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Centre number

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Surname

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Forename(s)

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# A-level PSYCHOLOGY

## Paper 1 Introductory Topics in Psychology

Monday 20 May 2019

Afternoon

Time allowed: 2 hours

### Materials

For this paper you may use:

- a calculator.

### Instructions

- Use black ink or black ball-point pen.
- Fill in the boxes at the top of this page.
- Answer **all** questions.
- You must answer the questions in the spaces provided. Do **not** write outside the box around each page or on blank pages.
- Do all rough work in this book. Cross through any work you do not want to be marked.

### Information

- The marks for questions are shown in brackets.
- The maximum mark for this paper is 96.
- Questions should be answered in continuous prose. You will be assessed on your ability to:
  - use good English
  - organise information clearly
  - use specialist vocabulary where appropriate.

| For Examiner's Use |      |
|--------------------|------|
| Section            | Mark |
| A                  |      |
| B                  |      |
| C                  |      |
| D                  |      |
| <b>TOTAL</b>       |      |



J U N 1 9 7 1 8 2 1 0 1

**Section A****Social influence**

Answer **all** questions in this section.

|   |   |
|---|---|
| 0 | 1 |
|---|---|

Outline **two** explanations of resistance to social influence.

**[4 marks]**

*Social support: resistance is more likely when the person sees others resisting. A dissenter breaks the unanimity of the majority, giving the individual confidence and a model of disobedience or non-conformity to follow. In Asch's variation with one dissenting confederate, conformity fell to about 5.5%, and in Milgram's variation with two disobedient peers, obedience fell to 10%.*

*Locus of control (Rotter): people with an internal locus of control believe they control their own behaviour and what happens to them, so they take personal responsibility and base decisions on their own beliefs. They are therefore more likely to resist pressure to conform or obey than people with an external locus of control, who believe events are controlled by luck, fate or powerful others.*

Extra space



In 1987, a survey of 1000 young people found that 540 said they smoked cigarettes, whilst 460 said they did not. In 2017, a similar survey of another 1000 young people found that 125 said they smoked cigarettes, whilst 875 said they did not.

0 2

Calculate the ratio of smokers to non-smokers in 2017. Give your answer in simplest form.

Show your workings.

[2 marks]

*Smokers : non-smokers in 2017 = 125 : 875*

*Highest common factor is 125:  $125 \div 125 = 1$  and  $875 \div 125 = 7$*

*Ratio = 1 : 7*

0 3

Which statistical test should be used to calculate whether there is a significant difference in reported smoking behaviour between the two surveys? Give **three** reasons for your answer.

[4 marks]

*Chi-squared test.*

*1. The researchers are looking for a difference between the two surveys*

*(1987 vs 2017) in the number of smokers and non-smokers.*

*2. The data are nominal (categorical): each young person is simply counted into a category, smoker or non-smoker.*

*3. It is an independent groups design, so the data are unrelated: the 1000 young people surveyed in 2017 were different people from those in 1987.*

**Turn over for the next question**

**Turn over ►**



0 4

The survey shows that fewer young people are smoking today than in 1987.

Using your knowledge of social influence processes in social change, explain possible reasons for this change in behaviour.

[6 marks]

*Minority influence: anti-smoking campaigners were originally a minority, but they gave a consistent message over many years that smoking causes cancer. Their commitment, e.g. campaigning despite pressure from tobacco companies (augmentation principle), and flexibility, e.g. accepting health warnings on packets before full bans, made the majority think deeply about the issue, leading to internalised conversion.*

*Through the snowball effect, more and more people gave up, so the minority view became the majority view and today's young people grow up with not smoking as the norm.*

*Normative social influence: the group norm among young people today is to be healthy and fit, so a young person who smokes risks rejection or disapproval from peers and complies by not smoking to fit in.*

*Informational social influence: far more is known now about the harms of smoking, so young people accept this evidence as correct and internalise the view that smoking is dangerous.*

Extra space *Obedience: laws from legitimate authority, such as banning smoking in enclosed public places and raising the age for buying cigarettes to 18, mean young people obey these rules and are less likely to start.*



0 5

Discuss ethical issues in social influence research.

[8 marks]

*A key ethical issue is deception, which prevents fully informed consent.*

*Asch's participants were told the study was about visual perception and did not know the others were confederates, and Milgram's participants believed they were giving real electric shocks. A second issue is protection from harm: Milgram's participants showed extreme distress such as sweating, trembling and nervous laughter, and in Zimbardo's Stanford prison experiment (SPE) the prisoners were humiliated and some showed signs of severe distress. The right to withdraw was also undermined, as Milgram used verbal prods such as 'the experiment requires that you continue' and SPE prisoners felt pressured to stay.*

*However, deception can be justified because it increases validity: if participants knew the true aim, demand characteristics would make their behaviour unnatural, and obedience would be almost impossible to study honestly. A cost-benefit analysis also suggests the benefits to society, understanding the dangers of blind obedience, outweighed the short-term costs to participants.*

*Harm was also reduced by debriefing. Milgram fully debriefed participants and reunited them with the 'learner', and in a follow-up questionnaire 84% said they were glad to have taken part, a form of retrospective consent. On the other hand, debriefing cannot undo harm already done, such as participants learning they were capable of hurting another person.*

*Finally, these studies took place before formal ethical guidelines were established, so judging them by today's standards may be unfair. Their controversy helped bring in the codes that now protect participants, and the SPE led to reforms of real prisons.*

Turn over ►



Extra space



**Section B****Memory**Answer **all** questions in this section.Only **two** answers for this question are allowed.

For each answer completely fill in the circle alongside the appropriate answers.

CORRECT METHOD



WRONG METHODS



If you want to change your answer you must cross out your original answer as shown.



If you wish to return to an answer previously crossed out, ring the answer you now wish to select as shown.

**0 6**Which **two** of **A, B, C, D** and **E** are associated with the cognitive interview technique?Shade **two** boxes only.**[2 marks]****A** Alter the perspective**B** Change the speaker**C** Match the direction**D** Remove the context**E** Reverse the order**Turn over for the next question****Turn over ►**

0 7

Evaluate the cognitive interview as a way of improving the accuracy of eyewitness testimony.

[6 marks]

*A strength is strong research support. Köhnken et al's (1999) meta-analysis of 53 studies found that the cognitive interview (CI) produced on average 34% more correct information than the standard interview, suggesting it improves the amount recalled by eyewitnesses.*

*However, the same meta-analysis found that the CI also increased the amount of incorrect information recalled, so it does not always improve accuracy and police need to treat the extra details with caution.*

*Also, some elements of the CI are more useful than others. Milne and Bull (2002) found that each technique on its own produced more information than a standard interview, but combining 'report everything' and 'context reinstatement' gave the best recall, so a shortened version could be used.*

*A further limitation is that the full CI is time-consuming and requires special training, so with limited resources police may use simplified versions, which reduces its effectiveness in real investigations. Even so, the enhanced cognitive interview, which adds rapport building and reducing witness anxiety,*

Extra space *is now widely used, showing its practical value.*



Most PIN codes are 4 digits long and are easy to remember. In contrast, mobile phone numbers are 11 digits long. Most people would not be able to remember a friend's new mobile phone number unless they were able to say it to themselves several times without interruption.

**0 8**

Discuss the multi-store model of memory. Refer to the information above in your answer.

**[16 marks]**

You may use this space to plan your answer.

*The multi-store model (Atkinson and Shiffrin, 1968) is an information processing model which sees memory as three separate, unitary stores linked in a linear sequence. Information from the environment first enters the sensory register, which has a very large capacity, a duration of less than half a second and modality-specific coding (iconic for visual, echoic for sound). Information that is paid attention to passes into short-term memory (STM). STM has a limited capacity of about 7 plus or minus 2 items (Miller), a duration of about 18 to 30 seconds without rehearsal and mainly acoustic coding; information is lost through decay or displacement by new items. Maintenance rehearsal keeps information in STM in a rehearsal loop, and if rehearsed enough it transfers to long-term memory (LTM), which has an unlimited capacity, a duration of up to a lifetime and mainly semantic coding. Information is retrieved from LTM back into STM when needed. The model explains why a 4-digit PIN code is easy to remember: four digits are well within the limited capacity of STM. An 11-digit mobile number*

**Turn over ►**



exceeds 7 plus or minus 2 items, so some digits are displaced, unless the person chunks the number into a few groups, e.g. 07700 900 123. Saying the number to themselves several times is maintenance rehearsal, which keeps it in STM and, with enough repetition, transfers it to LTM.

Interruption stops rehearsal and the new information displaces the digits from STM, so they are forgotten.

A strength is research support for separate stores. Glanzer and Cunitz (1966) found a serial position effect: words at the start of a list were recalled well (primacy effect, as they had been rehearsed into LTM) and so were words at the end (recency effect, as they were still in STM). When recall was delayed by 30 seconds the recency effect disappeared but primacy remained, suggesting STM and LTM are functionally separate. Further support comes from research into the stores' characteristics, e.g. Baddeley (1966) showed acoustic coding in STM and semantic coding in LTM, and Peterson and Peterson (1959) showed STM duration is about 18 seconds.

However, the model is too simple, as it sees STM as a unitary store.

Shallice and Warrington (1970) studied KF, who after brain damage had poor STM for verbal information but could still process visual information normally, suggesting there are separate short-term stores. This supports the working memory model, which has several components such as the phonological loop and the visuo-spatial sketchpad. LTM is not unitary either, as Clive Wearing could no longer form new episodic memories but kept procedural memories such as playing the piano.

A further limitation is that the model overemphasises maintenance rehearsal. Craik and Lockhart argued that elaborative rehearsal, processing meaning, leads to better long-term recall, and we remember many things without any rehearsal. Also, Cowan (2001) suggests STM capacity may be closer to 4



chunks, which would explain even more clearly why 4-digit PINs are easy but phone numbers are not. Finally, much of the supporting research used artificial materials such as digit or word lists, so it may lack ecological validity, although everyday examples like remembering phone numbers do fit the model well. Overall, the model was a useful starting point which led to more detailed models of memory.

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[illegible]

**Section C****Attachment**

Answer **all** questions in this section.

|   |   |
|---|---|
| 0 | 9 |
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Outline findings from research into the role of the father in attachment.

**[4 marks]**

*Schaffer and Emerson (1964) found that most infants formed their first specific attachment to the mother, but by 18 months 75% of infants had also formed an attachment to their father. Grossmann et al (2002) found that the quality of infants' attachment to the father was less important than attachment to the mother in predicting attachment quality in adolescence, but that fathers' sensitive, challenging play was linked to it, suggesting the father has a different, play-based role rather than an emotional one. Field (1978) found that fathers who were primary caregivers smiled, imitated and held their infants more than secondary caregiver fathers, showing fathers can adopt the more traditional maternal role.*

Extra space

**Turn over for the next question**

**Turn over ►**



1 0

Explain the economic implications of research into the role of the father in attachment.

**[4 marks]**

Research such as Field (1978) suggests that fathers can be just as effective primary caregivers as mothers, because responsiveness matters more than gender. This has economic implications, as families can decide on childcare based on finances: if the mother earns more, she can return to work and contribute to the economy while the father stays at home. It has also supported laws on shared parental leave, which is partly government-funded and costs employers, but helps mothers stay in the workforce and may reduce the gender pay gap. In contrast, Bowlby's view that the mother is the primary attachment figure implied the father's role is economic, as the breadwinner, which kept many mothers out of paid work.

Extra space



1 1

Discuss research into the influence of early attachment on childhood **and/or** adult relationships.

[16 marks]

You may use this space to plan your answer.

Bowlby proposed that the first attachment, usually to the mother, creates an internal working model (IWM): a mental representation of what relationships are like, which acts as a template for later relationships. A child with a loving, sensitive caregiver expects relationships to be trusting and supportive, whereas a child with a rejecting or inconsistent caregiver expects others to be unreliable.

In childhood, attachment type is linked to peer relationships. Kerns (1994) found securely attached children tend to form the best quality friendships, and Myron-Wilson and Smith (1998) found that securely attached children were unlikely to be involved in bullying, while insecure-avoidant children were most likely to be victims and insecure-resistant children most likely to be bullies. In adulthood, Hazan and Shaver (1987) used a 'love quiz' in a newspaper and found that people classified as securely attached (56%) had happy, trusting and long-lasting romantic relationships, avoidant respondents feared intimacy, and resistant respondents tended to be jealous and preoccupied. The IWM also affects parenting: Bailey et al (2007) found that most mothers had the same attachment type to their own mothers as their babies had to them, suggesting attachment types are passed on through

Turn over ►



generations.

Strong support comes from longitudinal research. Simpson et al (2007) found that infants who were securely attached were rated as more socially competent as children, closer to friends as adolescents and more emotionally attached to their partners as adults. Because attachment was measured in infancy rather than recalled, this avoids retrospective bias.

However, much research, including Hazan and Shaver, relies on self-report questionnaires and retrospective recall of childhood, which may be distorted by memory or social desirability bias, reducing validity. The IWM itself is a hypothetical construct which cannot be directly observed, so it is difficult to measure and test.

Also, the findings are correlational, so cause and effect cannot be established. Confounding variables such as parenting style or the child's innate temperament could affect both infant attachment and later relationships. Furthermore, not all research shows continuity: Zimmermann (2004) found little relationship between infant attachment type and adolescent attachment, as life events such as parental divorce had a greater impact.

This raises the issue of determinism. The IWM suggests that people with insecure early attachments are doomed to poor relationships, which could be socially sensitive and create self-fulfilling prophecies. In reality many people with insecure early attachments go on to form secure, happy relationships ('earned security'), and Clarke and Clarke argue that the effects of early experience can be reversed. This suggests early attachment has a probabilistic rather than fixed influence.

Finally, animal research such as Harlow's, where monkeys raised with a wire mother became poor parents and socially abnormal, supports the role of early



*attachment, but it is difficult to generalise from monkeys to complex human relationships.*

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[illegible]

## Section D

## Psychopathology

Answer **all** questions in this section.

|   |   |
|---|---|
| 1 | 2 |
|---|---|

Outline **two** behavioural characteristics of depression.

**[4 marks]**

*Changes in activity levels: depressed people often show reduced energy (lethargy) and withdraw from work, education and social life, losing interest in activities they used to enjoy, and may neglect personal hygiene. Some show the opposite, with psychomotor agitation such as pacing.*

*Disruption to sleep: sleep may be reduced, as in insomnia with early morning waking, or increased, as in hypersomnia, where the person sleeps much more than usual. This lack of restful sleep adds to their fatigue and makes*

Extra space *everyday tasks harder.*

Turn over for the next question

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Agoraphobia is an extreme fear of open or public spaces. It affects less than 1% of adults in the UK. In many cases, people with agoraphobia are unable to leave their homes and may not even be able to look outside, perceiving threats everywhere. The condition is very stressful for the individual, and for their family, and may prevent sufferers from living a normal life and achieving their potential.

1 3

Referring to the description above, outline **three** definitions of abnormality.

[6 marks]

*Statistical infrequency defines abnormality as behaviour that is statistically rare in the population. Agoraphobia 'affects less than 1% of adults in the UK', so it is statistically infrequent and would be defined as abnormal.*

*Deviation from social norms defines abnormality as behaviour that goes against the unwritten rules of acceptable behaviour in a society. Being 'unable to leave their homes', or even look outside, violates the norm that adults go out to work, shop and socialise, so sufferers are not living a 'normal life'.*

*Failure to function adequately defines abnormality as being unable to cope with the demands of everyday life, or causing distress to oneself or others. Agoraphobia is 'very stressful for the individual, and for their family' and*

Extra space *stops sufferers leaving home, so they cannot hold down a job or achieve their potential.*



One explanation for phobias, including agoraphobia, is the two-process model.

1 4

Outline **one** limitation of the two-process model.

[2 marks]

*Not everyone with a phobia can recall a traumatic experience that caused it (e.g. Di Nardo et al), and many people who have a frightening experience, such as being bitten by a dog, do not develop a phobia. So classical and operant conditioning cannot fully explain phobias; factors such as biological preparedness or cognition must also be involved.*

A researcher wanted to investigate agoraphobia by studying Patient X. The researcher designed a questionnaire to find out about Patient X's experiences. However, a colleague suggested that the researcher might do better to conduct a case study.

1 5

Explain **one or more** reasons why it might be better to conduct a case study than a questionnaire.

[4 marks]

*A case study of Patient X would produce rich, detailed qualitative data about their experience of agoraphobia, such as how the fear developed and how it affects daily life, whereas a questionnaire with closed questions gives only a limited picture of such a rare and complex condition.*

*Also, a case study uses several methods, such as interviews with Patient X and their family and observation, so findings can be cross-checked (triangulation), increasing validity. A questionnaire is a single self-report method open to social desirability bias, and gives a one-off snapshot, whereas a case study can be longitudinal and track changes over time.*

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1 6

Outline and evaluate **one or more** neural explanations of obsessive-compulsive disorder.**[8 marks]**

One neural explanation is abnormal neurotransmitter levels. Low levels of serotonin are thought to disrupt the transmission of mood-related information, so obsessive thoughts and anxiety are not regulated, and high levels of dopamine are linked to compulsive behaviours. A second explanation is abnormal brain structure and function: the 'worry circuit', involving the orbitofrontal cortex (OFC), the caudate nucleus in the basal ganglia and the thalamus, is hyperactive in OCD. Normally the caudate nucleus filters out minor worries, but if it is damaged the thalamus is alerted and signals back to the OFC, creating a loop of worry the person tries to relieve through compulsions. The parahippocampal gyrus, which processes unpleasant emotions, may also function abnormally.

Support comes from drug treatments: SSRIs increase the availability of serotonin and reduce symptoms in many patients, suggesting low serotonin plays a causal role. Brain scans also show raised OFC activity in OCD patients, especially when symptoms are provoked.

However, a significant proportion of patients do not respond to SSRIs, which casts doubt on serotonin being the main cause. Causation is also unclear, as neural abnormalities may be a consequence of OCD rather than its cause.

Some findings have not been replicated, e.g. Aylward et al found no consistent basal ganglia differences between OCD patients and controls.

Finally, neural explanations are reductionist, ignoring cognitive and environmental factors such as stressful life events, so a diathesis-stress approach may explain OCD more fully.



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[illegible]

**END OF QUESTIONS**

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