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

GCE AS/A LEVEL

2290U10-1

S23-2290U10-1

MONDAY, 15 MAY 2023 – AFTERNOON

PSYCHOLOGY – AS unit 1

Past to Present

1 hour 30 minutes

For Examiner's use only		
Question	**Maximum Mark**	**Mark Awarded**
1.	**4**	
2.	**10**	
3.	**10**	
4.	**12**	
5.	**10**	
6.	**8**	
7.	**10**	
8.	**8**	
9.	**8**	
Total	**80**	

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01

INSTRUCTIONS TO CANDIDATES

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

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

Answer **all** the questions.

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

INFORMATION FOR CANDIDATES

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

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

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

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Answer **all** questions.

1. Describe how **one** assumption from the biological approach can explain the formation of relationships. [4]

One assumption of the biological approach is that behaviour is the product of evolution: behaviours that increased our ancestors' chances of surviving and reproducing were naturally selected and passed on in genes. This explains relationship formation through mate preferences. Trivers' (1972) parental investment theory states that females invest far more in offspring (pregnancy, breastfeeding), so they should be choosy and prefer partners who can provide resources and protection, whereas males invest less and should prefer partners showing fertility cues such as youth and physical attractiveness. Buss (1989) supported this in a cross-cultural survey of over 10,000 people in 37 cultures: women valued good financial prospects more, while men valued youth and good looks more. So, according to this assumption, we are attracted to and form relationships with partners who maximise the reproductive success of our genes.

Additional space for question **1** only:

2. (a) Identify **two** stimuli used by Watson and Rayner in the procedures of their 1920 research 'Conditioned emotional reactions'. [2]

1. A white rat.

2. A loud noise, made by striking a steel bar with a hammer behind Albert's head.

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(b) Describe the conclusions of Watson and Rayner's (1920) research 'Conditioned emotional reactions'. [4]

Watson and Rayner concluded that a fear response (a conditioned emotional reaction) can be created in a child through classical conditioning, by pairing a neutral stimulus (the rat) with a loud noise. The fear transferred to similar objects (rabbit, dog, fur coat) and persisted, although its intensity may be lost over time. They concluded it is probable that many phobias are true conditioned emotional reactions, either of the direct or the transferred type, and that persistence may only be found in people who are not as 'strong willed'. Adult emotional disturbances cannot be traced to sex alone, as Freudians claim, but to conditioned and transferred responses set up in infancy in love, fear and rage.

(c) Discuss **one** ethical issue in Watson and Rayner's (1920) research 'Conditioned emotional reactions'. [4]

A key ethical issue is protection from harm. Little Albert was deliberately conditioned to fear a white rat by a frightening loud noise, which made him cry, tremble and crawl away, so he was caused significant distress. This is made worse because he was a vulnerable participant, only about 9 months old at the start, who could not consent himself or understand what was happening. His fear generalised to other objects, and he was removed from the hospital before any attempt was made to extinguish (decondition) the responses, so he may have been left with lasting phobias. They claimed the harm was no worse than the 'rough and tumble of the home', and the study did improve understanding of phobias, leading to therapies such as systematic desensitisation. However, by today's BPS guidelines the risk of harm would be unacceptable and the study would not be approved.

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3. Describe the main components of **one** therapy from the positive approach (mindfulness **OR** quality of life therapy). [10]

Mindfulness is a therapy from the positive approach that trains people to pay attention, on purpose, to the present moment, non-judgementally (Kabat-Zinn). Rather than changing thoughts, the client learns to observe thoughts and feelings as passing mental events, so they are less likely to ruminate or react automatically.

Formal practice: the core component is meditation. In mindful breathing the client focuses attention on the sensation of the breath; when the mind wanders (which is expected), they notice this without criticism and gently bring attention back. Other formal practices include the body scan, where attention is moved slowly through each part of the body noticing sensations, sitting meditation, and mindful movement such as gentle yoga.

Mindfulness Based Stress Reduction (MBSR): Kabat-Zinn developed this programme in 1979 at the University of Massachusetts Medical School. It is an 8-week group course with a weekly 2.5 hour session, a whole-day silent retreat, and around 45 minutes of daily home practice using guided recordings. Participants are taught attitudes such as non-judging, patience, beginner's mind, trust, non-striving, acceptance and letting go. A related programme, MBCT, combines this with cognitive therapy to prevent relapse in depression.

The .b schools programme ('Stop, Breathe and Be') from the Mindfulness in Schools Project is a classroom course of short, engaging lessons for pupils, teaching skills such as 'beditation' and 'FOFBOC' (feet on floor, bum on chair) to manage stress and improve focus.

Informal practice: clients are encouraged to bring mindful awareness into everyday activities such as eating, walking, washing up or brushing teeth, e.g. the 'raisin exercise' of eating slowly with full attention, and the 3-minute

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breathing space used at stressful moments. This helps the skills generalise to daily life.

Role of the therapist: the therapist is a teacher or facilitator rather than an expert who 'fixes' the client. They should have their own regular meditation practice so they can model mindful, non-judgemental awareness, guide the practices, and lead 'inquiry' afterwards, where clients describe their experience. Responsibility for daily practice lies with the client.

4. Describe the methodology and procedures of Loftus and Palmer's (1974) research 'Reconstruction of automobile destruction: an example of the interaction between language and memory'. [12]

Methodology: Loftus and Palmer conducted two laboratory experiments using an independent groups design. The participants were students at the University of Washington: 45 in Experiment 1 and 150 in Experiment 2, tested in groups of various sizes. The aim was to investigate whether the wording of a leading question affects eyewitness estimates of speed (Exp. 1) and whether it actually alters the memory of the event (Exp. 2). Both used standardised films and questionnaires so every group received identical procedures apart from the verb. Experiment 1: the IV was the verb used in the critical question (smashed, collided, bumped, hit, contacted) and the DV was the speed estimate in mph. Participants were shown seven film clips of traffic accidents, taken from driver safety films; the segments ranged from 5 to 30 seconds and four showed staged crashes. After each film they were given a questionnaire. The first question asked them to 'give an account of the accident you have just seen',

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followed by a series of specific questions about it. The critical question was 'About how fast were the cars going when they hit each other?'. Nine participants were asked this question; the remaining participants were equally divided into groups of nine and the word 'hit' was replaced with 'smashed', 'collided', 'bumped' or 'contacted'. The order of the films was different for each group. Speed estimates in each group were recorded, and the experiment lasted about an hour and a half.

Experiment 2: 150 students were shown a film of a multiple car accident lasting less than a minute; the accident itself lasted less than 4 seconds. They then completed a questionnaire, first describing the accident in their own words, followed by questions. 50 participants were asked 'How fast were the cars going when they smashed into each other?', 50 were asked the same question with 'hit', and 50 were a control group who were not asked about speed at all. One week later all participants returned and, without seeing the film again, answered

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ten questions about the accident. The critical question, placed in a random position, was 'Did you see any broken glass?' (yes/no), which was the DV. There was no broken glass in the film, but because broken glass is associated with high-speed accidents, participants in the 'smashed' condition were expected to say 'yes' more often if the verb had altered their memory.

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5. Compare and contrast the behaviourist and psychodynamic approaches in terms of their similarities and differences. [10]

One similarity is that both approaches are deterministic: behaviour is caused by forces outside our free will. However, they differ in the cause. The behaviourist approach sees behaviour as environmentally determined by past conditioning (e.g. Little Albert's fear), whereas the psychodynamic approach sees it as psychically determined by unconscious drives and childhood conflicts.

Both also stress early experience, as Watson argued that responses set up in infancy shape adult emotions and Freud believed personality is largely formed by the end of the phallic stage. But they differ on nature/nurture: behaviourism is almost entirely nurture (we are born a 'blank slate'), whereas the psychodynamic approach takes both into account, with innate drives (the id, Eros and Thanatos, the fixed psychosexual stages) interacting with parenting experiences.

A major difference is scientific status. Behaviourists study only observable behaviour in controlled laboratory experiments, often with animals (Pavlov's dogs, Skinner's rats), producing objective, replicable data. Freud's concepts such as the unconscious and the Oedipus complex cannot be directly observed or falsified, and were based on case studies such as Little Hans, interpreted subjectively.

Linked to this, behaviourism is nomothetic, seeking general laws of learning that apply to all organisms, whereas psychodynamic psychology is more idiographic, studying individuals in depth.

Both approaches are applied to therapy, but very differently. Behaviourist therapies such as systematic desensitisation and aversion therapy treat the symptom (the learned behaviour) relatively quickly, while psychodynamic therapies such as dream analysis and free association aim to uncover the unconscious cause, which is lengthy. Both can also be seen as reductionist, reducing complex behaviour to stimulus-response links or to a few unconscious drives.

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In conclusion, the approaches are similar in being deterministic, emphasising early experience and having therapeutic applications, but differ fundamentally in method and focus: behaviourism is more scientific and nomothetic, whereas the psychodynamic approach offers richer, idiographic insight into the mind but with less empirical support.

6. Using examples from psychology, describe **two** assumptions of the psychodynamic approach. [4 + 4]

Assumption 1: behaviour is driven by the unconscious mind. Freud compared the mind to an iceberg: the conscious mind is the tip, the preconscious lies just below, and the largest part is the unconscious, containing repressed memories, desires and conflicts that we cannot access but which influence our behaviour. The unconscious reveals itself through dreams and Freudian slips. To protect us from anxiety the ego uses defence mechanisms, such as repression (forcing a traumatic memory out of awareness), denial (refusing to accept reality) and displacement (redirecting feelings onto a safer target, e.g. shouting at a sibling after being told off by a teacher). Psychological problems can arise from these unconscious conflicts, as in the case of Anna O, whose hysterical symptoms were linked to repressed memories.

Assumption 2: early childhood experiences shape adult personality through the

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psychosexual stages: oral (0 to 1), anal (1 to 3), phallic (3 to 6), latency and genital. At each stage the libido is focused on a different part of the body, and a conflict must be resolved. Unresolved conflict leads to fixation, producing personality types; for example, harsh potty training can cause an anal-retentive personality (tidy, obsessive, stubborn), while fixation at the oral stage may lead to smoking or nail-biting. In the phallic stage the boy experiences the Oedipus complex and resolves it by identifying with his father, which explains gender development and the formation of the superego. Freud illustrated this with Little Hans, whose phobia of horses was interpreted as a displaced fear of his father.

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7. Rhian has been suffering with a mental health problem and has been advised to consider using a therapy from the cognitive approach. Before she starts the therapy, she expresses concerns to her doctor that it may not work and wants to know if there are any ethical considerations she should be aware of.

With reference to Rhian's concerns, evaluate the therapy from the cognitive approach you have studied (either cognitive behavioural therapy **OR** rational emotive behaviour therapy). [10]

I have studied cognitive behavioural therapy (CBT), which assumes that Rhian's problem is maintained by faulty, irrational thinking and helps her identify and challenge negative automatic thoughts, then test them through homework and behavioural experiments.

Rhian's first concern is whether it will work. There is strong evidence that it can: Hofmann et al. (2012), reviewing over 100 meta-analyses, found strong support for CBT especially for anxiety disorders. In the TADS study (March et al., 2007) with depressed adolescents, combined CBT and fluoxetine helped 71%, fluoxetine alone 61% and CBT alone 43%, compared with 35% for placebo. So CBT may work for Rhian, but she might benefit more from combining it with drug therapy, especially if her symptoms are severe. Its success also depends on Rhian herself: CBT requires motivation, active effort and homework, so if she is very depressed or lacks energy she may drop out. However, CBT teaches skills she can keep using, so relapse rates are often lower than after stopping drugs.

Another issue is the validity of the assumption. If Rhian's problem is caused by a biological factor, such as low serotonin, or by genuinely difficult life circumstances such as poverty, CBT may treat her thinking rather than the real cause and so may not be appropriate.

Rhian also asked about ethics. CBT is fairly ethical: it is collaborative, she gives informed consent, sets goals with the therapist, has the right to withdraw and is protected by confidentiality. Unlike drugs, it has no physical side effects.

However, she should know that challenging her beliefs and confronting feared situations can be distressing in the short term, there is a power imbalance with

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the therapist, and placing responsibility on her thoughts could make her feel to blame for her problem.

In conclusion, CBT is well supported and ethically sound, so Rhian's concerns are understandable but can largely be reassured, provided she is motivated and her problem is linked to her thinking; otherwise a combined approach may suit her best.

8. Evaluate Myers and Diener's (1995) research 'Who is happy?'. [8]

Myers and Diener's 'Who is happy?' is a literature review, which is a strength because it draws together data from large numbers of people, for example Inglehart's (1990) surveys of around 170,000 people in 16 nations, so the conclusions that happiness does not depend greatly on age, gender or wealth are based on very large samples. However, the authors chose which studies to include, so there is a risk of researcher bias: studies supporting their view may have been selected.

Many of the studies reviewed are correlational, for example the link between happiness and close relationships, religious faith or traits such as self-esteem. Correlation cannot show cause and effect: being happy may lead people to marry or have more friends, rather than the reverse, so conclusions about causes of happiness must be cautious.

Subjective wellbeing was measured by self-report questionnaires, which raises

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validity issues. People may give socially desirable answers, claiming to be happier than they are, and happiness is a subjective concept that may mean different things to different people. In support, Myers and Diener noted that self-reports correlate with ratings by friends and family, which increases confidence in their validity.

Although many nations were included, most data came from Western, individualist cultures, and wellbeing scales may reflect Western ideas of happiness, so findings may not generalise to collectivist cultures where happiness is tied more to social harmony.

Ethically, the research is low risk: it used existing data from anonymous surveys, so there was little risk of harm, although asking about life satisfaction might make some respondents reflect on unhappy circumstances.

The research is useful to society, as it challenges the myth that wealth brings

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happiness and shows the value of relationships, purpose and faith, which can inform positive psychology interventions and policy. However, it is socially sensitive, as suggesting that certain groups, such as married or religious people, are happier could be used to judge others.

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9. Identify and explain **two** strengths of the biological approach. [4 + 4]

Strength 1: the biological approach is scientific. It uses objective, controlled methods such as laboratory experiments, brain scanning (PET, fMRI) and twin and adoption studies, which produce quantitative data that can be replicated and checked for reliability. For example, Raine et al. (1997) used PET scans to compare the brains of murderers pleading not guilty by reason of insanity with matched controls, and found lower activity in the prefrontal cortex. Because its concepts, such as neurotransmitters, hormones and genes, can be directly measured, its explanations can be tested and falsified, unlike untestable concepts such as Freud's unconscious. Its explanations are also nomothetic, producing general laws (e.g. the role of the amygdala in fear) that apply to all people. This gives the approach high credibility and status as a science.

Strength 2: the approach has useful real-world applications, especially drug therapy. Understanding that depression is linked to low levels of serotonin led to SSRIs such as fluoxetine, which increase serotonin at the synapse, and antipsychotics that reduce dopamine activity are used to treat schizophrenia. These treatments are relatively cheap, quick to take effect and easy to use compared with talking therapies, so they have helped millions of people live in the community rather than in institutions, and reduce costs to the NHS. Similarly, knowledge of genetic influences allows genetic counselling for families at risk. Research into localisation of function has also helped surgeons and those rehabilitating patients after brain injury, showing that the approach improves people's lives.

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