GCE AS

B290U10-1

S18-B290U10-1

PSYCHOLOGY – AS component 1
Psychology: Past to Present

MONDAY, 14 MAY 2018 – AFTERNOON

1 hour 45 minutes

ADDITIONAL MATERIALS

A WJEC pink 16-page answer booklet.

INSTRUCTIONS TO CANDIDATES

Use black ink or black ball-point pen.

Answer **all** questions.

Write your answers in the separate answer booklet provided.

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 need for good English and orderly, clean 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. *(a)* Identify and briefly outline the methodology of Bowlby's (1944) research *'Forty-four juvenile thieves: Their characters and home-life'.* [2]

(b) Describe the conclusions of Bowlby's (1944) research *'Forty-four juvenile thieves: Their characters and home-life'.* [4]

2. Discuss the ethical considerations of drug therapy **OR** psychosurgery. [4]

3. Describe the localisation of brain function and **one** other assumption of the biological approach in explaining human behaviour. [3+3]

4. Analyse the weaknesses of the cognitive approach. [6]

5. Describe the procedures of Watson and Rayner's (1920) research *'Conditioned emotional reactions'.* [10]

6. Alex has suffered from mental health issues all his adult life; anxiety, depression and phobias. His psychologist has explained that his behaviour is due to biological reasons.

Outline how the biological **and** psychodynamic approaches would explain Alex's behaviour. [5+5]

7. *(a)* Describe the components of cognitive behavioural therapy (CBT) **OR** rational emotive behaviour therapy (REBT). [8]

(b) Evaluate cognitive behavioural therapy (CBT) **OR** rational emotive behaviour therapy (REBT). [10]

8. Linley et al. (2006) suggests that positive psychology *'shines the light of scientific enquiry into previously dark and neglected corners'.*

Using psychological knowledge discuss to what extent positive psychology is relevant to today's society. [20]

END OF PAPER

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Surname	StemUp Model Solution
Answer booklet	Write the question number in the left-hand margin at the start of each answer.

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1. (a) Bowlby used the case study method. He studied 44 juvenile thieves (31 boys and 13 girls, aged 5 to 16) referred to a London Child Guidance Clinic, compared with a control group of 44 children at the clinic who were emotionally disturbed but did not steal. Each child had mental tests and a psychiatric interview, and a social worker interviewed the mother about the child's early history. The thieves were graded on the seriousness of their stealing.

1. (b) Bowlby concluded that prolonged early separation from the mother or mother figure is a major cause of delinquency and of the 'affectionless character'. Of the 14 affectionless thieves, 12 had experienced a long separation in their first five years, and 17 of the 44 thieves overall had been separated for six months or more compared with only 2 of the 44 controls.

This confirmed the psychodynamic assumption that the early years are of great importance in character development, as a broken early mother-child relationship can leave a child unable to form deep relationships and more likely to steal.

He also concluded that juvenile crime is not only a psychological problem but also a social and economic one, as poverty, poor housing and family breakdown contribute to it. Finally, he argued that knowledge of the damage caused by prolonged separations should lead to greater efforts to avoid them, for example in hospitals and care, and that this could prevent many cases of criminal behaviour.

2. Drug therapy raises the issue of informed consent. Patients with severe disorders such as schizophrenia may lack the capacity to understand the risks, and those

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sectioned under the Mental Health Act can be given medication against their will, which removes their autonomy. Even willing patients may not be fully informed if doctors give little information on alternatives such as CBT, so their consent is not truly informed.

Side effects are a major concern because they can cause harm. SSRIs can cause nausea, weight gain and sexual dysfunction, and older antipsychotics can cause tardive dyskinesia, which may be permanent. This conflicts with the principle of protecting patients from harm, so the benefits must clearly outweigh the risks.

The use of placebos in drug trials is also an ethical issue, because control participants are deceived and a depressed person may be denied an effective treatment during the trial. However, drugs can relieve severe symptoms quickly and allow people to function and engage with therapy, so withholding them could also be unethical.

3. Localisation of brain function is the assumption that different areas of the brain are responsible for different behaviours and functions. The cerebral cortex is divided into four lobes: the frontal lobe (planning, decision making and the motor cortex, which controls voluntary movement), the parietal lobe (the somatosensory cortex, which processes touch), the temporal lobe (the auditory cortex and memory) and the occipital lobe (the visual cortex). Language is localised in the left hemisphere: Broca's area in the left frontal lobe controls speech production and Wernicke's area in the left temporal lobe controls language comprehension, so damage to a specific area produces a specific deficit, such as Broca's aphasia.

Another assumption is that behaviour is influenced by neurotransmitters. These are chemical messengers released from the presynaptic neuron into the synaptic gap, where they bind to receptors on the postsynaptic neuron and make it more or less likely to fire. Levels of neurotransmitters affect behaviour and mood: low serotonin is linked to depression, excess dopamine to schizophrenia and GABA has an inhibitory, calming effect, so imbalances can explain abnormal behaviour

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and drugs that alter them can change it.

4. A major weakness of the cognitive approach is that it is mechanistic. The computer analogy treats the mind as an information processor with input, storage and output, but humans are not machines: emotion, motivation and fatigue affect thinking in ways a computer does not, for example anxiety can impair memory. This makes the approach's models, such as the multi-store model, oversimplified.

It is also reductionist, as it reduces complex behaviour to separate processes like attention and memory and largely ignores biological factors (such as genes and neurotransmitters) and social and cultural influences on thinking.

The approach is nomothetic, seeking general laws of mental processing that apply to everyone. This neglects individual differences and the unique experiences that shape how a particular person thinks.

Much cognitive research is carried out in laboratories using artificial tasks, such as recalling lists of words, so it lacks ecological validity and may not reflect how memory works in everyday life. Mental processes are also not directly observable, so they must be inferred from behaviour, which makes the approach less objective than it claims.

The approach also does not fully resolve the nature versus nurture debate, as it says little about where faulty schemas originally come from. Ethically, cognitive therapies can imply that a person's own irrational thinking is to blame for their problems, which may overlook real environmental causes such as poverty or abuse.

5. The participant was Albert B, a healthy and emotionally stable infant who had been brought up from birth in a hospital, the Harriet Lane Home for Invalid Children, where his mother was a wet nurse. The aim was to see whether a fear response could be conditioned to an animal, whether it would transfer to other objects and how long it would last. The procedure was recorded with a

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motion picture camera.

At approximately nine months old, Albert underwent emotional tests to check that he had no existing fears. He was suddenly confronted with a white rat, a rabbit, a dog, a monkey, masks with and without hair, cotton wool and burning newspapers. He showed no fear of any of them.

At 8 months 26 days, the researchers tested whether a fear reaction could be produced by a loud sound. A steel bar about four feet long was suspended behind him and struck with a hammer. Albert started violently, his lips trembled and on the third stroke he burst into tears, so the loud noise was an unconditioned stimulus producing fear.

Conditioning began at 11 months 3 days. The white rat (neutral stimulus) was taken from a basket and presented to Albert. When he reached out and touched it, the bar was struck immediately behind his head. This was repeated, giving two pairings in the first session. A week later, at 11 months 10 days, the rat was first presented alone, and then paired with the noise five more times, giving seven pairings in total. When the rat was then presented alone, Albert cried, turned away and crawled away so rapidly he had to be caught before reaching the edge of the mattress. Wooden blocks were given between trials to check that his general emotional state was normal. His thumb was taken out of his mouth during tests, as thumb sucking blocked his fear response.

At 11 months 15 days, Albert was tested for generalisation. He was shown the rat, blocks, a rabbit, a dog, a seal skin fur coat, cotton wool, Watson's hair and a Santa Claus mask.

At 11 months 20 days, the fear response to the rat was freshened with one further pairing, and the reactions to the rabbit and dog were also freshened with the noise. Albert was then moved to a different location, a well lit lecture room with four people present, to see whether the response would transfer to a new environment.

Finally, at 1 year 21 days, after 31 days with no further conditioning, Albert was tested again with the Santa Claus mask, fur coat, rat, rabbit and dog to

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see whether the conditioned responses persisted over time. The researchers had planned to remove the fears (detachment or reconditioning), but this was never carried out because Albert was taken out of the hospital on that day.

6. Biological approach: this approach would say Alex's anxiety, depression and phobias have a physical basis in his body and brain. His depression could be caused by low levels of the neurotransmitter serotonin, which regulates mood, and his anxiety by low levels of GABA, which normally has a calming, inhibitory effect, so his neurons are over-active. Because his problems have lasted all his adult life, they may be genetic: Alex may have inherited a predisposition from his parents, which twin studies support for both depression and anxiety. Localisation of brain function suggests an over-active amygdala, the area that processes fear, could explain why Alex reacts with such intense fear to his phobic objects. Evolution could also explain Alex's phobias: fears of things like snakes or heights helped our ancestors to survive, so humans are biologically prepared to develop them, and anxiety is an exaggerated version of the adaptive fight or flight response. As his psychologist says, the cause is biological, so he could be treated with drugs such as SSRIs.

Psychodynamic approach: this approach would say Alex's behaviour is driven by unconscious conflicts that stem from his childhood. His anxiety could be caused by his ego struggling to balance the demands of the id and a harsh superego, and his mental health issues may result from fixation at a psychosexual stage, for example the oral stage, causing dependence on others. Freud saw depression as anger turned inwards after a real or symbolic loss, such as losing a parent's love in childhood, so Alex directs this anger at himself. His phobias could be the result of the defence mechanism of displacement, where an unconscious fear is moved onto a safe object, as in Freud's case of Little Hans, whose fear of his father was displaced onto horses. Because these traumatic memories are repressed, Alex is unaware of the causes, so he would need psychoanalysis, using techniques such as free association and dream analysis, to bring them into

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	consciousness.
7. (a)	Cognitive behavioural therapy (CBT) is based on the idea that faulty, negative thinking causes negative emotions and maladaptive behaviour, so changing thoughts and behaviour will improve mental health. It is usually short term (around 5 to 20 weekly sessions) and the client and therapist work together in a collaborative relationship. Assessment: the therapist first assesses the client's problems and agrees clear, measurable goals for therapy. Cognitive aspect: the client is helped to identify negative automatic thoughts and irrational beliefs, such as Beck's negative cognitive triad (negative views of the self, the world and the future) and cognitive errors such as overgeneralisation, magnification and black and white thinking. The therapist uses Socratic questioning to challenge these thoughts, asking for evidence for and against them, so the client can replace them with more balanced, rational ones. Dysfunctional thought diary: the client records situations that upset them, their automatic thoughts, their emotions and how strongly they felt them, and then writes a more rational alternative response, rating how much they now believe it. This makes the link between thoughts and feelings clear. Behavioural aspect, reality testing: the client carries out behavioural experiments to test whether their beliefs are true, for example a client who believes 'nobody likes me' might start a conversation with colleagues and record what actually happens. Evidence that contradicts the belief weakens it. Behavioural activation: depressed clients often withdraw, so they schedule enjoyable and meaningful activities, which increases positive reinforcement, lifts mood and challenges the belief that nothing is worthwhile. Therapy outside therapy: homework is a key component. Clients practise skills between sessions, such as completing thought diaries or experiments, so they become their own therapist and can prevent relapse after therapy ends.

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7. (b)

A strength of CBT is the research evidence for its effectiveness. In the Treatment for Adolescents with Depression Study (March et al., 2007), 71% of adolescents improved after 12 weeks with CBT combined with fluoxetine, compared with 61% with fluoxetine alone, 43% with CBT alone and 35% with a placebo. By 36 weeks the CBT alone group had caught up with the others, suggesting CBT works more slowly but lasts. Hollon et al. (2005) also found lower relapse rates after CBT ended than after medication was stopped, as clients keep the skills they have learnt. As a result, NICE recommends CBT for depression and anxiety, and it is the main therapy offered through the NHS.

CBT also empowers the client. It is collaborative and teaches skills that clients can use for the rest of their lives, so they take control of their own recovery rather than relying on a therapist or drugs. It is also relatively ethical: it has no physical side effects, clients give informed consent to a clear, structured plan and it is short and cost effective.

However, CBT does not suit everyone, so individual differences matter. It requires motivation, effort and the ability to reflect on one's thoughts, so people with very severe depression, who may lack energy and concentration, or people with learning difficulties may not benefit. Elkin et al. (1985) found CBT was less effective than antidepressants for severely depressed patients. Some clients prefer to explore the past, which CBT largely ignores.

The success of CBT also depends on therapist competence. A less skilled therapist may challenge beliefs clumsily or fail to build a good therapeutic alliance, which reduces effectiveness, so outcomes in trials with expert therapists may not generalise to everyday practice.

There are ethical criticisms too. CBT focuses on the client's thinking as the problem, which could imply they are to blame, while ignoring real situational causes such as poverty, abuse or bullying. Challenging beliefs and homework can be stressful, and some clients drop out. Also, it is hard to say whether faulty thinking causes depression or is a symptom of it.

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In conclusion, CBT is a well supported and ethical therapy, especially for mild to moderate depression and anxiety, and its lower relapse rate is a major advantage over drugs. However, it is not suitable for every client, so it is most effective when matched to the individual and, for severe cases, combined with medication.

8. Positive psychology was launched by Martin Seligman in 1998 when he became president of the American Psychological Association. He argued that psychology had focused too heavily on mental illness and a disease model, and should also scientifically study what makes life worth living, such as happiness, strengths and wellbeing. This is what Linley et al. mean by shining the light of scientific enquiry into neglected corners. Its relevance to today's society can be judged by its applications, its evidence and its criticisms.

Positive psychology is highly relevant to therapy. Seligman's PERMA model identifies five elements of wellbeing: positive emotion, engagement, relationships, meaning and accomplishment. Peterson and Seligman (2004) classified 24 character strengths, such as kindness and perseverance, and interventions encourage people to use their signature strengths. Seligman et al. (2005) found that the 'three good things' exercise, where participants wrote down three things that went well each day, increased happiness and reduced depressive symptoms for six months. Sin and Lyubomirsky (2009), in a meta-analysis of 51 interventions with over 4,000 people, found that positive psychology interventions significantly increased wellbeing and reduced depression. This efficacy evidence suggests these techniques are useful today, especially as demand for mental health services far exceeds supply and many techniques are cheap and self-help. Mindfulness, which positive psychology has helped to popularise, is now used widely. Mindfulness-based cognitive therapy (MBCT) is recommended by NICE for preventing relapse in recurrent depression: Teasdale et al. (2000) found that for patients with three or more previous episodes, relapse was 37% with MBCT compared with 66% for usual treatment. It also builds on the humanistic

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tradition of Rogers' person-centred therapy, which emphasised unconditional positive regard and personal growth, showing how positive psychology integrates with and impacts other approaches.

Positive psychology is also relevant because it focuses on prevention rather than cure. Rather than waiting for depression or anxiety to develop, it aims to build resilience. The Penn Resiliency Programme teaches schoolchildren to challenge pessimistic thinking, and has been used in schools in the UK, and the US Army's Comprehensive Soldier Fitness programme trained soldiers in resilience. Seligman's earlier work on learned helplessness and learned optimism also supports the idea that optimism can be taught. With rising rates of anxiety and depression among young people today, this preventative approach is very relevant. It also applies to everyday life in workplaces, education (for example 'growth mindset' and wellbeing lessons) and in government: since 2010 the ONS has measured national wellbeing in the UK, showing that society now values happiness as well as economic growth.

However, there are strong criticisms of its relevance. The evidence is not always as strong as claimed: many studies use self-report measures of happiness, which are subjective and open to social desirability bias, and effect sizes in meta-analyses are often small, with programmes like the Penn Resiliency Programme having weaker effects when run by ordinary teachers rather than trained staff. This suggests positive psychology is less scientific than Linley et al. imply.

Positive thinking can even be harmful. Wood, Perunovic and Lee (2009) found that repeating positive self-statements such as 'I am a lovable person' made people with low self-esteem feel worse. Ehrenreich (2009) argued that a 'tyranny of positive thinking' in the media and self-help industry makes people feel guilty and to blame for being unhappy or ill, which ignores real problems. This links to the criticism that positive psychology locates happiness inside the individual and neglects social and economic causes of distress, such as poverty, unemployment and discrimination. Telling someone in poverty to count their

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blessings does not address the cause, so its relevance to the most disadvantaged in society may be limited.

Its universal applicability is also questionable. Much of the research has been carried out in Western, individualist cultures such as the USA, where happiness is seen as a personal achievement. In collectivist cultures, wellbeing may depend more on social harmony and duty, so concepts like PERMA may be culturally biased and not apply to all of today's multicultural society. Media portrayal has also turned positive psychology into a commercial 'happiness industry' of apps and books, which may oversimplify the science and damage public understanding.

In addition, other approaches still have much to offer. The biological approach shows that severe depression may require medication, and the cognitive approach's CBT has stronger evidence for treating disorders, so positive psychology is best seen as a complement to, not a replacement for, traditional treatments.

In conclusion, positive psychology is relevant to today's society to a large extent. It has broadened psychology beyond illness, produced evidence-based interventions such as MBCT and gratitude exercises, and shaped education, workplaces and government policy on wellbeing at a time of rising mental health problems. However, its relevance is limited by small effect sizes, reliance on self-report, cultural bias and a tendency to ignore social causes of unhappiness. It is most relevant when it is used alongside other approaches and when its claims are tested rigorously, which is exactly what Linley et al. call for.