# GCE AS/A LEVEL

2290U10-1

S18-2290U10-1

# PSYCHOLOGY – AS unit 1
## Past to Present

MONDAY, 14 MAY 2018 – AFTERNOON

1 hour 30 minutes

**ADDITIONAL MATERIALS**

A WJEC pink 16-page answer booklet.

**INSTRUCTIONS TO CANDIDATES**

Use black ink or black ball-point pen.

Answer **all** the 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.

You are reminded of the need 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.** *(a)* Using an example from psychology, describe the positive assumption of 'authenticity of goodness and excellence'. [4]

*(b)* Using an example from psychology, describe the positive assumption of 'focus on the good life'. [4]

**2.** Analyse the strengths **and** weaknesses of the psychodynamic approach. [10]

**3.** Describe the main components of cognitive behavioural therapy **OR** rational emotive behaviour therapy. [12]

**4.** Discuss **one** similarity and **one** difference between the biological and positive approaches. [4+4]

**5.** *(a)* Using an example from psychology, describe **one** assumption of the cognitive approach. [4]

*(b)* Describe how **one** assumption from the cognitive approach can be applied to the formation of relationships. [4]

**6.** Describe the findings of Bowlby's (1944) research *'Forty-four juvenile thieves: Their characters and home-life'.* [8]

**7.** *(a)* Describe the methodology of Watson and Rayner's (1920) research *'Conditioned emotional reactions'.* [4]

*(b)* *"Although there are ethical issues and methodological problems, the study of the conditioning of Little Albert is still an influential piece of research."*

With reference to the above statement, critically evaluate Watson and Rayner's (1920) research *'Conditioned emotional reactions'.* [10]

**8.** Evaluate drug therapy **OR** psychosurgery in terms of effectiveness **and** ethical considerations. [12]

**END OF PAPER**

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

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1. (a) The positive approach assumes that human strengths and virtues, such as kindness, courage, humour and generosity, are just as authentic (real and natural) as negative traits like anxiety or aggression. Seligman (2002) argued that psychology had treated goodness as less authentic, for example Freud saw altruism as a defence mechanism (reaction formation) covering selfish id impulses. Instead, positive traits should be studied scientifically and given equal attention. As Peterson (2006) put it, the 'true miracles of human activity receive scant attention from psychologists'.

An example is the Values in Action (VIA) classification by Peterson and Seligman (2004), which identifies 24 character strengths grouped into six virtues, measured by the VIA survey. Each person has 'signature strengths' that are genuinely part of who they are, and the positive therapist helps clients to identify and use them, which promotes wellbeing rather than just repairing weaknesses.

1. (b) The positive approach assumes psychology should focus on what makes life worth living, not only on mental illness. Seligman (2002) described three types of happy life. The pleasant life involves pursuing positive emotions about the past, present and future, such as contentment and pleasure. The good (engaged) life involves using our signature strengths in absorbing activities and positive connection to others, which produces 'flow' (Csikszentmihalyi), a state of total absorption where time passes unnoticed, for example a musician performing or an athlete in a match. The meaningful life involves using our strengths in the service of something bigger than ourselves, such as family, religion or a community, giving a sense of fulfilment.

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For example, Myers and Diener (1997) found that close, supportive relationships, rather than wealth, were among the best predictors of happiness, suggesting that relationships help us to achieve the good life.

2. One strength of the psychodynamic approach is that it takes into account both nature and nurture. Freud argued that behaviour is driven by innate biological instincts (the id, life and death drives) and that the psychosexual stages are biologically determined, but how a child passes through them depends on experiences with parents, for example harsh toilet training leading to an anal-retentive personality. This interactionist view is more complete than approaches that focus only on genes or only on learning.

A second strength is its application to therapy. Psychoanalysis, using free association and dream analysis, was the first 'talking cure' and aims to bring repressed conflicts into the conscious mind. It has influenced many later therapies and counselling. It is also idiographic: case studies such as Little Hans give rich, in-depth qualitative detail about an individual, and recognise that each person's unconscious conflicts are unique.

However, a major weakness is that it is unscientific. Concepts such as the unconscious mind, the Oedipus complex and the id cannot be directly observed or measured, so they are unfalsifiable (Popper): any behaviour can be explained after the event, for example a boy who loves his father may be accused of reaction formation. Its evidence comes mainly from Freud's own case studies, interpreted subjectively by Freud himself, so it lacks reliability and objectivity. The samples were small and unrepresentative, often middle-class Viennese women with neurotic problems, so findings cannot be generalised. Being idiographic also means general laws of behaviour are difficult to establish.

A further weakness is that it is deterministic. Psychic determinism suggests that behaviour is caused by unconscious forces and childhood experiences outside our control, which ignores free will and personal responsibility, unlike the positive approach. It may also be over-reliant on sexual motives. Compared with the

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behaviourist approach, which focuses on observable behaviour measured in controlled experiments, it is much harder to test. On the other hand, some concepts have received support, for example Williams (1994) found 38% of women with documented childhood abuse did not recall it, which is consistent with repression.

In conclusion, the psychodynamic approach was highly influential in recognising the importance of childhood and unconscious processes and in developing therapy, but because its key concepts are unfalsifiable and its evidence is subjective, its scientific value is limited.

3. I will describe cognitive behavioural therapy (CBT). CBT is based on the assumption that psychological problems such as depression and anxiety are caused by faulty, irrational thinking, which in turn affects emotions and behaviour. Beck proposed that depressed people have a negative cognitive triad: negative views of the self, the world and the future, maintained by negative automatic thoughts and cognitive distortions such as overgeneralisation, catastrophising and all-or-nothing thinking. CBT therefore has two main elements, cognitive and behavioural.

CBT is usually a short-term, structured therapy of around 5 to 20 weekly sessions of about 50 minutes. It begins with an assessment, where the therapist and client agree on the problems and set clear, measurable goals. The relationship is collaborative and active: the client is treated as a 'scientist' who tests their own beliefs, and the therapist uses Socratic questioning, for example 'What is the evidence that everyone thinks you are stupid?', rather than telling the client what to think.

The cognitive element works on faulty thoughts. The client learns to identify negative automatic thoughts, often using a dysfunctional thought diary. In this they record the situation, the emotion and how strong it was (for example 0 to 100%), the automatic thought, a rational response and the outcome. This makes the link between thoughts and feelings clear. Cognitive restructuring then

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involves challenging these irrational thoughts and replacing them with more realistic, balanced ones, for example changing 'I failed my test so I am a failure' to 'I did badly on one test, but I have passed others and can revise more next time'.

The behavioural element involves reality testing. The client carries out behavioural experiments to test whether their predictions come true, for example a socially anxious client who believes 'nobody will talk to me' goes to a party and records what actually happens. Homework is set between sessions, such as keeping the thought diary or practising new skills, so that the client applies the therapy in everyday life. Other behavioural techniques include activity scheduling, where depressed clients plan pleasant or achievable activities to increase positive reinforcement, graded exposure to feared situations, relaxation training and social skills training. Skills are practised through role play in sessions.

Finally, CBT aims to make the client their own therapist. Towards the end of treatment, the focus moves to relapse prevention: the client learns to recognise early warning signs and to use the techniques independently, and there may be booster sessions. Therefore CBT combines changing thoughts (cognitive restructuring) with changing behaviour (reality testing and homework) to improve how the client feels.

4. One similarity is that both approaches recognise the role of genetics in influencing behaviour. The biological approach assumes behaviour is largely caused by genes, for example twin studies show higher concordance rates for schizophrenia in MZ than DZ twins. Similarly, positive psychologists accept a genetic 'set point' for happiness: Lyubomirsky et al. (2005) suggested that about 50% of differences in happiness are due to genes, with 10% due to life circumstances and 40% to intentional activity. Both also use scientific methods to investigate this, such as twin studies, questionnaires (the VIA survey) and brain scans. However, the similarity is limited, because the positive approach stresses that the remaining 40% can be changed by our own actions, whereas

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| | the biological approach sees genes as more fixed.<br>One difference is their view of free will and determinism. The biological approach is deterministic: behaviour is caused by genes, neurotransmitters and brain structure, for example low serotonin is linked to depression, so people are not seen as freely choosing how they act. The positive approach assumes people have free will and can choose to change, for example by using their signature strengths or completing exercises such as gratitude letters to build happiness.<br>This leads to different treatments: the biological approach uses a disease model, treating abnormality with drugs or psychosurgery, whereas the positive approach focuses on promoting character strengths and wellbeing in everyone. This difference means the positive approach gives people more responsibility and optimism, but may blame individuals who cannot simply choose to be happy. |
| 5. (a) | One assumption of the cognitive approach is the computer analogy: the mind is seen as an information processor, like a computer, with information being input through the senses, processed (encoded, stored and retrieved) and then output as behaviour. The brain is the 'hardware' and mental processes such as attention, perception and memory are like the 'software'. This means internal mental processes can be studied scientifically, by inferring them from behaviour in controlled experiments.<br>An example is Atkinson and Shiffrin's (1968) multistore model of memory. Information is input to the sensory register, then attention transfers it to short-term memory, which has a limited capacity of about 7 ± 2 items, and rehearsal transfers it to long-term memory, where it is stored and later retrieved (output), like saving a file to a hard drive. |
| 5. (b) | The cognitive approach assumes that we use schemas, organised packets of information built up through experience, to make sense of the world quickly. In relationship formation, schemas lead to the halo effect: we have a 'what is beautiful is good' schema, so we assume physically attractive people also have |

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other positive traits such as kindness and intelligence (Dion, Berscheid and Walster, 1972). This makes us more likely to want to form relationships with them.

Schemas also explain the matching hypothesis (Walster et al., 1966). We hold a schema about our own attractiveness, and to avoid rejection we tend to seek and form romantic relationships with partners of a similar level of attractiveness to ourselves. Similar schema-driven processing also applies to friendships, where we are attracted to people we perceive as similar to us.

6. Bowlby studied 44 juvenile thieves referred to the London Child Guidance Clinic and a control group of 44 emotionally disturbed children who did not steal. He classified the children into six character types: normal, depressed, circular (alternating between depression and overactivity), hyperthymic (overactive, restless), affectionless and schizoid.

Only 2 of the 44 thieves were diagnosed as normal, and even these two showed characteristics of instability. Bowlby believed that without treatment the other 42 would develop neurotic or psychotic symptoms later in life. The most striking finding was the affectionless character type: 14 of the thieves were affectionless, but none of the control group were. These children showed a lack of affection or warmth, no sense of shame or responsibility and no deep or lasting relationships with others.

The degree of stealing was linked to character type. Of the 23 persistent (Grade 4) thieves, 13 (56%) were affectionless, and of the 14 affectionless thieves, 13 (93%) were persistent thieves, so affectionless children stole most seriously and persistently.

Bowlby also found evidence for the aetiology (cause) of delinquency in early separation. 17 of the 44 thieves had experienced a prolonged separation (six months or more) from their mother or mother-substitute in their first five years, compared with only 2 of the controls. Of the 14 affectionless thieves, 12 (86%) had suffered such a separation, and conversely, of the 19 cases

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| | where separation had occurred, 12 (63%) were affectionless. In contrast, very few of the other character types had been separated. Qualitative data from interviews also showed the emotional attitude of parents mattered, for example some mothers were anxious, irritable or rejecting and some fathers were hostile, which was more common in the thief group.<br>Bowlby concluded that prolonged maternal separation or deprivation in early childhood is a key cause of affectionless psychopathy and delinquency, supporting his maternal deprivation hypothesis. |
| 7. (a) | Watson and Rayner's study was a controlled observation and case study of one infant, 'Albert B', conducted at the Harriet Lane Home, Johns Hopkins University. Albert was nine months old at the start and was described as healthy, 'stolid and unemotional', 'extremely phlegmatic' and 'one of the best developed youngsters ever brought to the hospital', so he was chosen because the study was unlikely to harm him.<br>First a baseline was established: Albert was shown a white rat, a rabbit, a dog, a monkey, masks, cotton wool and burning newspaper, and showed no fear, but a loud noise (a steel bar struck with a hammer behind his head) made him cry. At 11 months the rat (neutral stimulus) was paired with the noise (UCS) seven times over two sessions a week apart. His reactions were then observed and filmed, including tests for generalisation to similar objects, transfer to a different room, and persistence after 31 days. Building blocks were given between trials as a control, to check his emotional state was otherwise normal. |
| 7. (b) | The statement is correct that there are serious ethical issues. Albert was deliberately caused distress and fear, which breaks the guideline of protection from harm. His mother, a wet nurse at the hospital, gave consent, but she may have felt pressured because she was employed there, so valid consent is doubtful, and Albert himself could not consent or withdraw. Most importantly, Albert left the hospital before the conditioned fear was removed (extinguished), |

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even though Watson and Rayner knew this would happen, so he may have kept the phobia. This study would not be allowed today.

There are also methodological problems. It used only one child, so the sample cannot be generalised: Albert may have been unusual, and later claims suggest he may have had neurological problems, which would make him unrepresentative. The fear responses were judged subjectively by the researchers, with no clear operational definitions of 'fear', so there may be researcher bias, especially as Watson wanted to prove behaviourism. Control of variables was inconsistent: Albert sucked his thumb, which reduced his fear, and his thumb was removed so that he would respond. Conditioning was also 'freshened' with extra pairings, and the laboratory setting lacks ecological validity, as real phobias develop in everyday situations.

However, there are strengths. The procedure was carefully controlled and recorded, with a baseline, the building block control and film evidence, which increases internal validity and allows replication. Alternative explanations of phobias exist, such as the psychodynamic view of Little Hans's fear of horses as displaced Oedipal anxiety, or the biological idea of preparedness (Seligman), but Watson and Rayner provided direct experimental evidence that fears can be learned through classical conditioning.

This is why it is still influential. It showed that emotional responses can be conditioned in humans, supporting the behaviourist approach, and led to treatments: Jones (1924) used counterconditioning to remove Little Peter's fear of rabbits, and later systematic desensitisation and aversion therapy are based on the same principles. It also had social implications, for example influencing advice on conditioning children's behaviour, and it helped to shape ethical guidelines.

In conclusion, I agree with the statement. Although the ethical issues and single-case, subjective methodology mean the findings should be treated with caution, the study remains influential because it provided the first experimental evidence that phobias can be learned, which led to effective behavioural

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therapies.

8. I will evaluate drug therapy. Drug therapy treats mental disorders by changing neurotransmitter levels, for example antidepressants such as SSRIs (fluoxetine) increase serotonin in depression, and antipsychotics such as chlorpromazine block dopamine D2 receptors in schizophrenia.

In terms of effectiveness, there is strong research support. Leucht et al. (2012) carried out a meta-analysis of antipsychotic trials and found that 27% of patients on drugs relapsed within a year compared with 64% on a placebo. Drugs act quickly, are cheap and easy to use, and have allowed many patients to live in the community rather than in institutions. However, Kirsch et al. (2008) found that antidepressants were only clinically significantly better than a placebo for the most severely depressed patients, suggesting much of their effect may be due to expectations. Drug trials are often funded by pharmaceutical companies, and negative results may not be published, which could exaggerate effectiveness. Drugs also treat symptoms rather than the cause, so relapse is common when patients stop taking them, and typical antipsychotics are less effective for negative symptoms of schizophrenia.

Comparison with other therapies is mixed. The TADS study (March et al., 2004) of depressed adolescents found a 61% response rate to fluoxetine alone, compared with 43% for CBT alone and 35% for placebo, but the highest rate (71%) for combined drug therapy and CBT. This suggests drugs are effective, but most effective alongside psychological therapy, which addresses faulty thinking and reduces relapse.

There are also ethical considerations. Drugs can have serious side effects: SSRIs can cause nausea, weight gain and sexual problems and have been linked to increased suicidal thoughts in young people, and typical antipsychotics can cause tardive dyskinesia (involuntary movements), which may be permanent. Valid consent is a problem, because patients with severe psychosis may not have the capacity to understand risks, and under the Mental Health Act they can be

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sectioned and given drugs against their will. Drugs have been criticised as a 'chemical straitjacket' to control patients, and some patients become dependent on them. On the other hand, it could be argued that it is unethical to withhold an effective treatment, and drugs are less invasive and more reversible than psychosurgery or ECT, as treatment can be stopped if side effects occur.

In conclusion, drug therapy is effective for many patients, especially for severe depression and for preventing relapse in schizophrenia, but its benefits may be overstated and it does not treat the underlying causes. The ethical issues of side effects and consent mean it should be used with careful monitoring and, ideally, combined with psychological therapies such as CBT.