Surname	StemUp Model Solution	Centre Number	Candidate Number
First name(s)			2

GCE A LEVEL

A290U10-1

S24-A290U10-1

FRIDAY, 17 MAY 2024 – MORNING

PSYCHOLOGY – A level component 1
Psychology: Past to Present

2 hours 15 minutes

For Examiner's use only		
Question	**Maximum Mark**	**Mark Awarded**
1.	**8**	
2.	**10**	
3.	**8**	
4.	**10**	
5.	**10**	
6.	**10**	
7.	**10**	
8.	**10**	
9.	**24**	
Total	**100**	

A290U101
01

INSTRUCTIONS TO CANDIDATES

Use black ink or black ball-point pen. Do not use gel pen or correction fluid.

Write your name, centre number and candidate number in the spaces at the top of this page.

Answer **all** questions.

Write your answers in the spaces provided in this booklet. Additional space is provided for some questions within the booklet (if required). If further space is required for any question, you should use the additional page(s) at the back of the booklet, taking care to number the question(s) correctly.

INFORMATION FOR CANDIDATES

The number of marks is given in brackets at the end of each question or part-question.

You are reminded of the necessity for good English and orderly presentation in your answers.

Assessment will take into account the quality of written communication used in your answers.

JUN24A290U10101

© WJEC CBAC Ltd.

stemup.co.uk

Examiner only

Answer **all** questions.

1. Describe the findings of Myers and Diener's (1995) research *'Who is happy?'*. [8]

Age: there was no real difference in happiness across the lifespan. Inglehart's (1990) survey of around 170,000 people in 16 countries found that no time of life is notably happier or unhappier than any other, although the predictors of happiness change with age (e.g. social relationships and health become more important in later life).

Gender: men and women report similar levels of happiness and life satisfaction. However, they differ in vulnerability to disorders: women are about twice as vulnerable as men to depression and anxiety, while men are about five times as vulnerable as women to alcoholism and antisocial personality disorder (Robins and Regier, 1991).

Race: there was little difference; for example, African Americans and European Americans report similar happiness, and minority groups score similarly on self-esteem (Crocker and Major, 1989).

Culture: there were large national differences. In Portugal only about 10% of people say they are very happy, compared with about 40% in the Netherlands.

Money: there were only moderate positive correlations between wealth and happiness, even though many adults believe a higher income would make them happier (Strumpel, 1976). Once basic needs are met, extra income adds little.

Traits: the best predictors of a happy person were high self-esteem, a sense of personal control, optimism and extraversion.

Relationships: people with more close friends were happier and had more positive emotion; those who could name several intimate friends were healthier and less likely to die prematurely than people with few or no friends. Married people also reported greater happiness than the never married or divorced.

© WJEC CBAC Ltd.

stemup.co.uk

Examiner only

Additional space for Question **1** only:

Flow and work: people with greater work satisfaction also had greater life satisfaction, as work gives personal identity, a sense of community and the chance to experience 'flow'.

Faith: religious people reported higher levels of happiness and life satisfaction than non-religious people.

2. Evaluate the biological approach in terms of its strengths and weaknesses. [10]

A strength is that the biological approach is highly scientific. It uses laboratory experiments and scanning techniques such as PET and fMRI, giving objective, measurable and observable data. Procedures are standardised, so studies can be replicated, giving high reliability; for example, Raine et al. (1997) used PET scans to measure glucose metabolism in murderers' brains. However, laboratory research often has low ecological validity. Raine's participants did a continuous performance task in a scanner, which is very different from real-life aggression, and much research uses animals (e.g. Kluver and Bucy's work on monkeys), so findings may not generalise to humans.

Another strength is real-world application. Biological research has led to drug therapies such as SSRIs for depression and antipsychotics for schizophrenia, which are cheap, quick to administer and allow many people to live independently. However, drugs often treat symptoms rather than causes, and relapse rates are high when medication stops; side effects also cause some patients to drop out.

There is strong evidence to support the approach. Twin studies, such as Gottesman and Shields (1966), show higher concordance rates for

© WJEC CBAC Ltd.

stemup.co.uk

Examiner only

schizophrenia in MZ than DZ twins, suggesting a genetic influence. However, concordance is never 100%, so environment must also play a role, which refutes a purely biological explanation.

A weakness is reductionism: complex behaviours such as aggression are reduced to genes, hormones or brain areas, ignoring cognitive, social and cultural factors. The approach is also biologically deterministic, suggesting we have no free will, which has implications for responsibility, for example in courts. It is also nomothetic, so it can overlook individual differences, such as why only some people with a genetic vulnerability develop a disorder.

Additional space for Question **2** only:

In conclusion, the biological approach is valuable because its scientific methods are reliable and have produced effective treatments, but its reductionism and determinism mean it gives only a partial explanation. An interactionist (diathesis-stress) view, combining biological and environmental factors, is likely to be more valid.

© WJEC CBAC Ltd.

stemup.co.uk

Examiner only

3. Evaluate the effectiveness of either systematic desensitisation **OR** aversion therapy. [8]

I will evaluate systematic desensitisation (SD).

There is research to support the effectiveness of SD. Capafons et al. (1998) treated people with aerophobia (fear of flying) using SD and compared them with a waiting-list control group. The treated group reported lower fear and showed fewer physiological signs of anxiety in a flight simulator than the controls, showing SD works. McGrath et al. (1990) also found that about 75% of patients with specific phobias responded to SD.

SD has a low dropout rate because the client works through the anxiety hierarchy at their own pace, using relaxation and reciprocal inhibition, and has control over moving to the next step. This makes it more effective and more ethical than flooding, and it is suitable for people with learning difficulties who may not cope with cognitive therapies.

However, the competence of the therapist can affect success: the therapist must build a suitable hierarchy and teach relaxation well, so outcomes may vary between therapists. Also, in vitro (imagined) exposure is less effective than in vivo exposure, as some clients cannot imagine the feared object vividly.

A further weakness is that SD treats the symptoms (the learned fear response) rather than the underlying cause. Psychodynamic psychologists argue the phobia may be a symptom of unconscious conflict, so symptom substitution may occur, with a new phobia appearing.

Research also challenges the learning theory that SD is based on. Bregman (1934) failed to condition fear of inanimate objects such as wooden blocks and cloth in infants, which supports Seligman's idea of biological preparedness. Phobias of evolutionarily dangerous stimuli (snakes, heights) may be partly innate, so SD may be less effective for some phobias than for others, such as social phobia.

© WJEC CBAC Ltd.

stemup.co.uk

Examiner only

Additional space for Question **3** only:

Overall, SD is an effective, quick and cheap therapy for specific phobias, but less so for complex anxiety disorders.

4. Raine, Buchsbaum and LaCasse's research *'Brain abnormalities in murderers indicated by positron emission tomography'* was published in 1997. Describe the findings and conclusions of this research. [10]

Findings: the 41 murderers pleading not guilty by reason of insanity (NGRIs) had reduced glucose metabolism (activity) compared with the 41 matched controls in the prefrontal cortex, an area linked to self-control, rationality and inhibiting impulsive behaviour. They also had lower activity in the superior parietal gyrus, the left angular gyrus (linked to language, learning and morality) and the corpus callosum.

There were abnormal asymmetries in the limbic system: NGRIs had lower activity than controls in the left amygdala, thalamus and medial temporal lobe including the hippocampus, but higher activity in the right side of these structures, areas linked with emotion and aggression.

There were no differences between NGRIs and controls in many structures associated with mental illness, such as the caudate, putamen, globus pallidus and midbrain, so the differences found were specific to areas linked with violence. Performance on the continuous performance task was similar in both groups, so the differences were not due to poor task performance.

Prefrontal deficits may make someone more impulsive, less controlled and more emotional, and less able to change their behaviour. Limbic deficits may

© WJEC CBAC Ltd.

stemup.co.uk

Examiner only

increase aggression: the amygdala controls urges and emotions, and the amygdala and hippocampus help in recognising emotional and social cues, so reduced activity could make it harder to judge social situations, leading to overreaction.

Conclusions: the study supports previous research showing links between specific brain areas and aggression, and shows a link between brain dysfunction and a predisposition towards violence in NGRIs. However, violence is most likely explained by disruption of many interacting brain mechanisms

Additional space for Question **4** only:

rather than one single area.

Raine warned that the findings do not show that violence is determined by biology alone: social, psychological and situational factors clearly play important roles. The findings do not mean that NGRIs are not responsible for their actions, that PET scans can diagnose murderers, or that brain dysfunction causes violence, as the differences could be an effect of violence or its lifestyle rather than the cause. The findings also only apply to this specific group of NGRI murderers, not to violent offenders in general.

© WJEC CBAC Ltd.

stemup.co.uk

Examiner only

5. 'A student wanted to investigate if she should study the cognitive approach or the positive approach at university. She asked her psychology teacher, Mr. Haggerty, which approach of the two was better'.
With reference to the scenario above, discuss what the teacher may advise by comparing and contrasting the cognitive approach and the positive approach. [10]

Mr. Haggerty could advise the student that neither approach is simply 'better'; it depends on what she wants to study at university, so he should compare them.

A difference is that the cognitive approach is often seen as more scientific. It uses laboratory experiments, e.g. Loftus and Palmer (1974), with controlled variables and quantitative data, so if the student wants a rigorous, scientific degree, he may advise the cognitive approach. The positive approach relies more on questionnaires and self-reports, e.g. Myers and Diener's surveys, which can suffer from social desirability bias.

A similarity is that both use questionnaires and both are largely nomothetic, seeking general laws, e.g. cognitive models of memory and Seligman's PERMA model of well-being.

A difference is their focus. The cognitive approach often studies faulty thinking and abnormal behaviour (e.g. Beck's negative triad), while the positive approach focuses on strengths, virtues and what makes life worth living. If the student is interested in wellbeing rather than disorder, Mr. Haggerty may suggest the positive approach.

Both see humans as having some free will: the cognitive approach believes we can change our thinking (soft determinism), and the positive approach believes we can choose to build our signature strengths. Both are also reductionist to some extent, reducing behaviour to cognitions or traits.

Both have therapies. CBT is well supported, with good success rates and relatively short treatment, while positive therapies such as gratitude exercises have growing but less extensive support. However, CBT may treat present

© WJEC CBAC Ltd.

stemup.co.uk

Examiner only

Additional space for Question **5** only:

symptoms rather than causes, whereas positive psychology aims at prevention. Ethically, both approaches are fairly ethical, though cognitive experiments may use deception. Mr. Haggerty might conclude that the cognitive approach is more established and scientific, but the positive approach is newer and growing, so she should choose based on her interests.

6. Describe either cognitive behavioural therapy **OR** rational emotive behaviour therapy. [10]

I will describe cognitive behavioural therapy (CBT).

CBT was developed by Aaron Beck in the 1960s, building on Ellis's REBT, to treat depression. It links to the assumptions of the cognitive approach: behaviour and emotion are caused by internal mental processes (schemas), and faulty, irrational thinking causes disorders, so changing thinking changes behaviour.

Beck proposed the negative cognitive triad: depressed people have negative views about the self ('I am worthless'), the world ('everyone is against me') and the future ('nothing will improve'). Negative schemas formed in childhood lead to cognitive distortions such as overgeneralisation, magnification and minimisation, and arbitrary inference.

The therapist's role is collaborative and active ('collaborative empiricism'): therapist and client work as a team to test the client's beliefs as if they

A290U101 09

© WJEC CBAC Ltd.

stemup.co.uk

Examiner only

were hypotheses. The therapist uses Socratic questioning, e.g. 'What evidence do you have for that?', to help the client identify and challenge automatic negative thoughts.

Techniques include a dysfunctional thought diary, in which the client records the situation, their automatic thought, the emotion and its strength, and then a rational response. In cognitive restructuring, irrational thoughts are replaced with more realistic, balanced ones. Homework tasks between sessions, such as behavioural experiments and activity scheduling (behavioural activation), test beliefs in real life, e.g. a client who believes nobody likes them arranges to meet a friend.

Therapy is usually short and structured, typically about 5 to 20 weekly sessions, with an agenda each session, and focuses on present problems rather than the past. The aim is for the client to become their own therapist, so they can use these skills to prevent relapse after therapy ends.

Additional space for Question **6** only:

© WJEC CBAC Ltd.

stemup.co.uk

Examiner only

7. Evaluate the ethical issues and social implications of Loftus and Palmer's (1974) research *'Reconstruction of automobile destruction: an example of the interaction between language and memory'*. [10]

Ethical issues: participants were deceived, as they were not told the true aim (the effect of the verb in a leading question on speed estimates and memory), so they could not give fully informed consent. However, the deception was mild and necessary, because knowing the aim would have produced demand characteristics, and they were debriefed.

There was some risk of psychological harm, as participants watched clips of car accidents, which could be distressing, especially for anyone who had been in a crash. However, the clips were short (5 to 30 seconds) and taken from driver safety films, so the risk was no greater than in everyday life. Using film clips rather than a real crash is more ethical, although it lowers ecological validity.

The samples were students (45 in Experiment 1 and 150 in Experiment 2), possibly taking part for course credit, so they may have felt unable to exercise their right to withdraw from a lecturer's study.

Social implications: the research showed that leading questions distort estimates ('smashed' gave a mean of 40.5 mph compared with 31.8 mph for 'contacted') and memory (32% in the 'smashed' condition falsely recalled broken glass compared with 14% for 'hit'). This has led to more effective policing, such as the cognitive interview, which avoids leading questions, and to guidance for juries that eyewitness testimony may be unreliable.

It has encouraged eyewitness statements to be used alongside CCTV and forensic evidence. The Innocence Project has found that mistaken eyewitness identification played a part in around 70% of wrongful convictions overturned by DNA evidence, which affects families of the wrongly convicted, victims and perpetrators, especially where the death sentence applies.

© WJEC CBAC Ltd.

stemup.co.uk

Examiner only

Additional space for Question **7** only:

However, the findings may be exaggerated, as real witnesses are emotionally involved (Yuille and Cutshall, 1986). Overall, the ethical issues were minor and justified by the very positive social implications.

8. Discuss why a psychologist from the psychodynamic approach would consider dream analysis **OR** psychodrama as an appropriate therapy. [10]

I will discuss dream analysis. Freud (1900) called dreams 'the royal road to the unconscious', so a psychodynamic psychologist would see dream analysis as appropriate because it makes the unconscious conscious, which is the goal of psychoanalysis.

The approach assumes behaviour is driven by unconscious drives from the id, which are repressed because they are unacceptable. During sleep the ego is weakened and its defences relax, while the id is stronger, so these drives appear as the storyline of the dream, as wish fulfilment.

However, a 'dream censor' disguises them through dream work, so the remembered manifest content hides the latent content. Defence mechanisms are used: displacement, where emotion about one person is shifted onto a less threatening object or symbol; condensation, where several ideas combine into

© WJEC CBAC Ltd.

stemup.co.uk

Examiner only

one image; symbolisation, e.g. a train entering a tunnel may symbolise sexual intercourse; and secondary elaboration, where the ego makes the dream into a logical story.

The client records dreams in a dream diary and reports them, and the analyst uses free association on each element to interpret the latent meaning. For example, a client who dreams of being chased by a faceless figure may be repressing anxiety about a conflict with a parent formed in childhood. Bringing this into consciousness allows catharsis and insight, so the conflict can be worked through and symptoms such as anxiety reduced.

Research can justify its use. Freud's case studies, e.g. Little Hans's giraffe dream, were interpreted as revealing unconscious Oedipal conflict. Solms (2000) found that dreaming involves dopamine-driven motivational circuits in the forebrain, consistent with dreams expressing wishes.

Additional space for Question **8** only:

However, interpretation is subjective, as analysts may interpret the same symbol differently, so the psychologist must avoid imposing their own meaning. Activation-synthesis theory (Hobson and McCarley, 1977) argues dreams are random brain activity. Even so, the psychodynamic psychologist would see it as appropriate because it directly accesses the unconscious causes of behaviour.

© WJEC CBAC Ltd.

stemup.co.uk

Examiner only

9. 'It is not essential that the mother is the primary caregiver of an infant.'
Discuss the extent to which you agree with this viewpoint. You should use psychological knowledge in your answer. [24]

This debate concerns whether infants need their mother as primary caregiver, or whether fathers, grandparents and alternative carers can provide the care needed for healthy development.

Freud's 'cupboard love' theory suggests the mother is essential. In the oral stage the infant's id seeks pleasure through the mouth, and the mother, as the source of food through breastfeeding, becomes the infant's first love object. Freud argued the mother-infant relationship is the prototype for all later relationships. However, Harlow (1959) found infant rhesus monkeys spent most time with a cloth-covered 'mother' that gave no food rather than a wire one that did, showing contact comfort matters more than feeding. As anyone can provide comfort, this suggests the mother is not essential.

Bowlby's (1951) maternal deprivation hypothesis argued that the infant needs a continuous relationship with the mother or a permanent mother-substitute, and that prolonged separation in the critical period (up to about 2.5 years) causes lasting harm. In his 44 juvenile thieves study, 14 thieves were diagnosed as affectionless psychopaths, and 12 of these had experienced prolonged early separation from their mother, compared with only 2 of 44 controls. His later theory of monotropy (1969) proposed one special attachment figure, usually the mother, as an internal working model.

However, Bowlby's evidence was correlational and relied on retrospective interviews, so it is low in reliability and cannot show cause. Rutter (1981) argued that privation, not deprivation, causes serious harm, and Bowlby himself said a mother-substitute could be the attachment figure, which supports the view that it need not be the mother.

Schaffer and Emerson (1964) observed 60 Glasgow infants and found that by

© WJEC CBAC Ltd.

stemup.co.uk

Examiner only

18 months most had multiple attachments, with about 75% attached to their father. Infants attached most strongly to whoever was most sensitive and responsive, not who fed them, and fathers were sometimes the main attachment figure. This strongly supports the viewpoint, although the data came from mothers' self-reports, which may be biased; observations such as the Strange Situation would improve reliability.

Research into fathers also supports the view. Field (1978) found that fathers who were primary caregivers smiled, imitated and held their babies more than secondary-caregiver fathers, behaving like mothers. Brain scan research reported in the New Statesman (2014) suggested fathers are 'hardwired' to be positive caregivers: in primary-caregiver fathers, including gay fathers, brain areas linked to emotional responsiveness were activated in a similar way to mothers. This suggests caregiving is not limited to mothers.

On the other hand, biological theories suggest mothers are better prepared. Oxytocin released during childbirth and breastfeeding promotes bonding, and the NHS recommends exclusive breastfeeding for about the first six months because it benefits the infant's immune system. This could support the mother being primary caregiver, although expressed or formula milk means fathers can still feed.

Social and economic factors are also relevant. Shared parental leave in the UK allows fathers to take time off, which can benefit the child, the mother's career and the father's bond. However, uptake is low, partly because fathers are still often viewed as the 'breadwinner'. Grandparents and other relatives provide much childcare, and nurseries and childminders allow parents to return to work and contribute to the economy. Reeves (1999) in the Guardian discussed the effects of nursery care, and some research links long hours in

© WJEC CBAC Ltd.

stemup.co.uk

Examiner only

day care to more behaviour problems, which could be used to argue for mothers staying at home. However, childcare costs can be prohibitive, so families may have no choice.

There are cultural differences. In many cultures care is shared: Efe infants in the Congo are cared for by several women, and on Israeli kibbutzim children were raised partly by communal carers, yet children still form secure attachments. This suggests the Western view of the mother as sole caregiver is culturally specific.

There are also ethical and political implications. After the Second World War, Bowlby's ideas were used to encourage women to leave work and stay at home, and mothers may feel guilty or inadequate whether they return to work or not. Fathers who are primary caregivers may feel isolated as baby and toddler groups are often aimed at mothers. Research in this area is socially sensitive and must be interpreted carefully. Individual differences also matter, as some infants cope well with several carers while others need more consistency.

In conclusion, I largely agree that it is not essential for the mother to be the primary caregiver. The evidence from Schaffer and Emerson, Harlow and Field suggests that sensitive, responsive and consistent care matters more than the gender or biological relationship of the carer. Mothers may have some biological advantages, such as breastfeeding and oxytocin, but these are not essential. The best arrangement is likely to depend on each family's circumstances.

© WJEC CBAC Ltd.

stemup.co.uk

Examiner only

Additional space for Question **9** only:

END OF PAPER

© WJEC CBAC Ltd.

stemup.co.uk

Question number	Additional page, if required. Write the question number(s) in the left-hand margin.

Examiner only

© WJEC CBAC Ltd.

stemup.co.uk

Question number	Additional page, if required. Write the question number(s) in the left-hand margin.

Examiner only

© WJEC CBAC Ltd.

stemup.co.uk

Question number	Additional page, if required. Write the question number(s) in the left-hand margin.

Examiner only

© WJEC CBAC Ltd.

stemup.co.uk