

3.3 *(Option application, health.)* Explain the socioeconomic health gradient using Whitehall II, and one implication for health promotion. [3]

Solutions

2.1 Social categorisation, social identification and social comparison (1). Tajfel's boys, split by a trivial criterion, allocated more points or money to anonymous in-group members even with nothing at stake for themselves: mere categorisation produces in-group favouritism (2).

2.2 About 75% of participants conformed at least once across 12 critical trials (1); overall roughly a third of critical trials went with the unanimous wrong majority (1). Reduction: the presence of ONE dissenting ally collapses conformity dramatically (accept: unanimity broken, private writing, individualist culture) (2).

2.3 Conformity is yielding to implicit PEER pressure – the majority's unanimity (1); obedience is complying with an explicit AUTHORITY's commands, as in Milgram's experimenter (1).

2.4 Assimilation, integration, separation, marginalisation (1). Integration (adopt the host culture AND keep the heritage culture) shows the best average outcomes (1).

2.5 Black and White American students took the same test (1). When it was framed as diagnostic of ability, Black students' performance dropped below White students'; when framed as a non-diagnostic puzzle, the groups performed equally (2). The comparison shows the stereotype itself – not ability – doing the work: activating the threat is the causal lever (1).

3.1 Rosenhan sent eight sane confederates to twelve hospitals complaining of hearing voices; all but one were admitted with schizophrenia (2). Findings: stays ran 7–52 days while staff read normal behaviour (note-taking) through the label; real patients, unlike staff, often detected sanity; all were discharged "schizophrenia in remission" – a label that stuck after the symptom vanished (2). Implications: diagnostic validity is fragile (the label reframes normal behaviour) and reliability falters when clinicians cannot distinguish sanity in context, so diagnosis is a judgement under framing, not a pure measurement (2).

3.2 Diffusion of responsibility: each bystander's sense of personal obligation shrinks as the perceived number of witnesses grows, so no one acts (2). "Apathy" does not fit: participants were visibly distressed and glanced at others; they CALIBRATED their response to the group – looking to others who were doing nothing, they concluded no emergency existed (pluralistic ignorance) (2). The mechanism is social inference, not indifference.

3.3 Whitehall II followed British civil servants: even among people in employment with the same access to healthcare, lower employment grade predicted higher morbidity and mortality (2). The gradient implies promotion cannot rely on access alone: the drivers include control over work, stress and health behaviours, so programs that target perceived control and stress management in lower grades – not just information – are the evidence-based route (1).

Local review guidance: percentages quoted with what each measures; the equal-performance control condition is the reason the study shows threat; (R1 3.1) the discussion distinguishes what the study shows from what it cannot. Authored classroom guidance.