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

GCE AS/A LEVEL

S24-2290U10-1

2290U10-1

MONDAY, 13 MAY 2024 – AFTERNOON

PSYCHOLOGY – AS unit 1
Past to Present

1 hour 30 minutes

For Examiner's use only		
Question	**Maximum Mark**	**Mark Awarded**
1.	**18**	
2.	**4**	
3.	**8**	
4.	**15**	
5.	**8**	
6.	**10**	
7.	**5**	
8.	**6**	
9.	**6**	
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** 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. (a) Using examples from psychology, describe the following assumptions of the psychodynamic approach:

(i) 'The unconscious mind'. [4]

Freud argued that the mind is like an iceberg: the conscious mind (thoughts we are aware of) is only the small tip above the water. Below it is the preconscious (memories that can be retrieved easily, e.g. a phone number) and, largest of all, the unconscious, which holds repressed memories, desires and instincts we cannot access but which still drive our behaviour.

Unconscious content leaks out in Freudian slips and dreams. Ego defence mechanisms such as repression, denial and displacement keep threatening material unconscious, but this can cause psychological problems: in the Little Hans case (Freud, 1909) Hans' fear of his father was displaced onto horses, producing a phobia.

(ii) 'Tripartite personality'. [4]

Freud proposed that personality has three parts. The id (present from birth) is the unconscious, selfish part that works on the pleasure principle, demanding instant gratification of instincts such as Eros and Thanatos. The ego (develops around 2 years) works on the reality principle, mediating between the id, the superego and the real world. The superego (around 5 years, after the phallic stage) is the moral part, the internalised values of the same-sex parent, working on the morality principle and punishing with guilt.

A healthy personality needs a strong ego balancing these demands using defence mechanisms. If one part dominates, personality is affected: a dominant id leads to selfish, aggressive or impulsive behaviour, while a dominant superego leads to anxiety, guilt and rigidity.

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(b) Evaluate the psychodynamic approach. [10]

One strength of the psychodynamic approach is that it was the first to stress the influence of childhood experiences and the unconscious mind, and it led to a whole range of therapies such as psychoanalysis, using dream analysis and free association. These "talking cures" are still used and many modern therapies (e.g. psychodynamic counselling) developed from them, so the approach has practical value.

Another strength is that it is interactionist. It combines nature (innate instincts and the id, a universal sequence of psychosexual stages) with nurture (how parents handle each stage, e.g. harsh toilet training leading to an anal retentive personality). This is a more complete explanation than purely biological or behaviourist views. It is also nomothetic, proposing general laws that apply to everyone, such as the tripartite personality, which allows predictions, although critics say it ignores individual and cultural differences.

However, a major weakness is its lack of scientific status. Concepts such as the unconscious, the id and the Oedipus complex cannot be directly observed or measured, so they are unfalsifiable (Popper): any outcome can be explained after the event. Freud's evidence came from case studies such as Little Hans, which relied on the father's reports and Freud's subjective interpretations, so the findings lack objectivity and reliability and cannot be generalised from one boy or from middle-class Viennese patients to everyone.

The approach is also deterministic (psychic determinism): behaviour is seen as caused by unconscious forces and early experiences, leaving no room for free will or personal responsibility. Compared with the positive approach, which stresses free will and strengths, it is pessimistic and focuses on abnormality.

Compared with the behaviourist approach, which uses controlled lab

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experiments, it is far less scientific, though behaviourism is reductionist in ignoring the mind.

There is some supporting evidence: Levinger and Clark (1961) found people took longer to give associations to emotionally threatening words, consistent with repression. Psychoanalysis is also time-consuming and expensive, and

Additional space for question **1**(b) only:

effectiveness is hard to measure.

In conclusion, the psychodynamic approach was highly influential and its ideas of the unconscious and childhood remain useful, but its deterministic, unfalsifiable concepts mean it is weak as a scientific explanation of behaviour.

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2. Describe how a relationship is formed, using **one** assumption from the behaviourist approach. [4]

The behaviourist approach assumes that all behaviour is learnt through conditioning, including relationships. In classical conditioning, food (UCS) naturally produces pleasure (UCR) in a baby. The mother (NS) is repeatedly present when the baby is fed, so she becomes associated with food and turns into a conditioned stimulus that produces pleasure on her own (CR). The baby then seeks her out, forming an attachment based on "cupboard love" (Dollard and Miller, 1950).

Operant conditioning also applies: a hungry baby feels discomfort, and being fed by the mother reduces this drive (negative reinforcement), so the mother becomes a secondary reinforcer and the baby repeats behaviours such as crying and smiling that bring her close. Similarly, a pet bonds with an owner who positively reinforces it with food and attention.

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3. Describe the findings of Watson and Rayner's (1920) research '*Conditioned Emotional Reactions*'. [8]

At about nine months, Albert showed no fear when shown a white rat, a rabbit, a dog, a monkey, masks, cotton wool and burning newspapers: "at no time did this infant ever show fear in any situation". At 8 months 26 days, when a steel bar was struck behind him he "started violently", his breathing was checked and his arms were raised; on the second strike his lips puckered and trembled, and on the third he broke into a sudden crying fit, the first time any fear was produced in the laboratory.

At 11 months 3 days, the rat was paired with the noise: Albert jumped

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violently, fell forward and buried his face in the mattress but did not cry; on the second pairing he whimpered. At 11 months 10 days, after further joint stimulations he cried, and when the rat was then presented alone he immediately began to cry, turned sharply and crawled away so rapidly he was caught before reaching the edge of the table: a conditioned emotional response had been established.

At 11 months 15 days the fear had generalised. He still played with blocks, but whimpered and withdrew from the rat, turned away and cried at the rabbit, cried at the dog, fretted at the fur coat, withdrew his hand from cotton wool (with less shock), reacted negatively to Watson's hair (but played with the observers' hair) and was "pronouncedly negative" to a Santa Claus mask.

At 11 months 20 days the reactions were less intense, so the rat was "freshened" with the noise; in a new room the responses were weaker but still present, e.g. he wailed when the dog barked. At 1 year 21 days, after a month with no trials, fear persisted: he withdrew and cried at the fur coat

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and mask and pushed the rabbit away, though reactions to the rat were slight. Incidentally, whenever upset he sucked his thumb, which blocked the fear response.

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4. (a) Explain why a psychologist from the biological approach would view drug therapy **OR** psychosurgery as an appropriate therapy. [5]

A biological psychologist would see drug therapy as appropriate because the approach assumes that behaviour, including mental illness, is caused by physical processes in the body, such as neurochemistry, genes and brain structure. This follows the medical model: mental disorders are illnesses with physical causes, so they should be diagnosed and treated physically, like any other illness.

If a disorder is caused by a neurotransmitter imbalance, drugs can correct it. For example, depression is linked to low serotonin, so SSRIs (e.g. fluoxetine) block the reuptake of serotonin at the synapse, increasing the amount available to the post-synaptic neuron. Schizophrenia is linked to excess dopamine, so antipsychotics such as chlorpromazine block dopamine receptors, and anxiety is treated with benzodiazepines that increase the calming effect of GABA. Because drugs directly change the biological cause, they are seen as the logical, appropriate treatment.

(b) Critically evaluate drug therapy **OR** psychosurgery. [10]

Drug therapy is effective for many patients. March et al. (2007) found that after 12 weeks 61% of depressed adolescents improved on fluoxetine compared with 35% on a placebo. However, Kirsch et al. (2008) found in a meta-analysis that antidepressants were only clinically better than placebos for the most severely depressed, suggesting much of their effect may be a placebo effect. Much drug research is funded by drug companies, so publication bias may exaggerate effectiveness.

Compared with other therapies, drugs are cheap, quick and need little effort from the patient, so they suit people who are too ill to engage with talking

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therapies. But they treat symptoms rather than causes, and relapse is common when medication stops, whereas CBT teaches lasting skills. March et al. found a combination of fluoxetine and CBT was best (71% improved), and CBT alone 43%, suggesting drugs work best alongside psychological therapy.

Ethically, side effects are a major issue: SSRIs can cause nausea, weight gain and sexual problems, and antipsychotics can cause tardive dyskinesia, so there is a risk of harm. Valid consent may be difficult because patients with severe disorders may lack capacity or be sectioned under the Mental Health Act and medicated against their wishes, and drugs can be used as a "chemical straitjacket". Dependency, e.g. on benzodiazepines, is also a concern.

Drugs also vary in effectiveness between individuals: around a third of patients with schizophrenia do not respond well to typical antipsychotics, and finding the right drug and dose can take weeks, while SSRIs often take several weeks to work, during which patients may feel worse.

Drug therapy is also reductionist, ignoring social and cognitive causes such as stressful life events. In conclusion, drugs are an effective, accessible first-line treatment for severe disorders, but because of side effects, consent issues and relapse they are best used together with psychological therapies.

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5. (a) Using examples from psychology, describe **one** assumption of the positive approach. [4]

One assumption is a focus on "the good life". Seligman (2002) argued psychology should study what makes life worth living, not just abnormality. He proposed three types of life. The pleasant life involves positive emotions about the past, present and future. The good life involves using our signature strengths (from the VIA classification, e.g. kindness, curiosity) in work, love and play to reach "flow" (Csikszentmihalyi), total absorption in a challenging task. The meaningful life involves using strengths in the service of something bigger than ourselves, e.g. family or community. Seligman claimed the good and meaningful lives bring longer-lasting happiness.

(b) Discuss **one** similarity between the positive and cognitive approaches. [4]

Both approaches have scientific status. The cognitive approach uses lab experiments, e.g. Loftus and Palmer, to study internal processes, and the positive approach measures happiness and strengths with standardised questionnaires and controlled studies (e.g. Seligman's interventions). This makes both more objective and testable than the psychodynamic approach,

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6. Describe the main components of the therapy you have studied from the cognitive approach (cognitive behavioural therapy **OR** rational emotive behaviour therapy). [10]

Cognitive behavioural therapy (CBT) assumes that faulty, irrational thinking causes maladaptive emotions and behaviour, so changing thoughts changes behaviour. It is usually short-term (around 6 to 20 sessions) and the client and therapist work collaboratively.

The cognitive element: first, the therapist helps the client identify negative automatic thoughts and faulty beliefs, e.g. Beck's negative triad (negative views of self, world and future) or cognitive distortions such as overgeneralisation and catastrophising. The client may keep a dysfunctional thought diary, recording the situation, the automatic thought, the emotion and its intensity. Through cognitive restructuring the therapist challenges these thoughts, asking questions such as "What is the evidence for this?", and replaces them with more rational, balanced thoughts.

The behavioural element: the client tests their beliefs in real life through reality testing and behavioural experiments. For example, a client who thinks "nobody likes me" might be set homework to start a conversation with a colleague and record the result, providing evidence against the belief. Other

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techniques include activity scheduling (planning rewarding activities to combat depression), graded exposure and role play, so new skills are practised between sessions.

For example, a depressed student who fails a test may think "I'm stupid, I'll never pass anything". In their thought diary they rate their sadness at 90%. The therapist uses Socratic questioning to point out past successes, and the student restructures the thought to "I didn't revise enough for this test, but I can improve", after which the sadness rating falls.

The therapeutic relationship is important: the therapist and client agree a problem list and goals at the start (collaborative empiricism), and each session follows a structure: agenda setting, review of homework, work on a specific problem and new homework. Progress is measured, for example with mood ratings or questionnaires such as the Beck Depression Inventory. The aim is for the client to become their own therapist, able to challenge negative

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thoughts independently, and the final sessions focus on relapse prevention.

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7. 'Loftus and Palmer's (1974) research has important and useful implications for society.'

With reference to the above statement, briefly explain the social implications of Loftus and Palmer's (1974) research '*Reconstruction of automobile destruction: an example of the interaction between language and memory*'. [5]

The statement is supported because Loftus and Palmer showed that leading questions distort eyewitness memory. Participants who heard "smashed" estimated 40.8 mph compared with 31.8 mph for "contacted", and a week later 16 out of 50 in the smashed group falsely recalled broken glass, compared with 7 in the hit group.

One implication is for police questioning: officers are trained to avoid leading questions, and the cognitive interview (Geiselman et al., 1985) uses open questions and free recall to get more accurate testimony. A second implication is for courts: eyewitness testimony should not be relied on alone, as the Devlin Report (1976) recommended, and juries should be warned about its unreliability. Misidentification is a factor in around 70% of DNA exonerations in the USA, so this research helps prevent wrongful convictions, which cost society in compensation, appeals and guilty people left free. It also raises awareness of leading questions in health and education, e.g. doctors interviewing patients or teachers questioning children about incidents.

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8. Describe the conclusions of Raine, Buchsbaum and LaCasse's (1997) research '*Brain abnormalities in murderers indicated by positron emission tomography*'. [6]

Raine et al. concluded that murderers pleading not guilty by reason of insanity (NGRI) have significant differences in glucose metabolism in certain brain areas compared with matched controls, supporting previous research linking these areas to aggression.

Reduced activity in the prefrontal cortex, parietal areas and corpus callosum, together with abnormal asymmetries in the amygdala, thalamus and hippocampus (less activity in the left than the right), may be one of many predispositions to violence in this group. Low prefrontal activity could mean poor self-control and impulsivity, and amygdala and hippocampus differences could affect fear and emotional responses.

They concluded that the neural processes underlying violence are complex and cannot be reduced to a single brain mechanism directly causing violence. They stressed what the results do not show: that violence is caused by biology alone (social, psychological and situational factors also matter); that NGRI murderers are not responsible for their actions; that PET can be used to diagnose violence; or a causal link between brain dysfunction and violence. The findings also cannot yet be generalised to other violent offenders, so independent replication and extension are needed.

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9. Evaluate mindfulness **OR** quality of life therapy in terms of its ethical considerations. [6]

Mindfulness is ethically positive because it promotes free will and empowerment: the client chooses to focus non-judgementally on the present moment and learns skills to manage their own wellbeing, rather than being a passive patient. It focuses on building strengths rather than labelling people as abnormal, avoiding the stigma of diagnosis.

It has a low risk of harm compared with drug therapy, which has side effects, or psychosurgery, which is irreversible. However, it is not risk-free: Britton et al. found some meditators experienced a "dark night" of anxiety, panic, depersonalisation or re-experienced trauma. This raises issues of informed consent, as clients may not be warned, and of competence, since many teachers and apps are unregulated, so vulnerable people (e.g. with psychosis or PTSD) should be screened.

Mindfulness is widely available and accessible to all, through free apps, NHS-recommended MBCT courses and group sessions, so it is cheap and fair. But this also means people may practise without professional support if problems arise. Overall it is an ethical therapy, provided clients are informed of possible negative effects and supervised appropriately.

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END OF PAPER

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5 (b)	though both study mental states that cannot be directly observed, so they still rely partly on self-report, which may be biased.

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