GCE A LEVEL

1290U30-1

S24-1290U30-1

WEDNESDAY, 22 MAY 2024 – MORNING

PSYCHOLOGY – A2 unit 3
Implications in the Real World

2 hours 30 minutes

ADDITIONAL MATERIALS

A WJEC pink 16-page answer booklet.

INSTRUCTIONS TO CANDIDATES

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

Answer **three** questions in Section A.

Answer **one** question in Section B.

Write your answers in the separate answer booklet provided following the instructions on the front of the answer booklet.

Use both sides of the paper. Write only within the white areas of the booklet.

Write the question number in the two boxes in the left-hand margin at the start of each answer for example, **0 1** .

Leave at least two line spaces between each answer.

INFORMATION FOR CANDIDATES

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

You are reminded that Section B of this paper is synoptic and so will test understanding of the connections between the different elements of the subject.

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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SECTION A: The study of behaviours

Answer **three** questions in full.

0 1 **Addictive behaviours**

a) Describe the characteristics of addictive behaviours. [10]

b) 'Some psychologists believe that social psychological explanations do not explain the cause of addictive behaviours.'

With reference to this statement, evaluate social psychological explanations of addictive behaviours. [15]

0 2 **Autistic spectrum behaviours**

a) Describe the Picture Exchange Communication System (PECS) as a method of modifying autistic spectrum behaviours. [10]

b) Evaluate individual differences explanations of autistic spectrum behaviours. [10]

c) Briefly explain how individual differences explanations could be applied to modifying autistic spectrum behaviours. [5]

0 3 **Bullying behaviours**

a) Rebecca is increasingly concerned about her son Samuel and his behaviour at school. She has received numerous phone calls from teachers regarding his bullying behaviour towards a younger pupil. Rebecca is struggling to understand why Samuel is behaving in this way. When questioned about this, Samuel thinks the pupil 'deserves it'.

Describe how **two** explanations of bullying behaviour could be applied to the above scenario. [15]

b) Evaluate social psychological explanations of bullying behaviours. [10]

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0 4 **Criminal behaviours**

a) Briefly describe and evaluate restorative justice as a method of modification of criminal behaviours. [10]

b) Briefly describe and evaluate **one** social psychological explanation of criminal behaviours. [10]

c) Briefly explain how individual differences explanations could be applied to modifying criminal behaviours. [5]

0 5 **Schizophrenia**

a) Briefly describe and evaluate **one** social psychological explanation of schizophrenia. [10]

b) Briefly describe and evaluate cognitive behavioural therapy as a method of modifying schizophrenia. [10]

c) Biological explanations can be applied to methods of modifying schizophrenia. Briefly explain how. [5]

0 6 **Stress**

a) Describe **two** individual differences explanations of stress. [10]

b) 'Biological explanations are probably the most accurate and useful way of explaining stress in modern society.'

With reference to this statement, evaluate biological explanations of stress. [15]

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SECTION B: Controversies

Answer **one** of the questions.

Either,

0 7 **Sexism**

'Although gender bias in psychology may be reducing, other aspects of sexism are still a problem.'

Using your knowledge of psychology, discuss this statement. [25]

Or,

0 8 **Ethical costs of conducting research**

Certain studies in psychology are seen as unethical, but even these studies may be beneficial to society.

Using examples from psychology, discuss the potentially negative consequences and benefits to society of unethical research. [25]

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.

Question number

0 1 (a) Griffiths (2005) proposed a components model of addiction, arguing that any behaviour, whether it involves a substance (alcohol, nicotine, heroin) or an activity (gambling, gaming, exercise, internet use), is an addiction if it shows six core characteristics.

1. Salience: the activity becomes the single most important thing in the person's life and dominates their thinking (preoccupation and cognitive distortions), feelings (cravings) and behaviour (social life deteriorates). Even when not doing it, a gambler is thinking about the next bet.

2. Mood modification: the activity is used to change the person's subjective experience. It can produce an arousing 'buzz' or 'high', or a tranquillising, numbing escape from problems, and the same person may use it for different effects at different times, for example a gamer playing to feel excited in the morning and to relax at night.

3. Tolerance: over time, increasing amounts of the activity are needed to achieve the same mood-modifying effect, so a gambler places bigger and bigger bets and a drinker needs more units to feel drunk.

4. Withdrawal symptoms: unpleasant feeling states and physical effects occur when the activity is stopped or suddenly reduced. These can be psychological, such as irritability, anxiety and moodiness, or physical, such as nausea, sweating, headaches and insomnia (for example the shaking of alcohol withdrawal).

5. Conflict: the addiction causes interpersonal conflict between the addict and those around them, such as arguments with partners, parents, siblings and friends; intrapersonal conflict within the person, who knows they should cut down but cannot (a subjective loss of control); and activity conflict, where the behaviour clashes with work, education, hobbies and social life.

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6. Relapse: the tendency to revert to earlier patterns of the behaviour after a period of abstinence or control. Even after years, a typical pattern of heavy use can be quickly restored, so an ex-smoker who has 'just one' cigarette may soon be back to twenty a day.

Griffiths argued that all six must be present for a behaviour to be a true addiction rather than an excessive but healthy enthusiasm. These characteristics overlap with DSM-5 criteria for substance use disorder and gambling disorder (such as craving, tolerance, withdrawal and repeated unsuccessful attempts to cut down), and they describe both physical dependence, where the body has adapted to the substance, and psychological dependence, where the person feels they need the activity to cope.

0 1 (b)

Social psychological explanations argue that addiction is caused by the social environment rather than by genes or brain chemistry. The specification identifies peer pressure, the role of the media and co-morbidity with mental illness.

Peer pressure explains addiction through social learning (Bandura): adolescents observe peers using alcohol, cigarettes or drugs, see the behaviour rewarded with status and acceptance (vicarious reinforcement), and imitate it to conform to group norms, through both normative and informational social influence.

Supporting this, Kandel (1973) found that adolescents' marijuana use was predicted more strongly by their best friend's use than by their parents' use.

This evidence is useful because it has been applied to prevention, such as school programmes teaching refusal skills and social norms campaigns that correct the overestimation of how much peers drink. However, the evidence is largely correlational. Bauman and Ennett (1996) argued that peer influence is overestimated because of selection: young people who are already inclined to use drugs choose friends who use them, so similarity between friends does not prove that peers cause the behaviour. This supports the statement, as peers may explain the initiation of drug use but not why only a minority of those who

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experiment go on to become addicted.

The media explanation argues that films, television, music, advertising and social media model addictive behaviours as glamorous, normal and without consequences. Gunasekera et al. (2005) analysed popular films and found that drug use was usually shown positively, with negative consequences rarely depicted, while Sargent et al. (2005) found that, in a large sample of US adolescents, greater exposure to smoking in films predicted starting to smoke, even after controlling for parental smoking and other factors. The explanation has been useful for social policy, such as the UK ban on tobacco advertising and the inclusion of age ratings for drug use in films. However, most people exposed to the same media never become addicted, and media effects research cannot easily rule out that young people already interested in smoking seek out such content. Therefore the media may shape attitudes and the availability of models rather than cause the addiction itself, which again supports the statement.

Co-morbidity with mental illness explains addiction as the result of an existing mental disorder: according to the self-medication hypothesis (Khantzian, 1985), people use alcohol or drugs to relieve symptoms of anxiety, depression or psychosis, and repeated use becomes addictive. The Epidemiologic Catchment Area study (Regier et al., 1990) found that about 29% of people with a mental disorder also had a substance use disorder, rising to about 47% of people with schizophrenia. This explanation is useful because it supports integrated 'dual diagnosis' treatment of both conditions. However, co-morbidity is again correlational, and the direction of causality is unclear: heavy cannabis use may trigger psychosis rather than the other way round, or a shared factor such as stress or genetic vulnerability may cause both. Its categorisation as a social explanation is also questionable, as it concerns the individual's mental state.

With reference to the statement, these weaknesses suggest that social psychological explanations do not fully explain the cause of addiction. Biological explanations can explain why only some people become addicted: twin studies show heritability of around 50% for alcohol dependence, and the dopamine

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reward pathway explains tolerance and withdrawal, the characteristics that social explanations ignore. However, biological explanations cannot explain why addiction rates differ between cultures and change over time, such as the fall in UK smoking after advertising bans, which can only be explained by social factors. Social explanations also show cultural bias, as most research comes from Western, individualist samples of adolescents.

In conclusion, the statement is partly correct. Social psychological explanations are weaker at explaining the cause of addiction in a particular individual, because their evidence is correlational and they ignore individual vulnerability. However, they are valid and useful in explaining how addictive behaviours are initiated and maintained, and they have led to effective prevention. The best explanation is a diathesis-stress or biopsychosocial one, in which a biological or psychological vulnerability interacts with social triggers such as peers, media and mental illness.

0 4 (a)

Restorative justice (RJ) is based on the principle that the offender should put right the harm they have done. It has two main aims: rehabilitation of the offender, so reducing recidivism, and atonement for the wrongdoing. It is now a central part of Home Office and Ministry of Justice policy. Instead of focusing only on punishment, RJ brings together the three parties affected by a crime: the offender, the victim and the wider community. In a face-to-face conference led by a trained facilitator, the offender must accept responsibility and hear how the crime affected the victim, while the victim gains a voice, can ask questions and has some power in the criminal process. Indirect forms include letters or messages passed by the facilitator. The meeting usually ends with an agreement on reparation, such as an apology, compensation or unpaid work in the community.

Research supports its effectiveness. A Ministry of Justice evaluation by Shapland

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et al. (2008) found that RJ reduced the frequency of reoffending by about 14% and that 85% of victims who took part were satisfied, and it was estimated to save up to £8 for every £1 spent by reducing reoffending. Sherman and Strang (2007) found that RJ reduced reoffending more for violent than property crimes and reduced victims' post-traumatic stress symptoms. Ethically, it gives victims a role and helps offenders, rather than simply excluding them as custodial sentences do, which may act as a 'school for crime'.

However, RJ is voluntary, so the offenders who take part may already be remorseful and less likely to reoffend, which is a self-selection bias that may exaggerate its effectiveness. It also requires the offender to feel genuine empathy and guilt, so offenders such as psychopaths may fake remorse to gain a lighter sentence, and meeting the offender may re-victimise the victim. It is not suitable for all crimes, for example domestic abuse. Compared with anger management, it focuses on the consequences of the crime rather than the offender's thinking, so the two may work best together.

0 4 (b)

Differential association theory (Sutherland, 1939, revised 1947) is a social learning explanation which argues that criminal behaviour is learned through interaction with other people, mainly in intimate personal groups such as the family and peers. Through this association a person learns the techniques of committing crime (for example how to break into a car) and the motives, drives, rationalisations and attitudes that support it. Sutherland's key principle is that a person becomes criminal when they are exposed to an excess of definitions favourable to breaking the law over definitions unfavourable to it. The impact of these associations depends on their frequency, duration, priority (how early in life) and intensity (how important the person is). So crime is learned in the same way as any other behaviour, through observation and imitation of role models.

Supporting evidence comes from the Cambridge Study in Delinquent Development

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(Farrington et al., 2006), which followed 411 boys from South London from age 8 to 48. Having a convicted parent was one of the strongest predictors of offending, and a small number of families accounted for about half of all convictions, as the theory predicts. Osborn and West (1979) found that 40% of sons of criminal fathers had a conviction compared with 13% of sons of non-criminal fathers. The theory is also useful because it explains crime across all social classes, including white-collar crime, and suggests that prisons may be 'schools for crime', supporting community-based alternatives.

However, family similarities could also be explained by genetics: adoption studies (Mednick et al., 1984) found that adopted sons' convictions were related to their biological parents' convictions, so the theory ignores individual differences. It is also difficult to test scientifically, because 'definitions favourable to crime' cannot easily be measured, and it cannot explain impulsive crimes or why people exposed to the same criminal influences do not all offend. A diathesis-stress approach combining social learning with individual vulnerability may therefore be more valid.

0 4 (c)

Individual differences explanations suggest that crime results from differences in personality and cognition, so modification should be tailored to the individual. Eysenck's criminal personality is high in extraversion, neuroticism and psychoticism. Extraverts condition poorly, so punishment is less effective, but CBT-based anger management (Novaco) could help, through stress inoculation: cognitive preparation (identifying triggers), skill acquisition (relaxation and self-talk) and application practice through role play, reducing the emotional reactivity linked to neuroticism. Low intelligence suggests offenders need programmes in simple, concrete language with education to improve problem-solving. Psychopathic personality, assessed using Hare's PCL-R, involves a lack of empathy and guilt, so restorative justice may be unsuitable as it relies on remorse, and screening with the PCL-R could identify who will benefit from

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which method.

0 5 (a) The expressed emotion (EE) explanation is part of the dysfunctional families explanation. Expressed emotion is the level of negative emotion that family members express towards a person with schizophrenia. High EE families show three features: critical comments (for example about the person's behaviour), hostility (rejection and anger) and emotional over-involvement (being overprotective, self-sacrificing or anxious). Low EE families show warmth and positive regard. High EE is a source of chronic stress which, according to the diathesis-stress model, can trigger relapse or the onset of symptoms in a vulnerable person. EE is measured using the Camberwell Family Interview. Research supports the explanation. Brown et al. (1972) found that 58% of patients returning to high EE families relapsed within nine months, compared with 16% returning to low EE families, and Vaughn and Leff (1976) found the risk was greatest when patients spent more than 35 hours a week in face-to-face contact with high EE relatives. Kavanagh (1992) reviewed 26 studies and found mean relapse rates of 48% in high EE families compared with 21% in low EE families. A strength is that it has been applied to therapy: family interventions that teach relatives to reduce criticism and hostility reduce relapse rates (Pharoah et al., 2010), which also helps the explanation's validity. However, EE explains relapse much better than the initial cause of schizophrenia, and the research is correlational: living with a person with severe symptoms may cause relatives to become critical, so the direction of causality is unclear. There is also cultural bias, as high EE is less common in families in India than in Britain, and what counts as over-involvement differs between cultures. It also ignores biological evidence such as the dopamine hypothesis and concordance rates in twins, so it is best seen as a stress trigger within a diathesis-stress model.

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0 5 (b)

Cognitive behavioural therapy for psychosis (CBTp) combines cognitive and behavioural approaches. It is based on the idea that distress is caused not only by the symptoms but by the way they are interpreted, so it makes connections between disordered thinking and the illness. Using the ABC model, the therapist identifies the Activating event (for example hearing a voice), the Belief (the voice is the devil and must be obeyed) and the Consequence (fear and acting on it). The patient is helped to challenge these beliefs through reality testing and behavioural experiments, for example testing whether anything bad happens if they ignore a command. Normalising information and coping strategies, such as distraction and humming to block voices, teach the patient to ignore symptoms. It mainly treats positive symptoms and does not cure schizophrenia; instead it aims to reduce distress and help the patient behave more normally.

NICE recommends at least 16 sessions, usually alongside antipsychotic drugs.

Research gives some support. Sensky et al. (2000) found that CBT and a befriending control both improved symptoms at the end of treatment, but only the CBT group maintained the improvement at a nine-month follow-up.

However, Jauhar et al. (2014), in a meta-analysis of over 50 studies, found that CBT had only a small effect on symptoms, which became even smaller in studies where assessors were blind to the condition, suggesting that earlier studies overestimated its effectiveness.

Ethically, CBT is more empowering than drugs, as the patient is an active partner, and it has none of the side effects of antipsychotics, such as tardive dyskinesia. However, it requires insight, motivation and the ability to concentrate, so it is unsuitable for acutely psychotic patients or those with severe negative symptoms. It is also expensive and trained therapists are scarce, so many patients cannot access it. Compared with antipsychotics, it is slower, but its effects may last longer, so it is most effective as part of a combined approach.

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0 5 (c) The dopamine hypothesis states that positive symptoms are caused by excess dopamine activity (hyperdopaminergia) in the mesolimbic pathway, for example too many D2 receptors. This is applied directly in typical antipsychotics such as chlorpromazine and haloperidol, which block D2 receptors so that dopamine cannot bind, reducing hallucinations and delusions. A revised hypothesis also links negative symptoms to too little dopamine in the prefrontal cortex, so atypical antipsychotics such as clozapine, which act on serotonin as well as dopamine, are used to treat negative symptoms with fewer side effects. As cannabis increases dopamine release, patients are advised to stop using it through psychoeducation. Enlarged ventricles are linked to negative symptoms and poor drug response, suggesting such patients may need psychosocial approaches such as CBT and rehabilitation instead.

0 8 Unethical research is research that breaks ethical guidelines, such as the BPS Code of Human Research Ethics, which requires respect for participants (informed consent, the right to withdraw, confidentiality, avoiding deception), protection from harm, and responsibility and integrity. Psychologists face a double obligation dilemma: they have a duty to their individual participants, but also to society, which benefits from new knowledge. Rosenthal and Rosnow (1984) argued that there are also ethical costs of failing to do research, because society loses knowledge that could reduce suffering. This essay will discuss examples of studies that would now be considered unethical, weighing their negative consequences against their benefits to society.

Watson and Rayner (1920) conditioned 'Little Albert', an 11-month-old baby, to fear a white rat by pairing it with a loud noise made by striking a steel bar. Albert's fear generalised to similar objects, such as a rabbit, a dog, a fur coat and a Santa Claus mask. The negative consequences for the individual were serious: Albert was deliberately caused fear and distress, his mother's consent

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was not fully informed, and he was removed from the study before he could be deconditioned, so he may have left with a lasting phobia. However, the study demonstrated that phobias can be learned through classical conditioning, which led to behavioural therapies such as systematic desensitisation (Wolpe, 1958) and flooding. These have helped millions of people with phobias, so it could be argued that the harm to one participant was outweighed by the benefits to society. On the other hand, it is questionable whether this justifies harming a child who could not consent, and the same principle could have been shown in a less harmful way.

Milgram (1963) studied obedience by asking 40 male volunteers to give what they believed were increasingly strong electric shocks to a 'learner'. All participants went to 300 volts and 65% went to the maximum of 450 volts. The study involved deception about its true aim and the shocks, prods such as 'you have no other choice, you must go on' that undermined the right to withdraw, and severe distress: participants sweated, trembled and three had full seizures. Baumrind (1964) argued that this harm was not justified and could damage trust in psychologists. However, Milgram debriefed participants and found that 84% were glad they had taken part and only about 1% regretted it. The benefits to society are significant: the research showed that ordinary people obey destructive orders in an agentic state, helping us understand atrocities such as the Holocaust, and it is used in training soldiers, nurses and pilots to question authority. Yet there is also a potentially negative consequence for society: if everyone is capable of obeying, the findings could be used to excuse people from personal responsibility for their actions, as in the defence of 'only following orders'. Later research such as Burger (2009), who stopped at 150 volts and screened out vulnerable participants, shows that some of the knowledge could have been gained more ethically, as 70% of participants were still willing to continue.

Bowlby's (1944) study of 44 juvenile thieves found that 14 were 'affectionless psychopaths', and 12 of these had experienced prolonged separation from their

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mothers in early childhood, compared with very few in a control group. This research, and his later maternal deprivation hypothesis, raised ethical concerns: Bowlby collected data from children in his own clinic, so his position may have pressured them, and the label 'affectionless psychopath' could stigmatise children and lead to discrimination. It also had negative social consequences, as it was used to argue that mothers should stay at home, causing guilt and limiting women's careers. However, Bowlby's work had great benefits for society: it changed hospital visiting policies for children, led to the replacement of large orphanages with foster care where a child receives individual attention, and shaped childcare policy worldwide.

A further negative consequence comes from socially sensitive research, defined by Sieber and Stanley (1988) as research with potential social consequences for the participants or the group they represent. Even if a study is conducted ethically, its findings may be misused. Genetic research into crime (Raine) or addiction (Goldman, 2005) could lead to discrimination, for example by insurers or employers, or to the idea that some people are 'born criminals', which might be used to justify harsher treatment. Blumstein and Schwartz (1983), who investigated the number of sexual partners of heterosexual and homosexual couples, risked reinforcing negative stereotypes of gay men at a time of prejudice. In this way unethical research can harm whole groups in society, not just individual participants. Similarly, Zimbardo's (1973) Stanford prison experiment, stopped after six days because of the extreme distress of the 'prisoners', has been criticised for causing harm while its findings have been challenged by Reicher and Haslam (2006), who found guards did not automatically become tyrannical. This shows that some unethical studies do not even provide reliable benefits, which weakens the argument that the ends justify the means.

One way psychologists deal with these issues is cost-benefit analysis by ethics committees before research is carried out, including risk management such as debriefing, the right to withdraw and the use of retrospective or presumptive

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consent. However, this is difficult because the costs and benefits cannot be predicted accurately in advance: Milgram himself did not expect such extreme obedience or distress. It also requires psychologists to weigh harm to identifiable individuals against uncertain benefits to an unknown future population, which is a subjective judgement. Diener and Crandall (1978) argued that this makes cost-benefit analysis unreliable. On the other hand, these strict guidelines mean that much important research is now impossible to replicate, so the knowledge from older studies remains valuable.

In conclusion, studies such as Watson and Rayner, Milgram and Bowlby caused real harm to individual participants and, in some cases, negative consequences for society through stigma, misuse of findings and loss of trust in psychology. However, they also produced knowledge that has benefited society greatly, through therapies for phobias, an understanding of destructive obedience and better childcare. This does not justify unethical research, because the same benefits could often have been achieved with more ethical methods, as Burger's replication shows, and some studies, such as the Stanford prison experiment, provided little reliable benefit. Therefore the best approach is the one modern ethical guidelines take: careful cost-benefit analysis and ethical review before research, so that society can still benefit while protecting participants from harm.