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

GCE A LEVEL

A290U10-1

O20-A290U10-1

MONDAY, 5 OCTOBER 2020 – AFTERNOON

PSYCHOLOGY – A level component 1
Psychology: Past to Present

2 hours 15 minutes

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Question	**Maximum Mark**	**Mark Awarded**
1.	**8**	
2.	**10**	
3.	**10**	
4.	**10**	
5.	**8**	
6.	**10**	
7.	**20**	
8.	**24**	
Total	**100**	

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INSTRUCTIONS TO CANDIDATES

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

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

Answer **all** the questions.

Write your answers in the spaces provided in this booklet. If you run out of space, 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, clear presentation in your answers. Assessment will take into account the quality of written communication used in your answers.

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Answer **all** *questions*

1. Evaluate **two** ethical issues of either drug therapy **OR** psychosurgery. [8]

I will evaluate two ethical issues of drug therapy, e.g. antipsychotics for schizophrenia or SSRIs for depression.

The first issue is valid informed consent and the use of vulnerable people. Patients with severe mental illness, such as a person with schizophrenia experiencing delusions, may not be capable of understanding their illness or the risks of the drug, so their consent may not be truly informed. Some are sectioned under the Mental Health Act and given medication against their will, which removes their right to refuse. However, consent can be sought from a family member or responsible adult, and treatment can be reviewed once symptoms reduce, so the patient can then give informed consent themselves. Withholding drugs could also be unethical if it leaves the person a danger to themselves.

The second issue is protection from harm. Drugs can cause physical harm through side effects: typical antipsychotics can cause tardive dyskinesia (involuntary movements), and SSRIs can cause nausea, weight gain and, in young people, increased suicidal thoughts. Some drugs, such as benzodiazepines, lead to increased tolerance and addiction. There is also psychological harm, as relying on a pill may reduce the patient's sense of free will and control over their recovery. On the other hand, drugs alleviate symptoms much more quickly than talking therapies, which reduces further harm, for example by lowering the risk of suicide, and they allow patients to live independently in the community. Using placebos in drug trials also raises deception, although this is justified by debriefing.

Overall, drug therapy raises serious ethical issues, but with careful consent procedures and monitoring of side effects the benefits usually outweigh the costs.

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2. Describe the findings and conclusions of Myers and Diener's (1995) research *'Who is happy?'*. [10]

Findings: Myers and Diener reviewed research on subjective well-being (SWB). Age did not predict happiness: a survey of about 170,000 people in 16 countries (Inglehart, 1990) found no time of life notably happier or unhappier, although the predictors of happiness change with age. Gender made little difference to happiness, although women are about twice as vulnerable as men to depression and anxiety, and men about five times as vulnerable to alcoholism and antisocial personality disorder. Race made little difference: people of different races score similarly on self-esteem (Crocker and Major, 1989). Culture made a large difference: about 10% of people in Portugal said they were very happy compared with about 40% in the Netherlands.

Wealth showed only a moderate positive correlation with happiness. Many adults believe more income would make them happier (Strumpel, 1976), yet in the USA income has more than doubled since 1957 while the proportion saying they are very happy has not risen. The best indicators of a happy person were four traits: self-esteem, a sense of personal control, optimism and extraversion. Happy people have close relationships: those who can name several intimate friends are healthier, less likely to die prematurely and happier. Work satisfaction gives flow, identity and community, and religious people report higher levels of happiness.

Conclusions: a theory of happiness must recognise adaptation, as the emotional response to events fades over time. A person's cultural template affects how events are interpreted, and having non-conflicting goals and making progress towards them predicts SWB. Knowing someone's age, race, sex and income tells us little about their happiness; traits, relationships, culture, engaging work and faith are better clues. This research complements studies of depression and helps people rethink their priorities to build a world that enhances well-being.

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3. 'Bowlby's (1944) research *'Forty-four juvenile thieves: Their characters and home-life'* was unethical and has had limited social implications.'

With reference to the statement, discuss the ethical issues and social implications of Bowlby's (1944) research. [10]

Bowlby studied 44 thieves at the London Child Guidance Clinic, giving each child mental (IQ) tests, while a social worker interviewed the mothers and he used school reports. By today's standards this raises ethical issues. The children could suffer psychological harm if IQ results or labels such as 'affectionless' were shared, and mothers may feel distress and guilt from being questioned about separations. It is unclear whether the mothers gave fully informed consent or knew their interviews would be published, or whether the children could withdraw their information. The data were also socially sensitive and confidentiality was not clearly protected. However, the data came from routine clinical assessment intended to help the children, and the case studies used initials, so anonymity was largely kept. The study was carried out before modern ethical guidelines, so the statement is only partly fair.

The claim of limited social implications is less convincing, as the study helped develop the maternal deprivation hypothesis, which changed society. In health, hospital visiting hours for children were extended and parents can now stay overnight with their child, and mothers of premature babies are encouraged to stay with them. For families, adoption and fostering now place children early in a stable home rather than in institutions. At work, maternity and parental leave and flexible working let parents bond with young children. In education, nurseries use key workers and offer support for children with attachment issues, and in the law, attachment is considered with young offenders, which may reduce crime costs. However, the findings were used to argue mothers should not work, reinforcing gender roles, and the link was only correlational. Overall, Bowlby's research has ethical flaws but had wide social implications.

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4. Compare and contrast the biological approach with the positive approach. [10]

One difference is their scientific nature. The biological approach is seen as more scientific, using laboratory experiments, brain scans and twin studies to measure objective variables such as neurotransmitter levels. The positive approach relies more on questionnaires and self-reports of happiness, which are subjective and open to social desirability bias. However, both use empirical methods, as positive psychologists such as Seligman et al. (2005) ran randomised controlled trials of interventions.

They also differ on causes. The biological approach is reductionist, explaining behaviour such as depression by genes or low serotonin, and deterministic, since behaviour is caused by biology beyond our control. The positive approach is more holistic and assumes free will, so people can choose to build signature strengths and well-being. The biological approach is nomothetic, looking for general laws, while positive psychology is also idiographic, focusing on each person's strengths.

Their treatments contrast. Drug therapy tackles the symptoms of illness and works quickly, but symptoms often return when drugs stop, and there are side effects. Positive therapies such as mindfulness and signature strengths aim to build well-being and prevent illness, with Seligman finding benefits lasting six months, but they are less useful for severe disorders such as schizophrenia.

A similarity is that both aim to improve mental health and both accept some biological basis, as positive psychologists suggest a genetic set point for happiness.

Ethically, drugs raise issues of consent and harm, whereas positive interventions carry little risk but may blame people for being unhappy.

Overall, the biological approach is more scientific and better for severe illness, while the positive approach is better for prevention, so they complement each other.

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5. Using examples from psychology, outline **two** assumptions of the cognitive approach. [4+4]

Assumption 1: the cognitive approach assumes the mind works like a computer (the computer analogy). Information is input through the senses, processed and stored by mental processes such as attention, encoding and rehearsal, then retrieved as output (behaviour). An example is Atkinson and Shiffrin's multi-store model of memory, in which information passes from the sensory register to short-term memory, which has a limited capacity of about 7 ± 2 items, and is transferred to long-term memory by rehearsal, like data being saved to a hard drive. Similarly, Broadbent's filter model treats attention as a limited-capacity processor.

Assumption 2: behaviour is influenced by schemas, mental frameworks of knowledge stored in long-term memory that are built from experience and culture. Schemas help us process information quickly and predict what will happen, but they can lead to distortion and stereotyping. For example, Bartlett (1932) asked English participants to recall the Native American story 'The War of the Ghosts'. Over repeated recall the story became shorter and unfamiliar details were changed to fit their own cultural schemas, e.g. 'canoe' became 'boat', showing that memory is reconstructive. Beck also argued that negative self-schemas cause depression.

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6. Evaluate the strengths and weaknesses of the psychodynamic approach. [10]

A strength is that the approach recognises the effects of childhood on adult behaviour. Freud argued that conflicts in the psychosexual stages shape personality, and this is supported by Bowlby's (1944) study, in which 12 of the 14 affectionless thieves had experienced prolonged early separation. This has real-world application, influencing childcare and hospital practices.

A further strength is that psychoanalysis treats the cause, not just the symptoms. Free association and dream analysis bring repressed conflicts into consciousness so the client gains insight. Leichsenring and Rabung (2008) found long-term psychodynamic therapy effective for complex disorders. However, Eysenck (1952) claimed about two-thirds of neurotic patients recover without treatment, a rate psychoanalysis did not exceed. Therapy can also take years, making it costly, and it focuses on the past rather than present problems.

A weakness is that the approach is unscientific. The id, ego, superego and unconscious cannot be directly observed or measured, so the theory is unfalsifiable. Evidence comes from case studies of a few mainly middle-class Viennese patients, such as Little Hans, with information second-hand from his father and interpreted subjectively, so findings lack reliability and generalisability. The approach is also psychically deterministic, ignoring free will, and reductionist, reducing behaviour to sexual and aggressive drives. It places blame on external influences such as parents, which may be unfair. Ethically, recalling repressed trauma can cause distress and therapists may create false memories, although the approach does consider individual differences in experience.

In conclusion, the approach lacks scientific support, but it was hugely influential in showing the importance of childhood and the unconscious and in developing talking therapies, so its strengths are mainly historical and practical.

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7. (i) Describe the main components of systematic desensitisation **OR** aversion therapy. [10]

I will describe systematic desensitisation (SD), developed by Wolpe (1958) to treat phobias. It is based on classical conditioning: the phobia is a learned association between a neutral stimulus (e.g. a spider) and fear. SD uses counterconditioning to replace this fear response with relaxation.

A key principle is reciprocal inhibition: two incompatible emotional states, such as fear and relaxation, cannot exist at the same time, so if the client stays relaxed in the presence of the feared stimulus the fear is inhibited.

First the client is taught relaxation techniques, such as progressive muscle relaxation (tensing and relaxing muscle groups), deep breathing or imagery, and sometimes drugs such as Valium.

Next, the therapist and client build a desensitisation (anxiety) hierarchy, a list of feared situations ranked from least to most anxiety-provoking, e.g. from seeing a picture of a spider up to holding a spider.

The client is then gradually exposed to each level while relaxed, starting at the bottom and only moving up when they feel calm at that step. Exposure can be in vitro (imagining the situation) or in vivo (real exposure), or virtual reality. The client controls the pace, and treatment usually takes around 4 to 6 sessions.

The role of the therapist is to explain the process, teach relaxation, construct the hierarchy with the client and monitor anxiety at each stage, stopping if anxiety becomes too high.

Research supports SD: Lang and Lazovik (1963) found students with snake phobias treated with SD showed less fear than controls, maintained at a 6 month follow-up.

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(ii) 'Behaviourist therapies are effective in treating mental illness.'

With reference to the above statement, discuss the effectiveness of the therapy that you described in **7**(i). [10]

The statement is supported for SD in treating phobias. McGrath et al. (1990) found that about 75% of people with phobias responded to SD. Gilroy et al. (2003) treated 42 people with spider phobia and found SD was more effective than relaxation alone, with improvements still present at a 33 month follow-up, showing long-term effectiveness. In vivo exposure appears more effective than in vitro, as Menzies and Clarke (1993) found with children's water phobia. SD is also effective because it suits a wide range of clients, including those with learning difficulties, and the client controls the pace, so dropout rates are lower than for flooding, which is quicker but more traumatic.

However, the statement claims behaviourist therapies are effective for mental illness in general. SD only works for anxiety disorders such as phobias; it is not effective for schizophrenia or severe depression, which need drugs or CBT. SD may be less effective for evolutionary fears such as snakes or heights: Ohman et al. (1975) found prepared fears were much harder to extinguish, so a biologically prepared phobia may not be learned and cannot be fully unlearned.

Psychodynamic psychologists argue SD tackles only the symptoms, not the underlying cause, so symptom substitution may occur, although there is little evidence for this. Success also depends on the client's ability to imagine the scene and relax, and on a skilled therapist. Research often relies on self-report measures of fear, which may be biased.

Compared with CBT, which also changes irrational thoughts, SD may be less complete for complex phobias such as social phobia. Overall, SD supports the statement for simple phobias, but behaviourist therapies are not effective for all mental illness.

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8. 'The positive approach is more relevant in today's society than other approaches in psychology.'

With reference to this statement discuss the debate of the relevance of positive psychology in today's society. [24]

Positive psychology was launched by Martin Seligman in his 1998 presidency of the American Psychological Association. He argued psychology had focused on illness and repairing damage, and set three aims: to make the lives of all people more productive and fulfilling, to identify and nurture talent, and to cure mental illness. It studies happiness, signature strengths and the good life, e.g. his PERMA model (positive emotion, engagement, relationships, meaning and accomplishment). The approach seems highly relevant today because rates of anxiety and depression are high, especially among young people, despite rising wealth. Myers and Diener (1995) found that income in the USA has more than doubled since 1957 without any rise in happiness, and that relationships, optimism and personal control predict well-being better than money. Governments now measure national well-being (the UK ONS has done so since 2011), not only GDP, showing positive psychology has shaped policy.

It is used in many settings. In schools, positive education programmes such as the Penn Resiliency Programme teach children to challenge pessimistic thinking, and some studies found reduced depressive symptoms. In the workplace, Oswald et al. (2009) showed participants a comedy clip or gave them snacks before a timed maths task, and those whose happiness increased were about 12% more productive, suggesting businesses benefit from employee well-being. In health care, the NHS offers mindfulness-based cognitive therapy, recommended by NICE for preventing relapse in recurrent depression. Seligman et al. (2005) found exercises such as using signature strengths in a new way and 'three good things' increased happiness and reduced depressive symptoms for up to six months. These treatments are cheap, can be delivered online and focus on prevention.

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Positive psychology is also relevant to physical health. In the Nun Study, Danner et al. (2001) rated the emotional content of autobiographies written by nuns in their early twenties and found that those who expressed the most positive emotions lived significantly longer, even though all lived similar lifestyles. Diener and Seligman (2002) found that the happiest 10% of students all had strong social relationships, which supports investing in community and family support. Fredrickson's broaden-and-build theory suggests positive emotions widen our thinking and build lasting psychological resources, such as resilience, which is relevant when people face stress at work or during a pandemic.

Positive psychology is also ethical in that it emphasises free will and strengths, avoids labelling people as abnormal and has few side effects, compared with drug therapy from the biological approach.

However, there are reasons to doubt it is more relevant than other approaches. Much of its evidence relies on self-reports of happiness, which are subjective and prone to social desirability bias, so validity is questionable, and many intervention studies have small effects and short follow-ups. Seligman et al.'s (2005) participants were volunteers recruited online who were already interested in becoming happier, so there may be sample bias and expectancy effects, and the findings may not generalise. Much research is correlational, e.g. the Nun Study, so it is unclear whether happiness causes health or health causes happiness. Biological measures, such as brain scans of activity linked to positive emotion, are more scientific but used less.

There are individual differences in positivity: some people find mindfulness stressful or it brings up distressing memories, and defensive pessimists perform better when they think negatively. Constant pressure to be happy can make people feel worse. There are also cultural differences: the approach reflects individualistic Western

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values of personal achievement, whereas collectivist cultures value harmony and duty, so the research may be culturally biased and less relevant globally.

Ethically, critics such as Ehrenreich argue that it can blame individuals for their unhappiness and ignore real social causes such as poverty, discrimination and unemployment, which require social change rather than gratitude diaries.

Other approaches remain highly relevant. The biological approach provides antipsychotic drugs that allow people with schizophrenia to live in the community, something positive psychology cannot do. The cognitive approach gives CBT, which has strong evidence for depression and anxiety, and the behaviourist approach gives systematic desensitisation, effective for phobias. Positive psychology was designed to complement these, not replace them, and is mainly aimed at people who are already functioning.

In conclusion, I partly agree with the statement. In today's society, where stress and depression are common and prevention is cheaper than cure, positive psychology is very relevant to schools, workplaces and the NHS. However, its subjective methods, cultural bias and limited use for severe disorders mean it is not more relevant than other approaches; it is most useful alongside them.

END OF PAPER

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