

Psychology: Theoretical Approaches and Application in Practice

Contents

Page

2. Perspectives in Psychology	
3. The Psychodynamic Perspective	
14. The Behavioural Perspective	
24. The Cognitive Perspective	
35. The Humanistic Perspective	
40. The Physiological or Biological Perspective	
45. The Socio-Cultural Perspective	
49. Contemporary Perspectives	
50. Positive Psychology	
54. Academic V's Applied Psychology	
55. Clinical Psychology	
75. Forensic Psychology	
107. Organisational Psychology	
134. Educational Psychology	
155. Health Psychology	
193. Theories of Human Growth and Development	
232. Bibliography	

Perspectives in Psychology

There are six major perspectives in psychology which are also referred to as models or approaches. Each approach involves assumptions about human behaviour and psychological functioning. The major perspectives are the Psychodynamic, Behavioural, Cognitive, Humanistic, Biological and Socio-cultural approaches or models. There may be different theories within each approach, but they all share some common assumptions.

Given the complexity of human behaviour and experience, it is not surprising that psychology has multiple pathways for approaching its subject matter. Most psychologists agree that no one perspective is fully able to explain human behaviour as each has its strengths and limitations and most disorders result from a combination of factors. Each approach has something unique to offer to our understanding of human behaviour but none offers a complete view. A contemporary holistic view however, is the Bio-psychosocial approach which assumes that biological, psychological and socio-cultural factors all combine and interact to produce psychological disorders.

An eclectic approach to understanding and treating human behaviour, one which draws and blends from theories, principles and therapies across the different perspectives is now used by many psychologists, practitioners and therapists.

Psychodynamic Perspective

Freud and Psychoanalysis

Sigmund Freud was the founder of psychoanalysis and the psychodynamic approach to psychology. Focused not only on the mind, but also on a region of the mind which he called the **unconscious**, Freud explained the unconscious as primitive sexual and aggressive drives or instincts and the impulses and urges that arise from those drives or instincts. He believed that the motives underlying our behaviour involve sexual and aggressive impulses that lie in the depths of the unconscious, hidden away from our ordinary awareness of ourselves.

Freud also believed that early childhood experiences play a determining role in shaping our personalities and behaviour, including abnormal behaviours. He held that abnormal behaviour patterns are rooted in unconscious conflicts originating in childhood. These conflicts involve a dynamic struggle within the unconscious mind between unacceptable sexual or aggressive impulses striving for expression and opposing mental forces seeking to keep this threatening material out of conscious awareness. Freud maintained that once these unconscious conflicts were brought into conscious awareness they could be resolved during the course of therapy.

The Tenets of Psychoanalysis

1. Inheritance and Childhood Events – a person's development is determined by often forgotten events in early childhood besides inherited traits.
2. Human attitude, mannerism, experience and thought are influenced by irrational drives.
3. Irrational drives are mostly unconscious
4. Defence mechanisms prevent people from seeing these irrational drives
5. Conflicts between the conscious and the unconscious can materialize in the form of mental or emotional disturbances
6. Liberating the elements of the unconscious is achieved through bringing this material into the conscious mind (therapeutic intervention)

Freud's psychoanalysis is the original psychodynamic theory, but the psychodynamic approach as a whole includes all theories that were based on his ideas including the works of Jung (1964), Adler (1927) and Erikson (1950).

Freud's psychoanalysis is both a theory and a therapy. The words 'psychodynamic' and 'psychoanalytic' are often confused. Freud's theories were psychoanalytic. However, the term 'psychodynamic' refers to both his theories and those of his followers.

Freud's Theories of Psychosexual Development

One of Freud's more famous theories is that of psychosexual development. He said that as children we move through a series of stages centred on erogenous zones. Successful completion of these stages, Freud argued, led to the development of a healthy personality, but fixation at any stage prevents completion and therefore the development of an unhealthy, fixated personality as an adult.

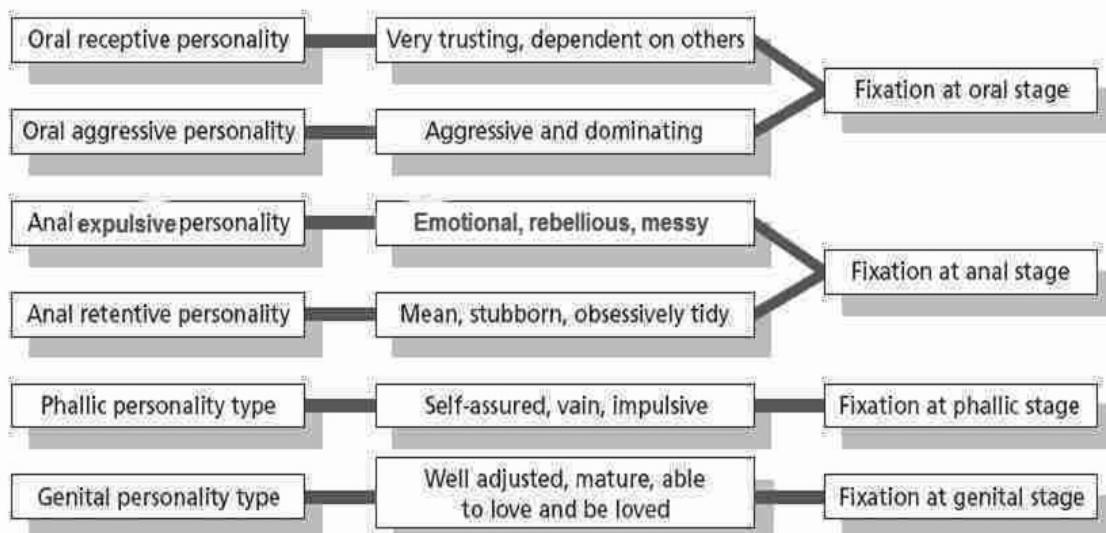
1. **Oral Stage (Birth to 18 Months):** Child becomes focused on oral pleasures such as sucking. Difficulties at this stage could lead to an oral personality in adulthood centred around smoking, drinking alcohol, biting nails and they can be pessimistic, gullible and overly dependent on others.
2. **Anal Stage (18 months to 3 Years):** Focus of pleasure here is on eliminating and retaining faeces and learning to control this due to societal norms. Fixation here can lead to perfectionism, a need to control or alternatively the opposite; messy and disorganised.
3. **Phallic Stage (Ages 3 to 6 Years):** During the phallic stage the child's pleasure move to the genitals and Freud argued that during this stage boys develop an unconscious sexual desire for their mothers and fear that because of this their fathers will punish them by castration. This became known as the Oedipus Complex after the Sophocles tragedy. A fixation at the stage could lead to confusion over sexual identity or engaging in sexual deviances.
4. **Latency Stage (Ages 6 to puberty):** Sexual urges remain largely repressed at this stage.

5. **Genital Stage (Puberty Onwards):** This final stage leads to the individual switching their interest to members of the opposite sex.

According to Freud, the development of personality occurs through a five-stage sequence of psychosexual development.

Freud's Psychosexual Stages

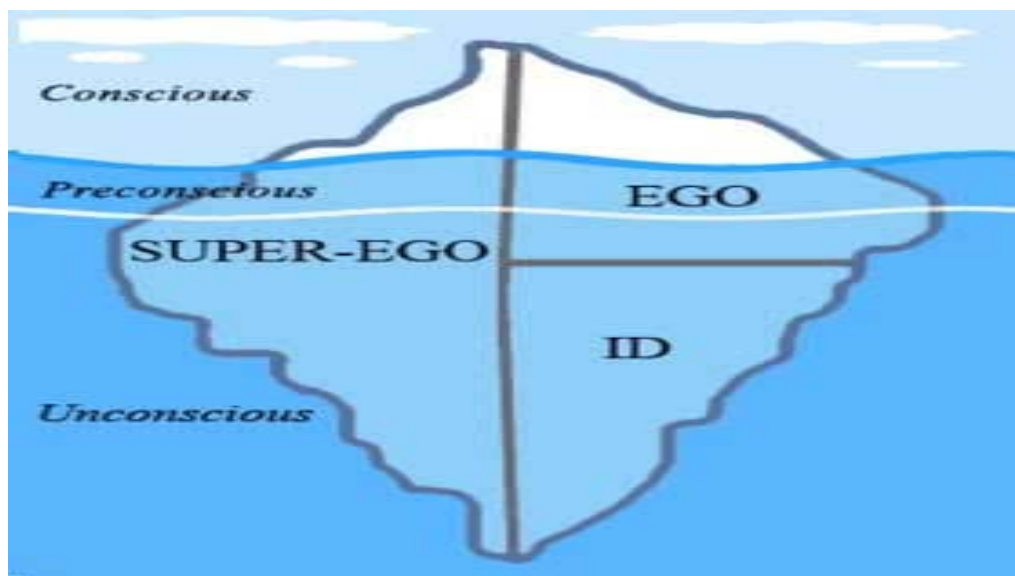
Stage	Focus
Oral (0-18 months)	Pleasure centers on the mouth--sucking, biting, chewing
Anal (18-36 months)	Pleasure focuses on bowel and bladder elimination; coping with demands for control
Phallic (3-6 years)	Pleasure zone is the genitals; coping with incestuous sexual feelings
Latency (6 to puberty)	Dormant sexual feelings
Genital (puberty on)	Maturation of sexual interests



In his later work, Freud proposed that the human psyche could be divided into three parts: Id, Ego and Superego. Freud discussed this model in the 1920 essay 'Beyond the Pleasure Principle', and elaborated upon "The Ego and the Id" (1923).

Id, Ego and Superego

Freud believed that the human mind was structured into three parts (tripartite), the id, ego and superego, all developing at different stages in our lives.



The Id (or it)

The **id** consists of the inherited (biological) components of personality, including the instinct **Eros** (libido), and **Thanatos** (aggression).

The id is the impulsive and unconscious part of our psyche which responds directly and immediately to instincts. The id demands immediate satisfaction and when this happens pleasure is experienced, but when it is denied we experience the opposite. The id is not affected by reality, logic or the everyday world. It operates on the **pleasure principle** which is the idea that every wishful impulse should be satisfied immediately, regardless of the consequences.

The Ego (or I)

The **ego** is “that part of the id which has been modified by the direct influence of the external world” (Freud 1923). The ego develops in order to mediate between the unrealistic id and the external real world.

Ideally the ego works by reason whereas the id is chaotic and totally unreasonable. The ego operates according to the reality principle, working out realistic ways of satisfying the id's demands, often compromising or postponing satisfaction.

Like the id, the ego seeks pleasure and avoids pain but unlike the id it is concerned with devising a realistic strategy to obtain pleasure. Often the ego is weak relative to the head-strong id. The ego has no concept of right or wrong; something is good simply if it achieves its end of satisfying without causing harm to itself or the id.

The Superego

The superego incorporates the values and morals of society which are learned from one's parents and others. It develops around the age of 4 – 5 during the phallic stage of psychosexual development. The superego's function is to control the id's impulses, especially those which society forbids, such as sex and aggression. It also has the function of persuading the ego to turn to moralistic goals rather than simply realistic ones and to strive for perfection. The superego consists of two systems: The conscience and the ideal self. The conscience can punish the ego through feelings of guilt and if the ego gives in to the id's demands the superego may make the person feel bad though guilt. The ideal self (or ego-ideal) is an imaginary picture of how one ought to be, and represents career aspirations, how to treat other people, and how to behave as a member of society.

Behaviour which falls short of the ideal self may be punished by the superego through guilt. The super-ego can also reward us through the ideal self when we behave ‘properly’ by making us feel proud. If a person's ideal self is too high then whatever the person does will represent failure. The ideal self and conscience are largely determined in childhood from parental values and how you were brought up.

Freud stated that in healthy individuals the ego is doing a good job in balancing out the needs of these two parts of the psyche, however in those where one of the other parts is dominant the individual struggles and problems develop in the personality. The balancing act between these two aspects of the psyche can sometimes be difficult for the ego and so it employs a variety of different tools to help mediate known as defence mechanisms. Examples of defence mechanisms are:

- **Displacement:**
- **Projection:**
- **Sublimation:**
- **Denial:**
- **Repression:**

Defence Mechanisms

Mechanism	Description	Example
Repression	Repression is an unconscious mechanism employed by the ego to keep disturbing or threatening thoughts from becoming conscious.	During the Oedipus complex aggressive thoughts about the same sex parents are repressed
Denial	Denial involves blocking external events from awareness. If some situation is just too much to handle, the person just refuses to experience it.	For example, smokers may refuse to admit to themselves that smoking is bad for their health.
Projection	This involves individuals attributing their own unacceptable thoughts, feeling and motives to another person.	You might hate someone, but your superego tells you that such hatred is unacceptable. You can 'solve' the problem by believing that they hate you.
Displacement	Satisfying an impulse (e.g. aggression) with a substitute object.	Someone who is frustrated by his or her boss at work may go home and kick the dog,
Regression	This is a movement back in psychological time when one is faced with stress.	A child may begin to suck their thumb again or wet the bed when they need to spend some time in the hospital.
Sublimation	Satisfying an impulse (e.g. aggression) with a substitute object. In a socially acceptable way.	Sport is an example of putting our emotions (e.g. aggression) into something constructive.

Freud experimented with a number of therapeutic techniques including hypnosis, free association, dream analysis transference and catharsis.

Modern Day Psychoanalysis

Although Freud's main theories have been subjected to criticism much of his work remains central to some of our most fundamental understandings of psychology, counselling and psychotherapy. The use of free association, transference and counter-transference, dream analysis, defence mechanisms and the unconscious mind are all of immense value to modern day psychodynamic and psychoanalytical practice.

Freud's theories radically altered the way that people understood the mind back in the 1900's, and his development of the "talking cure" cannot be underestimated. Freud's initial investigations and clinical practice are to psychology and psychiatry, as Newton is to physics. While we have in some respects rejected some of his theories in light of new evidence it was his ideas which provided a platform for other psychologists, philosophers, therapists and doctors to build on and explore.

Classical psychoanalysis was extremely lengthy. Freud preferred to see clients six times a week, and even 'mild' cases were seen for three sessions a week. In addition, because psychoanalysis used free association to bring insight into the clients' problems, and there may be weeks or even months between sessions in which significant insights were attained, analysis took many months or even years. More recent versions of psychoanalysis tend to be shorter, typically lasting fewer than twenty five sessions. They have three distinct phases: beginning, an active phase, and termination. Beginning involves assessment, developing a therapeutic alliance and preparing the client for therapy. In the active phase, the therapist determines the direction of therapy and the issues addressed within it. Strategies may involve the use of interpretation of current feelings in terms of past experiences, and the elicitation of emotions experienced at the time of any trauma. Issues of transference are deliberately minimized, for example, by discouraging client dependence. The end of therapy is a negotiated process, in which issues of loss and separation are considered and dealt with.

Psychodynamic Approach Criticisms

The greatest criticism of the psychodynamic approach is that it is unscientific in its analysis of human behaviour. Many of the concepts central to Freud's theories are subjective and as such impossible to scientifically test. In this respect the psychodynamic perspective is un-falsifiable as the theories cannot be empirically investigated. Most of the evidence for psychodynamic theories is taken from Freud's case studies (e.g. Little Hans, Anna O). The main problem here is that the case studies are based on studying one person in detail, and with reference to Freud the individuals in question are most often middle aged women from Vienna (i.e. his patients). This makes generalizations to the wider population difficult. The humanistic approach makes the criticism that the psychodynamic perspective is too deterministic, leaving little room for the idea of personal agency (free will).

Psychodynamic Approach Summary

Key Features	Methodology
• Collective Unconscious (Carl Jung) • Psychosexual Development (Freud) • Unconscious Mind (Freud) • Psyche (Freud) • Defence Mechanisms (Freud) • Psychosocial Development	• Case Study (Little Hans) • Dream Analysis • Free Association • Projective Tests (TAT, Rorschach) • Slips of the Tongue (parapraxes) • Hypnosis
Basic Assumptions	Areas of Application
• The major causes of behaviour have their origin in the unconscious. • Psychic determinism: all behaviour has a cause/reason. • Different parts of the unconscious mind are in constant struggle. • Our behaviour and feelings as adults (including psychological problems) are rooted in our childhood experiences.	• Gender Role Development • Therapy (Psychoanalysis) • Attachment (Bowlby) • Moral Development (super-ego) • Aggression (Displacement / Thanatos) • Personality (Erikson, Freud) • Highlighted the importance of the unconscious mind • Dream analysis
Strengths	Limitations
• Made the Case Study method popular in psychology • Defence Mechanisms • Free association • Projective Tests (TAT, Rorschach) • Highlighted the importance of Childhood	• Case Studies - Subjective / Cannot generalize results • Unscientific (lacks empirical support) • Too Deterministic (little free-will) • Biased Sample • Ignores Meditational Processes (e.g. thinking, memory) • Rejects Free will • Un-falsifiable (difficult to prove wrong)

Bibliography

Adler, A. (1927). *Understanding Human Nature*. New York: Greenburg.

Bennett, P (2007) *Abnormal Clinical Psychology; An Introductory Textbook* (Second edition). Maidenhead: Open University Press

Baltes, P. B., Reese, H., & Lipsett, L. (1980) *Lifespan developmental psychology*, *Annual Review of Psychology* 31: 65 – 110.

Buskist, W, C. Heth, C. Schmaltz, R. (2010) *Psychology: The Science of Behaviour*, Fourth Edition. Oxford University Press

Darwin, C. (1877). *A Biographical Sketch of an Infant*. *Mind*, 2, 285-294.

Eysenck, M.W. (2000) *Psychology: A Students Handbook*. New York; Psychology Press

Feldman, D, E. Papalia, R, D,(2010). *A child's world: infancy through adolescence* (12th ed. ed.). New York: McGraw-Hill. p. 57. ISBN 9780073532042.

Freud, S. (1962). *Three Essays on the Theory of Sexuality*. New York: Basic Books.

Freud, A. (1936). *Ego & the mechanisms of defense*.

Freud, S., & Breuer. J. (1895). *Studies on hysteria*. In *Standard edition* (Vol. 2, pp. 1–335).

Freud, S. (1896). *Heredity and the etiology of the neuroses*. In *Standard edition* (Vol. 3, pp. 142–156).

Freud, S. (1900). *The interpretation of dreams*. In *Standard edition* (Vols. 4 & 5, pp. 1–627).

Freud, S. (1909). *Notes upon a case of obsessional neurosis*. In *Standard edition* (Vol. 10, pp. 153–249).

Freud, S. (1909). *Analysis of a phobia of a five year old boy*. In *The Pelican Freud Library* (1977), Vol 8, *Case Histories* 1, pages 169-306

<http://www.harleytherapy.co.uk/counselling/freuds-main-theories-psychoanalysis.htm#ixzz3aJNKONax>

Jarvis, M. (2000). Theoretical approaches in psychology. London: Routledge

Kline, P. (1989). Objective tests of Freud's theories. Psychology Survey, 7, 127-45.

Lerner, R. M. (2002). Concepts and theories of human development. Mahwah, NJ: Erlbaum

McLeod, S. "Psychosexual Stages". Simply Psychology.
<http://www.simplypsychology.org/psychodynamic.html>

McLeod, S. "Developmental Psychology". Simply Psychology.
<http://www.simplypsychology.org/psychodynamic.html>

McLeod, S. A. (2007). Psychodynamic Approach.
<http://www.simplypsychology.org/psychodynamic.html>

Minsky, R. (1998). Psychoanalysis and culture. Cambridge, UK: Polity Press.

Myers, D. (1998) Psychology, fifth edition, New York; Worth publishers

Myers, D. (2002) Exploring Psychology, fifth edition, New York; Worth publishers

Myers, D. (2008). Exploring Psychology. Worth Publishers. ISBN 1-57259-096-3.

Newman, B, M. Newman, P. R. (2011). Development Through Life : A Psychosocial Approach. Belmont, CA: Wadsworth Cengage Learning. pp.215-217. ISBN 111134468X

Sulloway, F. J. (1991). Reassessing Freud's case histories: The social construction of psychoanalysis. Isis, 82(2), 245-275.

Thurschwell, P. (2000). Sigmund Freud. London: Routledge.

Upton, P, (2011). Developmental Psychology: Critical Thinking in Psychology. Exeter: Learning Matters. p. 62. ISBN 0857252763.

The Behavioural Perspective

Behaviourism also called the behavioural approach or perspective was the primary paradigm in psychology between 1920s and 1950s and is based on a number of underlying assumptions regarding methodology and behavioural analysis. Though traditional behaviourism continues to influence modern psychology, it is no longer the dominant force it was in the early to mid-1900s.

The behavioural perspective focuses on observable behaviour and the important role of learning in behaviour. However, many psychologists believe that traditional behaviourism is too simplistic or limited to explain complex human behavior. Psychologists today adopt a broader, learning-based perspective called the social-cognitive theory (formerly called *social-learning theory*). This perspective originated in the 1960s with a group of learning theorists who broke away from traditional behaviourism. They believed that behaviour is shaped not only by environmental factors, such as rewards and punishments, but also by cognitive factors, such as the value placed on different objects or goals and expectancies about the outcomes of behaviour.

The behavioural perspective led to the development of behaviour therapy which involves the systematic application of learning principles that are grounded in the behaviourist tradition of Watson and Skinner. Today, many behaviour therapists subscribe to a broader therapeutic approach, called cognitive-behavioral therapy, which incorporates techniques for changing maladaptive thoughts as well as overt behaviours.

The History of Behaviourism

- **Pavlov** (1897) published the results of an experiment on conditioning after originally studying salivation in dogs.
- **Watson** (1913) launches the behavioural school of psychology (classical conditioning), publishing an article, "Psychology as the behaviourist Views It".
- **Watson and Rayner** (1920) conditioned an orphan called Albert B (aka Little Albert) to fear a white rat.
- **Thorndike** (1905) formalized the "*Law of Effect*".
- **Skinner** (1936) wrote "The behaviour of Organisms" and introduced the concepts of operant conditioning and shaping.
- **Clark Hull's** (1943) *Principles of behaviour* published.
- **B.F. Skinner** (1948) published *Walden Two* in which he described a utopian society founded upon behaviourist principles.
- **Bandura** (1963) publishes a book called the "*Social leaning theory and personality development*" which combines both cognitive and behavioural frameworks.
- Journal of the *Experimental Analysis of Behaviour* (begun in 1958)
- **B.F. Skinner** (1971) published his book *Beyond Freedom and Dignity*, where he argues that free will is an illusion.

Classical Conditioning (Pavlov)

During the 1890s Russian physiologist Ivan Pavlov was looking at salivation in dogs in response to being fed, when he noticed that his dogs began to salivate whenever he entered the room, even when he was not bringing them food.

Pavlov started from the idea that there are some things that a dog does not need to learn. For example, dogs don't learn to salivate whenever they see food. This reflex is 'hard wired' into the dog. In behaviourist terms, it is an unconditioned response (i.e. a stimulus-response connection that required no learning). In behaviourist terms, we write: **Unconditioned Stimulus (Food) > Unconditioned Response (Salivate)**

Pavlov showed the existence of the unconditioned response by presenting a dog with a bowl of food and the measuring its salivary secretions. However, when Pavlov discovered that any object or event which the dogs learnt to associate with food (such as the lab assistant) would trigger the same response, he realized that he had made an important scientific discovery.

Pavlov knew that somehow, the dogs in his lab had learned to associate food with his lab assistant. This must have been learned, because at one point the dogs did not do it, and there came a point where they started, so their behaviour had changed. A change in behaviour of this type must be the result of learning.

In behaviourist terms, the lab assistant was originally a neutral stimulus. It is called neutral because it produces no response. What had happened was that the neutral stimulus (the lab assistant) had become associated with an un-conditioned stimulus (food).

In his experiment, Pavlov used a bell as his neutral stimulus. Whenever he gave food to his dogs, he also rang a bell. After a number of repeats of this procedure, he tried the bell on its own. The bell on its own now caused an increase in salivation.

The dog had learned an association between the bell and the food and a new behaviour had been learnt. Because this response was learned (or conditioned), it is

called a conditioned response. The neutral stimulus has become a conditioned stimulus:

Pavlov and his studies of classical conditioning have become famous since his early work (1890-1930). Classical conditioning is "classical" in that it is the first systematic study of basic laws of learning / conditioning.

John Watson proposed that the process of classical conditioning (based on Pavlov's observations) was able to explain all aspects of human psychology.

Classical conditioning involves learning a new behaviour through the process of association. In simple terms two stimuli are linked together to produce a new learned response in a person or animal. There are three stages to classical conditioning. In each stage the stimuli and responses are given special scientific terms:

Stage 1: Before Conditioning:

In this stage, the unconditioned stimulus (UCS) produces an unconditioned response (UCR) in an organism. In basic terms this means that a stimulus in the environment has produced a behaviour or response which is unlearned (i.e. unconditioned) and therefore is a natural response which has not been taught. In this respect no new behaviour has been learned yet. This stage also involves another stimulus which has no affect on a person and is called the neutral stimulus (NS). The NS could be a person, object, place etc. The neutral stimulus in classical conditioning does not produce a response until it is paired with the unconditioned stimulus.

Stage 2: During Conditioning:

During this stage a stimulus which produces no response (i.e. neutral) is associated with the unconditioned stimulus at which point it now becomes known as the conditioned stimulus (CS). Often during this stage the UCS must be associated with the CS on a number of occasions, or trials, for learning to take place. However, one trial can happen on certain occasions when it is not necessary for an association to be strengthened over time.

Stage 3: After Conditioning:

Now the conditioned stimulus (CS) has been associated with the unconditioned stimulus (UCS) to create a new conditioned response (CR).

Skinner: Operant Conditioning

By the 1920s John B. Watson had left academic psychology and other behaviourists were becoming influential, proposing new forms of learning other than classical conditioning. Perhaps the most important of these was B.F. Skinner.

Skinner's views were slightly less extreme than those of Watson. Skinner believed that we do have such a thing as a mind, but that it is simply more productive to study observable behaviour rather than internal mental events.

Skinner believed that the best way to understand behaviour is to look at the causes of an action and its consequences. He called this approach operant conditioning.

Skinner is regarded as the father of Operant Conditioning, but his work was based on Thorndike's law of effect. If the response in a connection is followed by a satisfying state of affairs, the strength of the connection is considerably increased whereas if followed by an annoying state of affairs, then the strength of the connection is marginally decreased. The second contribution was his rejection of the notion that man is simply another animal that can reason. He believed intelligence should be defined solely in terms of greater or lesser ability to form connections).

Skinner introduced a new term into the Law of Effect called **Reinforcement**. Behaviour which is reinforced tends to be repeated (strengthened); behaviour which is not reinforced tends to die out-or be extinguished (weakened).

Skinner (1948) studied operant conditioning by conducting experiments using animals which he placed in a "*Skinner Box*" which was similar to Thorndike's puzzle box.

B.F. Skinner (1938) coined the term operant conditioning; it means roughly changing of behaviour by the use of reinforcement which is given after the desired response. He identified three types of responses or operant's that can follow behaviour.

- **Neutral operant:** responses from the environment that neither increase nor decrease the probability of a behaviour being repeated.

- **Reinforcers:** Responses from the environment that increase the probability of a behaviour being repeated. They can be either positive or negative.
- **Punishers:** Response from the environment that decrease the likelihood of a behaviour being repeated. Punishment weakens behaviour.

Positive Reinforcement

Skinner showed how positive reinforcement worked by placing a hungry rat in his Skinner box. The box contained a lever in the side and as the rat moved about the box it would accidentally knock the lever. Immediately it did a food pellet would drop into a container next to the lever.

The rats quickly learned to go straight to the lever after a few times of being put in the box. The consequence of receiving food if they pressed the lever ensured that they would repeat the action again and again.

The removal of an unpleasant reinforcement also strengthens behaviour. This is known as negative reinforcement because it is the removal of an adverse stimulus which is 'rewarding' to the animal. Negative reinforcement strengthens behaviour because it stops or removes an unpleasant experience.

Negative Reinforcement

Skinner showed how negative reinforcement worked by placing a rat in his Skinner box and subjecting it to an unpleasant electric current which caused it some discomfort. As the rat moved about the box it would accidentally knock the lever. Immediately it did so the electric current would be switched off. The rats quickly learned to go straight to the lever after a few times of being put in the box. The consequence of escaping the electric current ensured that they would repeat the action again and again.

Skinner even taught the rats to avoid the electric current by turning on a light just before the electric current came on. The rats soon learned to press the lever when

the light came on because they knew that this would stop the electric current being switched on. These two learned responses are known as escape learning and avoidance learning.

It is not always easy to distinguish between punishment and negative reinforcement.

Punishment weakens behaviour. Punishment is defined as the opposite of reinforcement since it is designed to weaken or eliminate a response rather than increase it. Like reinforcement, punishment can work either by directly applying an unpleasant stimulus such as a shock after a response or by removing a potentially rewarding stimulus to punish undesirable behaviour.

Negative Reinforcement strengthens behaviour because a negative condition is stopped or avoided as a consequence of the behaviour. Punishment, on the other hand, weakens behaviour because a negative condition is introduced or experienced as a consequence of the behaviour.

The Behavioural Approach

Key Features

- Stimulus --> Response
- Classical Conditioning & Operant Conditioning
- Reinforcement & Punishment (Skinner)
- Objective Measurement
- Social Learning Theory (Bandura)
- Nomothetic
- Reductionism

Lab Experiments

- Little Albert
- Edward Thorndike(the cat in a puzzle box)
- Skinner box (rats & pigeons)
- Pavlov's Dogs
- Bandura's Bobo Doll
- Ethical Considerations

Basic Assumptions

- Psychology should be seen as a science, to be studied in a scientific manner.
- Behaviourism is primarily concerned with observable behaviour, as opposed to internal events like cognition and thinking.
- Behaviour is the result of stimulus – response (i.e. all behaviour, no matter how complex, can be reduced to a simple stimulus – response features).
- Behaviour is determined by the environment (e.g. conditioning).

Areas of Development

- Gender Role Development
- Behavioural Therapy
- Phobias
- Behavioural-Modification
- Aversion Therapy
- Scientific Methods
- Relationships
- Language
- Moral Development
- Aggression
- Addiction

Strengths

- Scientific
- Highly applicable (e.g. therapy)
- Emphasizes objective measurement
- Many experiments to support theories
- Identified comparisons between animals (Pavlov) and humans (Watson & Rayner - Little Albert)

Limitations

- Ignores meditational processes
- Ignores biology
- Too deterministic (little free-will)
- Experiments – low ecological validity
- Humanism – can't compare animals to humans
- Reductionist

Reductionism can be defined as the breaking down of a complex phenomenon into simpler components (Biology). There are many arguments against reductionism in psychology. One of the most predominant arguments is the involvement of environmental factors in shaping our behaviour.

Critical Evaluation

Humanism rejects the scientific method of using experiments to measure and control variables because it creates an artificial environment and has low ecological validity.

Ecological Validity is the degree to which the behaviours observed and recorded in a study reflect the behaviours that actually occur in natural settings. In addition, ecological validity is associated with "generability". Essentially this is the extent to which findings (from a study) can be generalized (or extended) to the "real world".)

Humanism also rejects the nomothetic approach of behaviourism as they view humans as being unique and believe humans cannot be compared with animals. This is known as an idiographic approach. Humanistic psychology also assumes that humans have free will (personal agency) to make their own decisions in life and do not follow the deterministic laws of science.

The psychodynamic approach criticizes behaviourism as it does not take into account the unconscious mind's influence on behaviour, and instead focuses on external observable behaviour. Freud rejects that idea that people are born a blank slate (tabula rasa) and states that people are born with instincts.

Biological perspective views that gene's, chromosomes neurotransmitters and hormones influence our behaviour too, in addition to the environment and the

cognitive approach views that mediation processes occur between stimulus and response, such as memory, thinking and problem solving.

Bibliography

Bennett, P (2007) Abnormal Clinical Psychology; An Introductory Textbook (Second edition). Maidenhead: Open University Press

Bandura, A., & Walters, R. H. (1963). Social learning and personality development. New York: Holt, Rinehart, & Winston.

Eysenck, M.W. (2000) Psychology: A Students Handbook. New York; Psychology Press

Hull, C. L. (1943). Principles of Behaviour: An Introduction to Behaviour Theory. New York: Appleton-Century-Crofts.

Myers, D. (1998) Psychology ,fifth edition, New York; Worth publishers

Myers, D. (2002) Exploring Psychology, fifth edition, New York; Worth publishers

Pavlov, I. P. (1897). The Work Of The Digestive Glands. London: Griffin

Skinner, B. F. (1938). The behaviour of Organisms: An Experimental Analysis. New York: Appleton-Century

Skinner, B. F. (1948). 'Superstition' in the pigeon. Journal of Experimental Psychology, 38, 168-172.

Skinner, B. F. (1971). Beyond Freedom and Dignity. New York: Knopf.

Slater, L. (2004). Opening Skinner's box: Great psychological experiments of the twentieth century. New York: Norton

Thorndike, E. L. (1905). The elements of psychology. New York: A. G. Seiler.

Watson, J. B. (1913). Psychology as the behaviourist views it, Psychological Review, 20, 158-178.

Watson, J. B. (1930). *Behaviourism* (revised edition). University of Chicago Press.

Watson, J. B., & Rayner, R. (1920). Conditioned emotional reactions. *Journal of Experimental Psychology*, 3, 1, pp. 1–14

The Cognitive Perspective

Throughout the 1950s there was a shift in emphasis from behaviourist's stimulus–response relationships to an approach that attempts to explain behaviour in terms of the mind. The cognitive approach began to revolutionize psychology in the late 1950's and early 1960's, to become the dominant approach in psychology by the late 1970s. Several factors were important in this: Dissatisfaction with the behaviourist approach in its simple emphasis on external behaviour rather than internal processes: The development of better experimental methods and: Comparison between human and computer processing of information. Cognitive psychologists study people's mental processes in an effort to understand how people gain knowledge about themselves and the world around them. It focuses on the way human's process information and internal processes including perception, attention, language, memory and thinking.

Ulric Neisser is credited with formally having coined the term "cognitive psychology" in his book *Cognitive Psychology*, published in 1967.

In the 1950's, psychologist Albert Ellis, and psychiatrist Aaron Beck, independently developed two very similar theories. Both of these theories resulted in effective forms of cognitive therapy and continue to be widely practiced today. While behavioural learning theory emphasizes the role of the environment, cognitive theory emphasizes the key role of the mind's cognitions in determining behaviour. These cognitions include a person's thoughts, feelings, beliefs, and perceptions.

Cognitive Therapy

According to the behavioural model, psychological disorders involve maladaptive behaviour which has been learned via conditioning or observational learning and treatment should be based on conditioning or relearning. The behavioural model and

therapy focuses on external stimuli and responses, and ignores the cognitive processes (thoughts /beliefs) happening between stimulus and response.

This omission was dealt with in the early 1960's with the introduction of cognitive therapy, based on the assumption that successful treatment can involve changing or restructuring clients cognitions or thought processes. Ellis (1962) was one of the first therapists to put forward a version of cognitive therapy.

Ellis's A B C Model

Ellis argued that anxiety and depression occur as the end point in a 3 point sequence.

- (A); **Activating** event (Antecedent)
- (B); **Beliefs**
- (C); **Consequences** of our beliefs.

The ABC model shows that **A** does not cause **C**. It is **B** that causes **C**. According to the ABC model, anxiety and depression are not a consequence (C) of unpleasant events (antecedent) (A). Instead these negative mood states (C) are produced by the irrational thoughts or beliefs (B) that follow from the occurrence of unpleasant events (A). The interpretations that are produced at point (C) depend on the individual's belief system (B).

In 1962 Ellis developed rational-emotive therapy as a way of removing irrational and self-defeating thoughts and replacing them with more rational and positive ones. He argued that individuals who are anxious or depressed should create a point D. This is a dispute belief system that allows them to interpret life's events in ways that do not cause them emotional distress.

Rational Emotive Therapy

Rational emotive therapy starts with the therapist making clients aware of the self-defeating nature of many of their beliefs. Clients are then encouraged to ask themselves searching questions about these beliefs in order to discover whether they are rational and logical. For example clients may be told to ask themselves the

questions such as “Why do I have to be liked by everybody“. “Does it really matter if I am not competent in every way?”

After this client’s are asked to replace their irrational beliefs with more realistic ones e.g. “It is impossible to be liked by everybody, but most people like me”. “I will strive to be fairly competent, and accept that perfection cannot always be achieved”. The crucial final step is for patients to have full acceptance of these new rational beliefs.

Aaron Beck- The Cognitive Triad

Aaron Beck is probably the most influential cognitive therapist. He developed forms of cognitive therapy for anxiety, but is better known for his work on depression. Beck (1976) argued that therapy for depression should involve uncovering and challenging the negative and unrealistic beliefs of depressed clients. Of great importance is the cognitive triad. The cognitive triad consists of negative thoughts about;

- **Themselves**
- **The World**
- **The Future**

Depressed clients typically regard themselves as helpless, worthless, and inadequate. They interpret events in the world in an unrealistically negative and defeatist way, and they see the world as posing obstacles that cannot be handled. The final part of the cognitive triad involves depressed individuals seeing the future as totally hopeless, because their worthlessness will prevent any improvement in their situation.

Cognitive Therapy

The first stage of cognitive therapy involves the therapist and the client agreeing on the nature of the problem and on the goals for therapy. This stage is called collaborative empiricism. The client’s negative thoughts are then tested out by the therapist challenging them or by the client engaging in certain forms of behaviour between therapy sessions. It is hoped that the client will come to accept that many of his/her negative thoughts are irrational and unrealistic.

Cognitive Behavioural Therapy

In recent years, there have been increasing efforts to add some of the more successful features of behaviour therapy to cognitive therapy. This combination is referred to as cognitive behavioural therapy. The goal of cognitive behavioural therapy is primarily one of cognitive change, although through the use of both behavioural and cognitive techniques.

CBT suggests that problems are often of your own making. That is, it is not the situation itself that makes you unhappy, but how you think about, and react to, the situation. CBT has a number of elements;

- Its primary goal is to change cognitive distortions.
- It is usually short term
- It maintains a large behavioural component
- It is directive
- Therapy focuses on the here and now
- It focuses on skills to help individuals cope better with their emotional problems
- CBT is one of the most effective treatments for conditions where anxiety or depression is the main problem
- It is the most effective psychological treatment for moderate and severe depression
- It is as effective as antidepressants for many types of depression.

Cognitive behavioural therapy (CBT) differs from most other types of therapies in a number of ways. These are;

- **Pragmatic** - CBT helps identify specific problems and then an attempt is made to solve them.
- **Highly structured** - rather than talking freely about their life, the individual and the therapist will discuss the specific problems and set goals for the client to achieve. As part of this, the client may be given homework in the form of activities that they should try to complete before the next therapy session.
- **Concerned with the present** - unlike some other therapies that attempt to explore and possibly resolve past issues, CBT is mainly concerned with how individuals think and act now.

- **Collaborative** - the CBT therapist will not tell the individual what to do; they will work with the client in order to help them to improve their situation.

A course of CBT therapy can comprise of 5-20 weekly sessions, with each session lasting between 30-60 minutes. The initial sessions will be spent breaking down what appears to be an insolvable problem, into smaller parts. One way to do this is to consider a certain situation, and then see how it affects the individual's thoughts, emotions, physical feelings, and actions.

Cognitive Techniques

- **Self instruction training:** this involves interrupting the flow of stress or negative emotion provoking thoughts by replacing them with pre-prepared realistic or coping ones.
- **Cognitive challenge-Socratic method or guided discovery:** this involves the therapist helping the client to identify distorted patterns of thinking that are contributing to their problems by directly challenging their assumptions. One technique developed to identify and challenge core beliefs is the downward arrow technique. Key questions include;
 - What is your concern about....?
 - What would the implications be...?
 - What would the consequences be....?
 - What would the ultimate consequences be....?

Behavioural Strategies

Two commonly used behavioural strategies used in depression are behavioural activation and behavioural challenge.

- **Behavioural activation** is usually targeted at people who are significantly depressed, and involves increasing levels of activity in a planned progressive manner.
- **Behavioural challenge** involves setting up behavioural experiments within the therapy session or as homework that directly test the cognitive beliefs that

clients hold, in the expectation that negative beliefs are disconfirmed and more positive ones affirmed.

Relaxation Techniques

The relaxation process most commonly taught is a derivative of Jacobson's deep muscle relaxation technique. This involves alternately tensing and relaxing muscle groups, throughout the body in an ordered sequence. As the client becomes more skilled, the emphasis of practice shifts towards relaxation without prior tension.

Computerised CBT

There are cognitive-behavioural therapy sessions in which the user interacts with computer software, instead of face to face with a therapist. It cannot replace face-to-face therapy, but it can provide an option for patients, especially in light of the fact that there are not always therapists available, or the cost can be prohibitive. Computerized CBT is clinically proven and drug-free. For people who are feeling depressed and withdrawn, the prospect of having to speak to someone about their innermost problems can be off-putting. In this respect, CCBT can be a good option.

Cognitive Therapies- Cognitive Analytic Therapy (CAT)

One increasingly popular approach is known as Cognitive Analytic Therapy (CAT). Cognitive analytic therapy is a short-term therapy developed by Dr. Anthony Ryle and is used in the treatment of a range of disorders and difficulties such as depression, anxiety, personal and relationship problems and is particularly used for the treatment of personality disorders.

It is an integrative therapy, drawing on psychodynamic and cognitive therapies. The main goal of CAT is to help individuals identify the pattern of repetitive sequences that has resulted in low mood or personal problems and then to develop alternative sequences to avoid these problems. CAT focuses its attention on discovering how problems have evolved and how the procedures devised to cope with them may be ineffective. It is designed to enable clients to gain an understanding of how the difficulties they experience may be made worse by their habitual coping

mechanisms. The focus is on recognising how these coping procedures originated and how they can be adapted and improved.

Cognitive Analytic Therapy is time limited. The duration of therapy usually ranges from four to twenty four sessions (average of sixteen). It can be used in the treatment of individuals and couples. As it is a cognitive therapy, it makes full use of the client's capacity to observe and think about themselves, their assumptions, feelings and behaviours, so they begin to understand what is hindering them from moving forward and resolving their difficulties. It is also an analytical therapy and unconscious factors are explored and their impact is recognised.

CAT therapy has four phases;

- 1) **Information gathering** which involves gathering information about the individual, their procedural sequences and coping strategies.
- 2) **Reformulation:** The therapist provides the client with a written account of their understanding of the information given acknowledging their emotional difficulties and providing a historical perspective of the procedural sequences throughout their life.
- 3) **Recognition & revision of procedural sequences:** This identifies two or three target problems, which form the initial focus of therapy. The client is encouraged to consider alternative ways of thinking and acting at such times and record their progress in a diary.
- 4) **Ending therapy:** This is seen as an important part of the process and is prepared for from the first session, as it involves ending the relationship with the therapist and may echo previous difficult relationship endings.

The last few sessions are spent working on a positive end of therapy. The therapist provides a written summary of the progress made, what needs further work, comments on progress and the therapeutic process.

Effectiveness of CBT

CBT combines the advantages of cognitive and behavioural therapy and so provides appropriate treatment for a wide range of disorders. Cognitive Behavioural Therapy has proven in scientific studies to be effective for a wide variety of problems, including mood disorders, anxiety disorders, personality disorders, eating disorders, substance abuse disorders, and psychotic disorders. It has been clinically demonstrated in studies to be effective for many psychiatric disorders and medical problems for both children and adolescents. CBT has been recommended in the UK by the National Institute for Health and Clinical Excellence as a treatment of choice for a number of mental health difficulties, including post-traumatic stress disorder, OCD, bulimia nervosa and clinical depression. There is good evidence for CBT's effectiveness in reducing symptoms and preventing relapse. As it is an inexpensive and cost effective form of treatment, it is increasingly being used as a preferred form of treatment. CBT is successful in the treatment of depression, anxiety disorders and panic disorders and is also more effective in treating OCD than behaviour therapy alone. However it is of little value in the treatment of disorders that do not involve irrational beliefs. CBT has limited appropriateness for the treatment of schizophrenia, however, schizophrenia is a very complicated disorder and extremely hard to treat successfully. Becks approach is considered more sophisticated than Ellis's. Ellis assumed that similar irrational beliefs underlie most mental disorders, whereas Beck argued that specific irrational beliefs tend to be associated with each disorder

Evaluation of the Cognitive Approach

Skinner criticizes the cognitive approach as he believes that only external stimulus - response behaviour should be studied as this can be scientifically measured. Therefore, mediation processes (between stimulus and response) do not exist as they cannot be seen and measured. Skinner continues to find problems with cognitive research methods, namely introspection due to its subjective and unscientific nature.

Carl Rogers believes that the use of laboratory experiments by cognitive psychology have low ecological validity and create an artificial environment due to the control

over variables. Rogers emphasizes a more holistic approach to understanding behaviour.

The information processing paradigm of cognitive psychology views that minds in terms of a computer when processing information. However, there are important difference between humans and computers. The mind does not process information like a computer as computers don't have emotions or get tired like humans.

Behaviourism assumes that people are born a blank slate (tabula rasa) and are not born with cognitive functions like schemas, memory or perception. The cognitive approach does not always recognize physical and environmental factors in determining behaviour.

Cognitive Approach Summary

Key Features	Methodology
• Mediation Processes • Information Processing • Computer Analogy • Introspection (Wundt) • Nomothetic • Schema • Machine Reductionism	• Lab Experiments • Introspection (Wundt) • Memory Psychology • Interviews (Kohlberg, Piaget) • Case Studies (KF, HM) • Observations (Piaget) • Computer Modelling
Basic Assumptions	Areas of Application
• Cognitive psychology is a pure science, based mainly on laboratory experiments. • Behaviour can be largely explained in terms of how the mind operates, i.e. the information processing approach. • The mind works in a way similar to a computer: inputting, storing and retrieving data. • Mediation processes occur between stimulus and response.	• Moral Development (Kohlberg) • Eyewitness Testimony • Memory • Forgetting • Selective Attention • Perception • Child Development (Piaget) • Language Acquisition • Cognitive Behavioral Therapy • Learning Styles (Kolb) • Information Processing • Cognitive Interview • Education (Vygotsky, Bruner) • Face Recognition (Bruce and Young)
Strengths	Limitations
• Scientific • Highly applicable • Combines easily with approaches: behaviourism + Cognitive = Social Learning. Biology + Cognitive = Evolutionary Psychology • Many empirical studies to support theories	• Ignores biology • Experiments - low ecological validity • Humanism - rejects scientific method • Behaviourism - can't objectively study unobservable behaviour • Introspection is subjective • Machine reductionism

Bibliography

Atkinson, R. C., & Shiffrin, R. M. (1968). Chapter: Human memory: A proposed system and its control processes. In Spence, K. W., & Spence, J. T. *The psychology of learning and motivation* (Volume 2). New York: Academic Press. pp. 89–195.

Beck, A. T. Rush, A. J, Shaw, B. F, Emery, G. (1979). *Cognitive Therapy of Depression*. New York: The Guilford Press. pp. 11. ISBN 0-89862-919-5.

Beck, A.T. (1976). *Cognitive therapy of the emotional disorders*. New York: New American Library.

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford press.

Bennett, P (2007) *Abnormal Clinical Psychology; An Introductory Textbook* (Second edition). Maidenhead: Open University Press

Duttweiler, P.C. (1984). The Internal Control Index: A Newly Developed Measure of Locus of Control. *Educational and Psychological Measurement*, 44, 209-221

Ellis, A. (1962). *Reason and emotion in Psychotherapy*. Secaucus, NJ: Prentice-Hall

Eysenck, M.W. (2005) *Psychology: A Students Handbook*. New York; Psychology Press.

Furnham, A. & Steele, H. (1993). "Measures of Locus of Control: A critique of children's, health and work-related locus of control questionnaires", *British Journal of Psychology* **84**, 443-79.

McLeod, S. A. (2007), *Cognitive Psychology*: Retrieved from <http://www.simplypsychology.org/cognitive.html>

Myers, D. (1998) *Psychology*, fifth edition, New York; Worth publishers

Myers, D. (2002) *Exploring Psychology*, fifth edition, New York; Worth publishers

Neisser, U (1967). *Cognitive psychology*. Appleton-Century-Crofts: New York

Newell, A., & Simon, H. (1972). *Human problem solving*. Prentice-Hall.

Rotter, J.B. (1966). Generalized expectancies of internal versus external control of reinforcements. *Psychological Monographs*, 80

Tolman E. C. (1948). Cognitive maps in rats and men. *Psychological Review*. 55, 189–208

Truax, C.B. (1966). Therapist's empathy, genuineness, and warmth and patient therapeutic outcome. *Journal of Consulting Psychology*, 30, 395-401

The Humanistic Perspective

In the 1950s, another force began to achieve prominence in psychology known as Humanistic psychology. Humanistic psychologists, including Abraham Maslow (1908–1970) and Carl Rogers (1902–1987), rejected the deterministic views of behaviourism and psychodynamic psychology.

Humanistic psychologists believe that free will and conscious choice are essential aspects of the human experience. Psychologists who adopt a humanistic perspective believe that psychology should focus on conscious experiences, even if those experiences are subjective and cannot be directly observed and scientifically measured. Humanistic psychologists view each of us as individuals who possess distinctive clusters of traits and abilities and unique frames of reference or perspectives on life. They emphasize the value of self-awareness and of becoming an authentic person by being true to oneself. They also stress the creative potentials of individuals and their ability to make choices that imbue their lives with meaning and purpose.

The humanist movement had an enormous influence on the course of psychology and contributed new ways of thinking about mental health. It offered a new approach to understand human behaviours and motivations and led to the development of new techniques and approaches to psychotherapy. Some of the major ideas and concepts that emerged as a result of the humanist movement include emphasis on:

- Self-concept
- Hierarchy of needs
- Unconditional positive regard
- Free will
- Client-centred therapy
- Self-actualization

- Fully-functioning person
- Peak experiences

Important Events in Humanistic Psychology

- 1943 - Abraham Maslow described his hierarchy of needs in "A Theory of Human Motivation" published in Psychological Review.
- 1951 - Carl Rogers published Client-Centred Therapy, which described his humanistic, client-directed approach to therapy.
- 1961 - The American Association for Humanistic Psychology is formed and the Journal of Humanistic Psychology was established.
- 1962 - American Association for Humanistic Psychology was formed.
- 1971 - Humanistic psychology becomes an APA division.

Strengths of Humanistic Psychology

One of the major strengths of humanistic psychology is that it emphasizes the role of the individual. This school of psychology gives people more credit in controlling and determining their state of mental health. It also takes environmental influences into account. Rather than focusing solely on our internal thoughts and desires, humanistic psychology credits the environment's influence on our experiences and continues to influence other areas such as therapy, education and healthcare. Humanistic psychology helped remove some of the stigma attached to therapy and made it more acceptable for normal, healthy individuals to explore their abilities and potential through therapy.

Criticisms of Humanistic Psychology

Humanistic psychology is often seen as too subjective as the importance of individual experience makes it difficult to objectively study and measure humanistic phenomena. How can we objectively tell if someone is self-actualized? The answer is that we cannot. We can only rely upon the individual's own assessment of their experience. Another major criticism is that observations are unverifiable and there is no accurate way to measure or quantify these qualities.

Critical Evaluation

The humanistic approach has been applied to relatively few areas of psychology compared to the other approaches. Therefore, its contributions are limited to areas such as therapy, abnormality, motivation and personality.

A possible reason for this lack of impact on academic psychology perhaps lies with the fact that humanism deliberately adopts a non-scientific approach to studying humans. For example their belief in free-will is in direct opposition to the deterministic laws of science. Also, the areas investigated by humanism, such as consciousness and emotion are very difficult to scientifically study. The outcome of such scientific limitations means that there is a lack of empirical evidence to support the key theories of the approach.

However, humanism can gain a better insight into an individual's behaviour through the use of qualitative methods, such as unstructured interviews. The approach also helped provide a more holistic view of human behaviour, in contrast to the reductionist position of science.

Humanistic Psychology Today

Today, concepts central to humanistic psychology can be seen in many disciplines including other branches of psychology, education, therapy, and political movements. Trans-personal psychology, positive psychology and person centered counselling draw heavily on humanist influences.

Summary of the Humanistic Approach

Key Features	Methodology
• Qualitative Research • Idiographic Approach • Congruence • Self Concept (e.g. self-worth, self-image, self actualization) • Holism (e.g. study to whole person) • Hierarchy of needs • Free Will	• Qualitative Methods • Case Study • Informal Interviews • Q-Sort Method (Stephenson, 1953) • Open-ended Questionnaires • Inter-rater /coder reliability
Basic Assumptions	Areas of Application
• Humans have free will; not all behaviour is determined. • All individuals are unique and have an innate (inborn) drive to achieve their maximum potential. • A proper understanding of human behaviour can only be achieved by studying humans - not animals. • Psychology should study the individual case (idiographic) rather than the average performance of groups (nomothetic).	• Person Centered Therapy • Qualitative Methods • Abnormal behavior (incongruent, low self-worth) • Education • Motivation
Strengths	Limitations
• Shifted the focus of behaviour to the individual rather than the unconscious mind, genes, observable behavior etc. • Humanistic psychology satisfies most people's idea of what being human means because it values personal ideals and self-fulfilment • Qualitative data gives genuine insight and more holistic information into behavior. • Highlights the value of more individualistic and idiographic	• Ignores Biology • Unscientific – subjective concepts. • Humanism ignores the unconscious mind. • Behaviourism – human and animal behavior can be compared. • Qualitative data is difficult to compare. • Ethnocentric (biased towards Western culture). • Their belief in free will is in opposition to the deterministic laws of science.

Bibliography

Association for Humanistic Psychology. (2001). Overview of humanistic psychology. Retrieved from <http://www.ahpweb.org/aboutahp/whatis.html>

Bennett, P (2007). Abnormal Clinical Psychology; An Introductory Textbook (Second edition). Maidenhead: Open University Press

Eysenck, M.W. (2000) Psychology: A Student's Handbook. New York; Psychology Press

Maslow, A. H. (1968). Toward a psychology of being (2nd ed.). Princeton, NJ: Van Nostrand.

Myers, D. (2002) Exploring Psychology, fifth edition, New York; Worth publishers

Rogers, C. R. (1951). Client-centred therapy. Boston: Houghton Mifflin.

Shaffer, J. B. P. (1978). Humanistic psychology. Englewood Cliffs, NJ: Prentice-Hall.

The Physiological or Biological Perspective

This approach views human's as biological organisms and the biological approach to psychopathology believes that disorders have an organic or physical cause. The focus of this approach is on genetics, neurotransmitters, neurophysiology and neuro-anatomy. The approach argues that psychological disorders are related to the physical structure and functioning of the brain, nervous system and neurotransmitters.

Biochemical models are often considered to be in opposition to psychological explanations as mental health problems are seen as either psychological in nature or to have a biological cause. A more appropriate way of thinking about the two approaches is that they provide different levels of explanation, somewhat analogous to the levels of explanation provided by physics and chemistry. Biochemical processes underpin our behaviour at all times.

The basis of biological explanations and treatments of psychological disorders is that behaviour and mood are regulated by brain systems. These allow us to perceive information, integrate that information with past memories and other salient factors, and then respond emotionally and behaviourally. Their disruption results in inappropriate perception, mood and behaviour. This may occur as a result of structural damage, or disruption of chemicals, known as neurotransmitters, responsible for activating different areas of the brain.

Until the late 18th century mental illness was thought to be linked to demonic influence, and people with abnormal behaviour were thought to be possessed. Trepanning, was carried out which consisted of boring holes in the skull to release the demons and evil spirits. Other treatments included exorcism, where a priest or holy man would perform a service to get rid of evil from the person's body. Understanding of mental illness evolved late into the 18th century, when Phillipe

Pinel developed a classification system for mental illness, comparable to physical illness. The first comprehensive system to classify mental illness was developed by Emil Kraepelin in 1896.

The medical model or biological model is taken from Kraepelin's original medical view of mental illness and is the basis of knowledge for all medically trained psychiatrists. This approach helped reduce stigma, but it also slowed down a broader understanding of mental disorder, in other words it limited the development of psychological, social and environmental explanations, until Freud's theories, which set the ball rolling in these directions.

The biological model considers that illnesses have physical causes which can be diagnosed, treated and in many cases cured. Applied to psychological disorders this model assumes that psychological illness can be diagnosed based on physical symptoms and cured through therapy. The medical model tends to treat mental health like any other physical condition, looking for explanations in pathology, microbiology, genetics, bio chemistry and neuro-anatomy. This approach suggests that mental disorder is due to a malfunction in one or more of these areas. The main advantage to this approach is that if there is a physical malfunction, then there is always a possible cure, by righting that malfunction in some way and therefore any treatment for psychological disorder will involve a biological intervention, such as medication to re- balance bio-chemistry.

Evolutionary Psychology

Evolutionary psychology is a movement within modern psychology that applies principles from Charles Darwin's theory of evolution to a wide range of behaviour in humans and other animals. Darwin (1809–1882) believed that all life forms, including humans, evolved from earlier life forms by adapting over time to the demands of their natural environments.

Evolutionary psychologists believe that behavioural tendencies or predispositions, such as aggression might be rooted in our genes, having been passed along from generation to generation. These traits may have helped ancestral humans survive, even if they are no longer adaptive in modern society. Evolutionary psychologists examine behaviours in different species that they believe may be influenced by evolutionary processes, including aggression, mating, and even acts of altruism, however they recognize that environmental factors, such as cultural and family influences, play an important role in determining whether these behavioural tendencies or predispositions lead to actual behaviour.

Summary of the Biological/ Physiological Model

Key Features	Methodology
• Natural Selection / Evolution • Adaptation • Heredity / Genetics • Nomothetic • Reductionist • Instincts / Sociobiology • Comparative Psychology	• Lab Experiments • Correlation • Twin research • Naturalistic observations (Kettlewell) • Ethical Considerations • Reliability and validity of research
Basic Assumptions	Areas of Application
• Psychology should be seen as a science, to be studied in a scientific manner (usually in a laboratory). • Behaviour can be largely explained in terms of biology (e.g. genes/hormones). • Human genes have evolved over millions of years to adapt behaviour to the environment. Therefore, most behaviour will have an adaptive / evolutionary purpose.	• Gender Role Development • Abnormal Psychology • IQ • Relationships • Medical Model • Stress Response (SRRS, stress immune system)
Strengths	Limitations
• Very Scientific • Highly application to other areas: Biology + Cog = Evolutionary Psychology • Helped develop comparative psychology • Strong counter argument to the nurture side of the debate • Many empirical studies to support theories	• Experiments – Low Ecological Validity • Humanism: too deterministic – little room for free-will • Doesn't recognize cognitive processes • Reductionist • Bio psychological theories often oversimplify the huge complexity of physical systems and their interaction with the environment.

Bibliography

Bennett, P (2007) *Abnormal Clinical Psychology; An Introductory Textbook* (Second edition). Maidenhead: Open University Press

Carlson, N. R. (2008). *Foundations of Physiological Psychology*. 7th ed. Boston: Pearson Education.

Carlson, N. R. (2013). *Emotion: Physiology of Behaviour*. Boston: Allyn and Bacon.

De Waal, F.B.M. (2002). *Evolutionary Psychology: The wheat and the chaff*. *Current Directions in Psychological Science*, 11, 187–191.

Eysenck, M.W. (2000) *Psychology: A Students Handbook*. New York; Psychology Press

Hamilton, W.D. (1964). The genetical evolution of social behaviour: I and II. *Journal of Theoretical Biology*, 7, 1–52.

Jarvis, M. (2000). *Theoretical approaches in psychology*. London: Routledge.

Le Doux, J. Emotional Circuits in the Brain. *Annual Review of Neuroscience*, 23, 155-183.

Myers, D. (1998) *Psychology*, fifth edition, New York; Worth publishers

Myers, D. (2002) *Exploring Psychology*, fifth edition, New York; Worth publishers

McLeod, S. A. (2007). *Psychology Perspectives*.
<http://www.simplypsychology.org/perspective.html>

McLeod, S. A. (2014). *Biological Theories of Gender*.
<http://www.simplypsychology.org/gender-biology.html>

Neumann, I. Brain Oxytocin: A Key Regulator of Emotional and Social Behaviours in Both Females and Males. *Journal of Neuroendocrinology*, 20, 858*865.

The Socio-Cultural Perspective

Social psychology bridges the gap between psychology and sociology looking at human behaviour as influenced by other people and the social context in which this occurs.

Key Figures in Social Psychology

Allport (1920) Social Facilitation
Bandura (1963) Social Learning Theory
Festinger (1950) Cognitive Dissonance
Tajfel (1971) Social Identity Theory
Weiner (1986) Attribution theory
Milgram (1963) Shock Experiment
Haney, Banks, Zimbardo (1973) Prison Study

The socio-cultural perspective refers to the effect that society and cultural norms have on personal behaviour. It focuses on the influences of age, ethnicity, gender, sexual orientation, lifestyle, income level, disability status, and culture on behaviour and mental processes.

The models so far discussed assume that psychological disorders arise as a result of problems within the individual, be they genetic, biochemical or psychological. By contrast, the socio-cultural approach assumes that external, social factors contribute to their development. Socio-cultural factors include a wide range of influences, from the family to wider socio-economic factors.

The socio-cultural approach to psychology originated almost exclusively with Lev Vygotsky (1896-1934). He is best described as an educational psychologist with a social theory. He believed strongly that a person's environment affects their cognitive

development. As his work got published and became well-known, it became influential in areas such as education and developmental psychology.

Vygotsky's major influences for his work on the socio-cultural approach to psychology were Ivan Pavlov, Karl Marx & Friedrich Engels. Vygotsky's work was much broader than Pavlov's work on conditioned responses. Vygotsky, a Russian Marxist, was impressed by many ideas from the writers of the Communist Manifesto Karl Marx & Friedrich Engels. For this reason, several "collective action" ideas can be found in Vygotsky's work. Vygotsky's approach helped to shape educational psychology and developmental psychology. His published work was not widely received in the Western world until 1978, when translated works of Vygotsky and his collaborators were published in a book called 'Mind in Society'.

Tenets of the Socio-cultural Approach

The major tenet of the socio-cultural approach to psychology is that society and culture shape cognition. According to the approach, the presence of the following can affect cognitive processes: Customs and traditions: Beliefs: Morals and values: Language and vernacular.

Vygotsky introduced a concept called the zone of proximal development that illustrates the difference between what a learner can do without help and with help. Through interactions with more experienced members of society, children learn problem-solving (dialectic processes). Vygotsky's approach influenced reformative leaders such as Benjamin Bloom (Bloom's Taxonomy) to change classroom settings and improve the quality of education.

Strengths and limitations of the Approach

The socio-cultural approach attempts to explain an individual's development in terms of society's impact on this development. The approach is able through both theory and research, to explain how an individual's environment affects the development of the individual. The approach is however, not able to explain why homogeneous

people in the same situation (twins) develop differently. The approach is not able to reliably estimate the extrinsic effects of society on a given individual.

The socio-cultural approach to psychology, and many of its tenets, rely on correlation research for evidence. Correlation research works by first isolating an independent variable and then manipulating it by changing the situation. This helps psychologists understand the relationships between variables. Multiple large-scale studies have been conducted in recent years in attempts to corroborate Vygotsky's theorems; and they have proven to be accurate.

A frequently occurring criticism against the socio-cultural approach to psychology (and social psychology in general) is that the experiments and studies that are used in research often seem artificial and don't pay attention to what the subjects are thinking about. These experiments are the basis for aligning hypothesis with fact, and crucial that they are accurate.

Another criticism against the socio-cultural approach is that it has not existed for long enough to get enough long-term research data to infer accurate conclusions.

Bibliography

- Allport, F. H. (1924). Response to social stimulation in the group. *Social psychology*, 260-291.
- Bennett, P (2007) *Abnormal Clinical Psychology; An Introductory Textbook* (Second edition). Maidenhead: Open University Press.
- Brown, J. S., Collins, A., Duguid, P. (1989). Situated cognition and the culture of learning: Proximal development: *Educational Researcher*, 18 (1), 32-34.
- Cole, M. (1985). The zone of where culture and cognition create each other: Vygotskyian perspective. Cambridge: Cambridge University Press.
- Cole, M. (2005). Culture in Development. In: Bornstein, M. Lamb, M. (ED's). *Developmental Science. An Advanced Textbook*. (pg. 45-102). Mahwah, NJ: Lawrence Erlbaum Associates.
- Eysenck, M.W. (2000) *Psychology: A Students Handbook*. New York; Psychology Press.
- McDougall, W. (1908). *An introduction to social psychology*. London: Methuen.
- McLeod, S. A. (2007). *Social Psychology*.
<http://www.simplypsychology.org/social-psychology.html>
- Murchison, C. (1935). *A handbook of social psychology*.
- Murphy, G., & Murphy, L. B. (1931). *Experimental social psychology*.
- Myers, D. (1998) *Psychology*, fifth edition, New York; Worth publishers
- Myers, D. (2002) *Exploring Psychology*, fifth edition, New York; Worth publishers
- Sherif, M. (1935). A study of some social factors in perception. *Archives of Psychology* (Columbia University).
- Shweder & Herdt, G. (2000) *Cultural Psychology* (pp259-286). Cambridge: Cambridge University Press.

- Vygotsky, L.S. (1978). *Mind in society. The development of higher psychological processes*. Cambridge: Cambridge University Press.
- Wertsch, J. V. (1985). *Vygotsky and the social formation of mind*. Cambridge: Harvard University Press.

Contemporary Perspectives

It is important to realize that no one perspective is exactly right and the others wrong. Each major perspective in contemporary psychology focuses on different aspects of behaviour or psychological functioning. Each has something unique to offer to our understanding of human behaviour but none offers a complete view. Given the complexity of human behaviour and experience, it is not surprising that psychology has multiple pathways for approaching its subject matter. It is also not surprising that many psychologists today identify with an eclectic approach to understanding human behaviour, one that draws on theories and principles representing different perspectives.

Contemporary psychology is not divided as neatly into different schools of thought, as in the early days. There is overlap among the different perspectives. A contemporary holistic perspective is the bio-psychosocial approach which assumes that biological, psychological and socio-cultural factors combine and interact to produce psychological disorders.

In addition to the major perspectives of contemporary psychology, there is a growing movement called **positive psychology**. Psychologists have devoted a great deal of attention to understanding human weaknesses and deficits, including emotional problems, effects of stress, and problem behaviours. Founded by psychologist Martin Seligman, positive psychology focuses on the virtues, strengths and positive aspects of human experience, not weaknesses.

Positive Psychology

Positive psychology is one of the newest branches of psychology to emerge. While many branches of psychology tend to focus on dysfunction, abnormal behaviour and what can go wrong with people's lives, positive psychology is centred on helping people become happier.

Positive psychology can have a range of real-world applications in areas including education, health, self-help, stress management and workplace issues. Using strategies from positive psychology, teachers, coaches, therapists and employers can motivate others and help individuals understand and develop their personal strengths.

The term "positive psychology" is a broad one, encompassing a variety of techniques that encourage people to identify and further develop their own positive emotions, experiences, and character traits. In many ways, positive psychology builds on the key tenets of humanistic psychology.

Carl Rogers' client-centred therapy, for example, was based on the theory that people could improve their lives by expressing their authentic selves. Abraham Maslow identified traits of self-actualized people that are similar to the character strengths identified and used in some positive psychology interventions.

To counter the traditional focus on pathology, Seligman and Peterson, formalized the tenets of positive psychology in a book, *Character Strengths and Virtues: A Handbook and Classification (CSV)*, which they created as a counterpoint to the *Diagnostic and Statistical Manual of Mental Disorders*. Just as the DSM classifies a range of psychiatric disorders, the CSV provides details and

classifications for various strengths that enable people to thrive. The book identifies 24 character strengths, organized according to six overarching virtues.

Positive Psychologists

- Martin Seligman
- Mihaly Csikszentmihalyi
- Christopher Peterson
- Carol Dweck
- Daniel Gilbert
- Kennon Sheldon
- Albert Bandura
- C. R. Snyder
- Philip Zimbardo

Major Topics in Positive Psychology

- Happiness
- Optimism and helplessness
- Mindfulness
- Flow
- Character strengths and virtues
- Hope
- Positive thinking
- Resilience

Therapies- Well being therapy

Well-being therapy promotes recovery from depression and other affective disorders by having a client focus on and promote the positive, as well as alleviating negative

aspects of life. Developed by Giovanni Fava in Italy, well-being therapy is based largely on the work of psychologist Carol Ryff and her multidimensional model of subjective well-being.

Ryff's model consists of six tenets:

- **Mastery of the environment**
- **Personal growth**
- **Purpose in life**
- **Autonomy**
- **Self-acceptance**
- **Positive relationships.**

In practical terms, well-being therapy is much like cognitive behavioural therapy. A client keeps a journal to keep track of and recognize the positive events that occur each day. When the client starts recognizing negative thoughts and beliefs that distract from or disrupt positive events the goal is to challenge and eventually change negative ways of thinking, to enable positive events to have more of an impact on the client's life.

Therapies-Positive Psychotherapy

Seligman and colleagues developed positive psychotherapy as a way to treat depression by building positive emotions, character strengths, and sense of meaning, not just by reducing negative symptoms such as sadness. This therapy uses a combination of exercises that can be practiced individually or in groups.

- **Using signature strengths.** Identify five strengths and try to use them in some new way daily.
- **Three good things.** Every evening, write down three good things that happened that day and think about why they happened.
- **Gratitude visit.** Write a letter to someone explaining why you feel grateful for something they've done or said. Read the letter to the recipient, either in person or over the phone.

Integrating positive psychology in practice

Kauffman discussed four techniques for integrating the principles of positive psychology into more traditional types of individual or group therapy.

- **1) Reverse the focus from negative to positive.**
- **2) Develop a language of strength.**
- **3) Balance the positive and negative.**
- **4) Build strategies that foster hope.**

Evaluation of Positive Psychology

Only one large randomized controlled trial of a positive psychology intervention for people with clinical depression has been published since 2005.

Other studies have been short-term in nature and have involved people who did not have psychiatric diagnoses. This means it remains unclear whether positive psychology techniques will help people suffering from depression and other psychiatric disorders.

Another limitation in the research so far is that investigators have evaluated mostly individual strategies, but positive psychology interventions usually combine several techniques at once.

It is also unclear how best to combine positive psychology interventions with more traditional types of therapy, such as cognitive behavioural therapy, or with medication.

Although the clinical impact of positive psychology is still not fully known, there are few risks involved when someone discovers his or her strengths or focuses on the positive side of life. There may well be very valuable benefits, and leaders in the field are encouraging patients and clinicians to try positive psychology technique.

Academic V's Applied Psychology

Psychology defined by the British Psychological Society “is the scientific study of people, the mind and behaviour. It is both a thriving academic discipline and a vital professional practice”.

Academic Psychology is concerned with developing psychological knowledge and exploring our understanding of human beings: mental processes: developing better ways of looking at human experience and observing how physiological and developmental factors influence people.

The basic premise of **applied psychology** is the application of psychological principles, research and theories to overcome problems in real life situations by developing and applying appropriate interventions in practice and evaluating outcomes.

Academic Psychology is based on theories and a general overview of human behaviour while applied psychology is a specific field and is more inclined towards practical applications and real world then theoretical psychology. Academic psychologists are involved in teaching and research, while applied psychologists put psychological knowledge to work.

For much of the 20th Century applied and academic psychology were seen as separate entities, but in many ways the distinction has been an artificial one. Today

academic and applied psychology while still split in the USA, are not in most other parts of the world where they share a healthy two way relationship.

The following chapters will provide an understanding of the discipline of psychology in applied settings, discussing the theory, research and practice of clinical, forensic, organisational, and educational and health psychology and the theories of human growth and development.

Clinical Psychology

Clinical psychology includes the study and application of psychology for the purpose of understanding, preventing, and relieving psychologically-based distress or dysfunction to promote subjective well-being and personal development. Central to its practice are psychological assessment and psychotherapy, although clinical psychologists may also engage in research, teaching, consultation, forensic testimony, program development and administration. Some clinical psychologists focus on the clinical management of patients with brain injury, known as clinical neuropsychology.

The work performed by clinical psychologists tends to be done within the various therapy models, all of which involve a formal relationship between professional and client, usually an individual, couple, family, or small group that employs a set of procedures intended to form a therapeutic alliance, explore the nature of psychological problems, and encourage new ways of thinking, feeling and behaving. The four major perspectives are psychoanalytic, cognitive behavioural, humanistic, and systems or family therapy.

Clinical psychologists do not usually prescribe medication, although there are a growing number of psychologists who do have prescribing privileges, in the field of medical psychology. In general, when medication is warranted many psychologists work in cooperation with psychiatrists so that clients get all their therapeutic needs met.

Clinical psychologists may also work as part of a team with other professionals, such as social workers and nurses. With clients, clinical psychologists usually do not just

adopt one single approach. Instead they draw on elements from a number of different approaches. This is known as an eclectic approach. A most important tool is the clinical interview: listening skills, and psychologists are trained in the use and analysis of psychometric tests. Psychometric tests are not just questionnaires but carefully developed questions or tasks which give an insight into particular psychological issues. Each item has been through a rigorous process of development, being tested, retested, standardised on different populations, and carefully balanced with the other test items to produce an exact result. Some tests are diagnostic while others are used to assess how skilled someone is, or how severe a particular problem is. Other tests by contrast are used to give a general picture of what a person is like, such as personality or general intelligence tests. Clinical psychologists have a detailed knowledge and training in the different types of psychological therapies. Training in clinical psychology is rigorous and lengthy. It takes at least eight years to become a qualified basic grade psychologist followed by many more years study to specialise in a particular area.

Mental health is not just the absence of mental illness. It is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. (WHO, 2007) Mental Health concerns how we feel about ourselves: How we feel about others and how we are able to meet the demands of life

Mental Ill Health refers to the kind of general mental health problems we can all experience in certain stressful circumstances; for example, work pressures can cause us to experience: poor concentration, mood swings and sleep disturbance. Such problems are usually of a temporary nature, are relative to the demands a particular situation makes on us and generally respond to support and reassurance. All of us suffer from mental health problems at times, and such temporary problems do not necessarily lead to mental illness. However, being mentally unhealthy limits our potential as human beings and may lead to more serious problems.

Mental illness is the experiencing of severe and distressing psychological symptoms to the extent that normal functioning is seriously impaired. Examples of such symptoms include: anxiety, depressed mood, obsessions, delusions and hallucinations. Professional medical help is usually needed for recovery or management, and this help may take the form of counselling or psychotherapy, drug treatment and/or lifestyle change.

What is normal behaviour?

The 'norm' is something that is usual, regular or typical. If we can define what is most common or normal, then we also have an idea of what is not common i.e. abnormal. Researchers and government agencies collect statistics to inform us what is normal or typical.

Normality traits

- 1) Efficient perception of reality.
- 2) Voluntary control over behaviour
- 3) Self esteem and acceptance
- 4) Ability to form affectionate relationships
- 5) Productivity

(Atkinson, R., Smith, E., Bem, D., Hoeksema, S (1998))

Abnormal psychology is the interpretive and scientific study of abnormal thoughts and behaviour in order to interpret, describe, predict, explain, and change abnormal patterns of functioning. The definition of what constitutes 'abnormal' has varied across time and cultures, and varies among individuals within cultures. In general, abnormal psychology studies people who are consistently unable to adapt and function effectively in a variety of conditions. An individual's ability to adapt and function can be affected by a number of variables, including one's genetic makeup, physical condition, learning and reasoning, and socialization.

Theoretical Approaches

There are many different types of therapy, all with different assumptions but the main approaches are;

- **Psychoanalytical**
- **Behavioural**
- **Cognitive**
- **Humanistic**

Psychoanalytical approach

Some of the earliest forms of clinical psychology were based on the psychoanalytical approach pioneered by Freud and developed by Jung, Klein, Adler and others. The idea is of an unconscious mind which can influence us without our awareness of it. According to this model the roots of psychological disorder are to be found in the unconscious mind underpinned by unresolved conflicts and traumas, often from childhood.

Treatment is based on various techniques, hypnosis, free, association, transference, and catharsis designed to permit the patient to retrieve repressed memories and to gain insight into their meaning. Using hypnosis, word association and close investigation of the patients personal memories while investigating what was then known as 'hysterical disorders'- physical symptoms but without a physical cause, Freud came to the conclusion that these disorders were psychosomatic, real physical (somatic) disorders of the body, but their origins were in the person's mind (psyche).

There appeared to be an unconscious dimension to the mind which took control of the body to produce physical symptoms. Freud explored the unconscious dimension further, and found that it appeared to be able to influence many aspects of living, including how people talked, the decisions they made, the ways they reacted to people and events and the emotions that they felt. Moreover, he discovered that parts of the unconscious mind were elemental, primitive and demanding. Freud developed an extensive theory of how the mind developed, in which he emphasised the importance of sexuality and sexual energies.

Other psychoanalysts who worked with Freud believed that different types of energies were important. Jung was concerned the mystical and symbolic aspects of unconscious experience. Adler focused on the feelings of inferiority experienced by young children in the adult world. There are many other approaches to psychoanalysis but they have in common the idea of the unconscious mind underlying and influencing our everyday experience.

According to the Freudian approach, the conscious rational part of the mind (Ego), is constantly keeping the balance between the unconscious, unreasonable demands of the (Id) and the equally unconscious and unreasonable demands of the (Superego). What is more important for psychoanalysts is the idea that the unconscious parts of the mind reflect buried conflicts and traumas from infancy and childhood.

The ego is usually able to maintain a satisfactory balance between the demands of the id and the superego, but in cases where childhood trauma was very powerful or created a lot of unresolved conflict it would be unable to do so.

Clinical problems such as neurosis or obsession disorders are seen by psychoanalysts as the result of those unresolved conflicts. Clinical psychologists adopting the psychoanalytical approach tend to explore the persons childhood history, bringing unresolved pain or disturbance to the surface so that the person can learn to cope with it. This process can be very traumatic in the case of child sexual abuse.

Behavioural Approach

The behavioural approach stems from a wider view of psychology which was very popular during the first half of the 20th Century. Behaviourists are of the view that people are a product of their own learning experiences through conditioning or observational learning. It can account for abnormal behaviour, impulses, fears and phobias.

Behaviourists believe these behaviours arise from faulty learning and the linking of inappropriate responses to stimuli and that treatment is based on re- conditioning or re-learning. Behaviourists believe if a response has been learned it can be unlearned

and that therapy should be aimed towards helping the person learn a new more appropriate set of responses to the stimuli producing the inappropriate behaviour in the first place.

The behavioural approach is quite useful in clinical psychology particularly with obsessive reactions, fears and phobias

Classical Conditioning Therapies include: systematic desensitization, flooding implosion therapy and aversion therapy.

Operant Conditioning Therapies include: extinction, selective punishment and selective positive reinforcement

Humanistic Approach

Humanistic psychology looks at the person holistically. Therapies focus on self-development, growth and responsibilities. It aims to help individuals recognise their strengths, creativity and choice in the 'here and now'. There are four types but the main form of humanistic therapy is Person-Centred therapy, "Client-Centred" or "Rogerian" Counselling. 'Carl Rogers' starting point for Humanistic therapy was the concept of self based on our conscious experience of ourselves and of our position in society. People often seek humanistic therapy or counselling when there is incongruence between the self concept and ideal self. Most people have some similarities between the two but researchers who have explored this idea found that people who came for therapy because of neurotic problems often had very little connection between their self-concept and their ideal self. Their ideals were so unrealistically high and impossible to achieve that they lived with a constant sense of failure and inferiority which produced their problems. Humanistic therapy could help these clients by teaching them to develop a more realistic ideal self.

Counselling as a Humanistic Therapy

Counselling is a process centred on a therapeutic relationship between the client and the therapist in a confidential, non-judgemental, one to one setting. Therapists focus on clarifying what the client is saying, but should not express approval or disapproval of what he or she is saying. Through this relationship, the therapist endeavours to

create a feeling of safety and support for the client. In a trusting environment, the client is able to express and explore their thoughts, feelings and emotions. Through the therapeutic process, the client can gain self-awareness and insight and understand their own flow of feelings and emotions. This allows the client to discover their own inner resources and potential and determine their own way forward in their lives and permits them to make more meaningful decisions and choices.

Counselling Techniques

The pattern of counselling sessions has a predictable rhythm with an introduction, information gathering, discussion and a conclusion. Location, timing, preparation, resources, establishing ground rules, creating openness, trust, rapport and confidentiality are all important elements. It involves:

Active listening - "listens for meaning". The counsellor says very little but conveys much interest. The counsellor only speaks to find out if a statement has been correctly heard and understood and uses expressions such as 'so you have told me that'.....or 'I have heard you say.....'

Body language takes into account facial expressions, angle of body, proximity to the client, placement of arms and legs. A lot can be expressed by raising and lowering eyebrows.

Tone of voice: The counsellor monitors the tone of voice in the same way they monitor their own body language. The client may not remember what was said, but will remember how the counsellor made them feel.

Good counselling techniques

Open questions are used in order to gather lots of information and asked with the intent of getting a long answer.

Closed questions are used to gather specific information and can usually be answered with either a single word or a short phrase.

Paraphrasing is when the counsellor restates what the client said. The counsellor may be using this to draw attention to a particular concern or aspect or sometimes paraphrasing is used to clarify.

Note taking is the practice of writing down pieces of information, often in a shorthand and messy manner. The counsellor needs to be discreet and not disturb the flow of thought, speech or body language of the client.

Summarizing is focusing on the main points of a counselling session or conversation in order to highlight them. At the same time as giving the “gist”, the counsellor is checking to see if they are accurate.

Feedback and Homework

Client Centred Therapy (Counselling)

Part of the reason why client centred therapy or counselling increases the self esteem of the client is because it allows him or her to develop a greater sense of being in control of their destiny. Client centred therapy differs from psychodynamic therapy in that the focus is very much on current concerns and hopes for the future, whereas in psychodynamic therapy the emphasis is on childhood experiences.

Client centred therapy involves the therapist being; **Unconditional in positive regard**: this involves the therapist accepting and valuing the client, and avoiding being critical or judgemental: **Genuine**: in the sense of allowing true feelings and thoughts to emerge: **Empathic**: understanding the other person's feelings.

Rogers believed that therapists who possess these characteristics really listen to what the clients are telling them, rather than being influenced by their own beliefs. However it is easier for the therapist to be genuine, empathic and unconditional in positive regard with some clients than with others. Those who discuss their feelings or problems openly and subjectively at the first interview recovered more in therapy than those who discussed their problems as if they were somebody else's.

The effectiveness of client centred therapy is hard to assess. This is partly due to the fact that there is no attempt to diagnose or classify the client's symptoms, so it is not easy to compare the client's state before and after therapy. Humanistic therapists tend to rely on clients self reports when deciding whether they have recovered, paying little attention to their behaviour. Self reports can be distorted and even humanistic therapists accept that people are often unaware of their true feelings.

Effectiveness of Humanistic Therapy

Client centred therapy is limited in the kinds of disorder for which it is appropriate. According to Davidson and Neale (1996); "As a way to help unhappy but not severely disturbed people understand themselves better, client centred therapy may very well be appropriate and effective". This explains why there is considerable use of client-centred therapy in counselling, and why it is hardly used any more in the treatment of severe mental disorders such as schizophrenia.

Clients who have a strong urge in the direction of exploring themselves and their feelings and who value personal responsibility may be particularly attracted to the person-centred approach. Those who would like a counsellor to offer them extensive advice, to diagnose their problems, or to analyse their psyches will probably find the person-centred approach less helpful.

Cognitive Approach

The cognitive approach to therapy relates to how people think about their problems. It takes the view that what matters is 'how we perceive' what is happening to us. Some people are able to deal with challenging problems in a positive and constructive way, while others become discouraged and depressed. Cognitive therapy teaches people positive ways of thinking about their problems, which helps them to deal with them more effectively. Different clinical psychologists have different ways of using the cognitive approach. Cognitive therapy tends to focus on four different aspects of our thinking..

- **Expectation and self efficacy**
- **Appraisal**
- **Attributions**
- **Beliefs**

Expectations

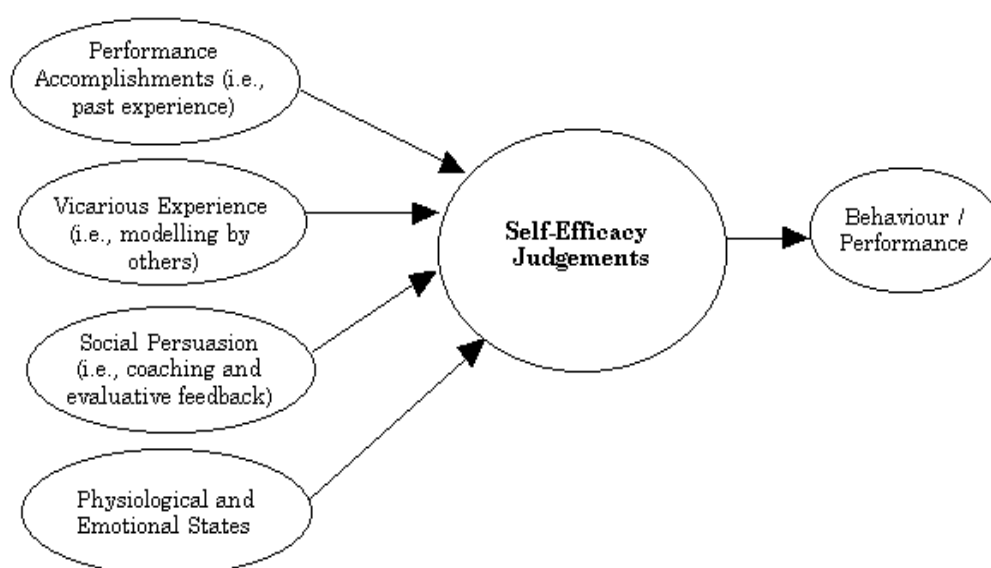
Our expectations are generally about what is likely to happen. People who are neurotic or depressed can be very negative about their expectations, while

psychologically balanced individuals tend to be more optimistic. Being optimistic allows individuals to feel better and provides more psychological resilience to deal with problems as they occur

Self Efficacy

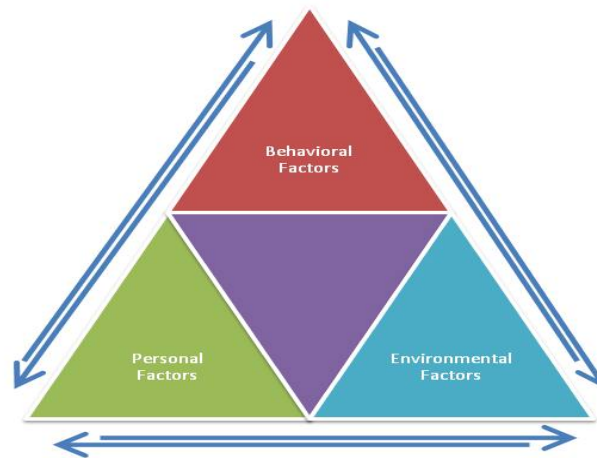
Self-efficacy is a person's belief in his or her ability to succeed in a particular situation. The concept of self-efficacy lies at the centre of Bandura's social cognitive theory. Bandura believed that direct reinforcement could not account for all types of learning. His theory added a social element, arguing that people can learn new information and behaviours by watching other people. Known as observational learning or modelling, this type of learning can be used to explain a wide variety of behaviours. There are three core concepts at the heart of social learning theory. First is the idea that people can learn through observation. Next is the idea that internal mental states are an essential part of this process. Finally, this theory recognizes that just because something has been learned, it does not mean that it will result in a change in behaviour.

Bandura's theory emphasizes the role of observational learning, social experience and reciprocal determinism in the development of personality. According to Bandura, reciprocal determinism is a model composed of three factors that influence behaviour: the environment, the individual, and the behaviour itself.



Sources of Self-efficacy Information

Bandura's Triadic Reciprocal Determinism



Appraisal

How we feel about a certain situation is determined by our appraisal or evaluation of the event. Sometimes people make very self defeating appraisals. The way they appraise the situation is unrealistic and much more negative than it needs to be. Becks showed that negative appraisals induce anxiety which can exaggerate other problems. Clinical psychologists use the cognitive approach to teach clients how to challenge negative appraisals

Attribution

An attribution is a reason which somebody gives for why things happen. We make unconscious attributions all the time and the types of attributions we make can have a direct affect upon our behaviour. **Internal attribution** also known as dispositional attribution is an inference that an event or a person's behaviour is due to personal or individual factors such as traits, abilities, or feelings. **External attribution** also known as situational attribution, involves blaming an outside factor as the cause of an event. Fundamental **attribution error** is to see our own actions dictated by the situation, but other peoples as dictated by their disposition or personality.

Beliefs

This relates to a person's beliefs about the world and the people in it. Personal constructs are how individuals make sense of the world based on their own past

experiences. Clinical psychologists using the cognitive approach generally focus on the long term beliefs that the client holds and helping them change negative thought processes into more positive ones.

There are several specific forms of cognitive therapy.

Cognitive Therapy

According to the behavioural model, psychological disorders involve maladaptive behaviour which has been learned via conditioning or observational learning and treatment should be based on conditioning or relearning. The behavioural model and therapy focuses on external stimuli and responses, and ignores the cognitive processes (thoughts or beliefs) happening between stimulus and response.

The omission was dealt with in the early 1960's with the introduction of cognitive therapy, based on the assumption that successful treatment can involve changing or restructuring clients cognitions or thought processes.

Albert Ellis

Ellis (1962) was one of the first therapists to put forward a version of cognitive therapy. He argued that anxiety and depression occur as the end point in a 3 point sequence (ABC)

- (A); The activating event (Antecedant)
- (B); Beliefs.
- (C); Cognitive, emotional or behavioural **consequences** of our beliefs.

The ABC model shows that **A does not cause C. It is B that causes C.**

Albert Ellis's ABC sequence

According to the A, B, C model, anxiety and depression are not a consequence (C) of unpleasant events (antecedent) (A). Instead these negative mood states (C) are produced by the irrational thoughts / beliefs (B) that follow from the occurrence of

unpleasant events (A). The interpretations that are produced at point (C) depend on the individual's belief system. (B)

Ellis (1962) developed rational-emotive therapy as a way of removing irrational and self-defeating thoughts and replacing them with more rational and positive ones. He argued that individuals who are anxious or depressed should create a point D. This is a dispute belief system that allows them to interpret life's events in ways that do not cause them emotional distress.

Rational Emotive Therapy

Rational emotive therapy starts with the therapist making clients aware of the self-defeating nature of many of their beliefs. Clients are then encouraged to ask themselves searching questions about these beliefs in order to discover whether these beliefs are rational and logical. For example clients may be told to ask themselves the questions such as "Why do I have to be liked by everybody?" "Does it really matter if I am not competent in every way?" After this client's are asked to replace their irrational beliefs with more realistic ones e.g. "It is impossible to be liked by everybody, but most people like me". "I will strive to be fairly competent, and accept that perfection cannot always be achieved". The crucial final step is for clients to have full acceptance of these new rational beliefs.

Self Defeating Rule (Irrational Beliefs)

Ellis suggested that a number of core beliefs underlie most unhelpful emotions and behaviours. Core beliefs are underlying rules that guide how people react to the events and circumstances in their lives. The following are examples of these:

1. I need love and approval from those around to me.
2. I must avoid disapproval from any source.
3. To be worthwhile as a person I must achieve success at whatever I do.
4. I cannot allow myself to make mistakes.
5. People should always do the right thing. When they behave obnoxiously, unfairly or selfishly, they must be blamed and punished.
6. Things must be the way I want them to be.
7. My unhappiness is caused by things that are outside my control – so there is nothing I can do to feel any better.

8. I must worry about things that could be dangerous, unpleasant or frightening – otherwise they might happen.
9. I must avoid life's difficulties, unpleasantness, and responsibilities.
10. Everyone needs to depend on someone stronger than themselves.
11. Events in my past are the cause of my problems – and they continue to influence my feelings and behaviours now.
12. I should become upset when other people have problems, and feel unhappy when they're sad.
13. I shouldn't have to feel discomfort and pain.
14. Every problem should have an ideal solution.

Arron Beck

Aaron Beck is probably the most influential cognitive therapist. He developed forms of cognitive therapy for anxiety, but is better known for his work on depression. Beck (1976) argued that therapy for depression should involve uncovering and challenging the negative and unrealistic beliefs of depressed clients. Of great importance is the cognitive triad which consists of negative thoughts about;

- **Themselves**
- **The World**
- **The Future**

Depressed clients typically regard **themselves** as helpless, worthless, and inadequate. They interpret events in the **world** in an unrealistically negative and defeatist way, and they see the world as posing obstacles that cannot be handled. The final part of the cognitive triad involves depressed individuals seeing the **future** as totally hopeless, because their worthlessness will prevent any improvement in their situation.

Locus of Control

Locus of Control refers to an individual's perception about the underlying main causes of events that happen in their life. Is destiny controlled by yourself or by external forces? Individual Locus of control can be **internal**, meaning the person

believes that they are responsible for events that occur in their life or **external** meaning they believe that their environment, some higher power, or other people control or affect their decisions and events that occur in their life.

Understanding of the concept was developed by Julian B. Rotter in 1954 as an important aspect of personality. The most famous questionnaire to measure locus of control is the 13-item forced choice scale of Rotter (1966), but this is not the only questionnaire. Furnham and Steele (1993) cite data which suggest that the most reliable and valid of the questionnaires for adults is the Duttweiler scale(1984).

Cognitive Therapy

The first stage of cognitive therapy involves the therapist and the client agreeing on the nature of the problem and on the goals for therapy. This stage is called collaborative empiricism. The client's negative thoughts are then tested out by the therapist challenging them or by the client engaging in certain forms of behaviour between therapy sessions. It is hoped that the client will come to accept that many of their negative thoughts are irrational and unrealistic. In recent years, there have been increasing efforts to add some of the more successful features of behaviour therapy to cognitive therapy. This combination is referred to as cognitive behavioural therapy.

Cognitive Behavioural Therapy

The goal of cognitive behavioural therapy is primarily one of cognitive change, although through the use of both behavioural and cognitive techniques. CBT suggests that problems are often of your own making, that it is not the situation itself that makes you unhappy, but how you think about, and react to, the situation. CBT has a number of elements;

- Its primary goal is to change cognitive distortions
- It is usually short term
- It maintains a large behavioural component
- It is directive
- Therapy focuses on the here and now

- It focuses on skills to help individuals cope better with their emotional problems

CBT Effectiveness

CBT is one of the most effective treatments for conditions where anxiety or depression is the main problem. It is the most effective psychological treatment for moderate and severe depression and is as effective as antidepressants for many types of depression. Cognitive behavioural therapy differs from most other types of therapies in a number of ways;

- **Pragmatic:** CBT helps identify specific problems and then an attempt is made to solve them.
- **Highly structured:** rather than talking freely about their life, the individual and the therapist will discuss the specific problems and set goals for the client to achieve. As part of this, the client may be given homework in the form of activities that they should try to complete before the next therapy session.
- **Concerned with the present:** unlike some other therapies that attempt to explore and possibly resolve past issues, CBT is mainly concerned with how individuals think and act now.
- **Collaborative:** the therapist will not tell the individual what to do; they will work with the client in order to help them to improve their situation.

A course of CBT therapy can comprise of 5-20 weekly sessions, with each session lasting between 30-60 minutes. The initial sessions will be spent breaking down what appears to be an insolvable problem, into smaller parts. One way to do this is to consider a certain situation, and then see how it affects the individual's thoughts, emotions, physical feelings, and actions.

CBT combines the advantages of cognitive and behavioural therapy and so provides appropriate treatment for a wide range of disorders. Cognitive Behavioural Therapy has proven in scientific studies to be effective for a wide variety of problems, including mood disorders, anxiety disorders, personality disorders, eating disorders, substance abuse disorders, and psychotic disorders. It has been clinically demonstrated in numerous studies to be effective for many psychiatric disorders and

medical problems for both children and adolescents. It has been recommended in the UK by the National Institute for Health and Clinical Excellence as a treatment of choice for a number of mental health difficulties, including post-traumatic stress disorder, OCD, bulimia nervosa and clinical depression.

There is good evidence for CBT's effectiveness in reducing symptoms and preventing relapse. As it is an inexpensive and cost effective form of treatment, it is increasingly being used as a preferred form of treatment. CBT is successful in the treatment of depression, anxiety disorders and panic disorders. However it is of little value in the treatment of disorders that do not involve irrational beliefs. CBT is also more effective in treating OCD than behaviour therapy. CBT has limited appropriateness for the treatment of schizophrenia, however, schizophrenia is a very complicated disorder and extremely hard to treat successfully.

Beck's approach is considered more sophisticated than Ellis's. Ellis assumed that similar irrational beliefs underlie most mental disorders, whereas Beck argued that specific irrational beliefs tend to be associated with each disorder.

Specific and Common factors

The effectiveness of any therapy depends on specific factors unique to that therapy. It also relies on common factors related to all therapies such as warmth, acceptance and empathy. It has been argued (Strupp 1996) that about 85% of the variation in the effectiveness of therapy depends on common rather than specific factors.

Positive common factors include a therapist's empathic personality and encouragement to handle issues that clients find hard to deal with. Negative common factors include therapists, who display a lack of empathy, underestimate the severity of the client's problems and who disagree with the client about the process of therapy. Clients who are poorly motivated, expect that therapy will be easy, or who have poor interpersonal skills are most likely to experience negative outcomes.

Family Therapy

Sometimes a problem cannot be resolved with just individual treatment, because it has its origin in how the whole family interacts. Many clinical psychologists work in family therapy which focuses on the family's relationships, including alliances, feuds and tendencies to make individuals scapegoats for everyone else. Modern family therapists look at the family in terms of working systems, with everyone interlinked and affecting everyone else.

Therapy aims to teach family members to become aware of their impact on others, learning to respond sensitively to one another instead of just reacting to other family members as a source of irritation. The emphasis is not so much on the dysfunctional aspects of family life but on its positive aspects and how they can be strengthened. Feedback is provided, to allow the family develop ways of adjusting to a more psychologically healthy state, allowing interaction in a positive and constructive manner. Therapy methods vary considerably;

- **Acting out crucial events** so they can examine how they reacted at the time
- **Charts/ diagrams** of alliances and splits
- **Sculpting**- families arrange themselves without speaking to show how close or distant they are to each other

Sometimes therapists see several families together, as it is often easier for individuals to recognise disturbed functioning in someone else's family than their own and observing others can provide valuable insight into individuals own situation.

Bibliography

Beck, A., Davis, D. & Freeman, A. (2007). *Cognitive Therapy of Personality Disorders*, 2nd Ed. New York: Guilford Press. ISBN 978-1-59385-476-8

Benjamin, L. (2005). "A history of clinical psychology as a profession in America and a glimpse at its future". *Annual Review of Clinical Psychology* 1 (1): 1–30.

Benjamin, L. (2007). *A brief history of modern psychology*. Malden, MA: Blackwell Publishing. ISBN 978-1-4051-3206-0.

Bennett, P. (2007) *Abnormal Clinical Psychology; An Introductory Textbook* (Second edition). Maidenhead: Open University Press

Bitter, J. & Corey, G. (2001). "Family Systems Therapy" in Gerald Corey (ed.), *Theory and Practice of Counseling and Psychotherapy*. Belmont, CA: Brooks/Cole.

Cheshire, K. & Pilgrim, D. (2004). *A short introduction to clinical psychology*. London; Thousand Oaks, CA: Sage Publications. ISBN 0-7619-4768-X

Compas, B. Gotlib, I. (2002). *Introduction to clinical psychology*. New York, NY: McGraw-Hill Higher Education. ISBN 0-07-012491-4.

Coolican, H. (2007). *Applied Psychology*. (2nd Edition). London: Hodder Arnold.

Eysenck, M.W. (2000) *Psychology: A Students Handbook*. New York; Psychology Press

Gabbard, G. (2005). *Psychodynamic Psychiatry in Clinical Practice*, 4th Ed. Washington, DC: American Psychiatric Press. ISBN 1-58562-185-4

Hall, J., Llewelyn, S. (2006). *What is clinical psychology* (4th Edition). United Kingdom: Oxford University Press. ISBN 0-19-856689-1.

Hayes, N. (2010) *Understanding Applied Psychology*. London: Hodder Education.

Myers, D. (2002) *Exploring Psychology*, fifth edition, New York; Worth publishers

Myers, D. (2008). Exploring Psychology. Worth Publishers. ISBN 1-57259-096-3.

O'Donohue, W.; Ferguson, K.E. (2006). "Evidence-based practice in psychology and behaviour analysis" Behav Analyst Today 7 (3): 335–50. doi:10.1037/h0100155

Klusman, L. (2001). "Prescribing Psychologists and Patients' Medical Needs; Lessons From Clinical Psychiatry". Professional Psychology: Research and Practice 32(5): 496–500. doi:10.1037/0735-7028.32.5.496

Leichsenring, F. Leibing, E. (2003). "The effectiveness of psychodynamic therapy and cognitive behaviour therapy in the treatment of personality disorders: A meta-analysis". The American Journal of Psychiatry 160 (7): 1223–33.

Lezak, M., Howieson, D. Loring, D. (2004). Neuropsychological assessment (4th ed.). New York, NY: Oxford University Press. ISBN 0-19-511121-4.

McMillan, M. (2004). The Person-Centred Approach to Therapeutic Change. London, Thousand Oaks: SAGE Publications. ISBN 0-7619-4868-6

Nicholas, D. R. & Stern, M. (2011). Counseling psychology in clinical health psychology: The impact of specialty perspective. Professional Psychology: Research and Practice, 42(4), 331-337. doi:10.1037/a0024197

Plante, T.(2005). Contemporary clinical psychology. New York, NY: Wiley & Sons. ISBN 0-471-47276-X.

Reisman, J. (1991). A history of clinical psychology. United Kingdom: Taylor Francis. ISBN 1-56032-188-1.

Seligman M., Csikszentmihalyi M. (2000). "Positive psychology: An introduction". American Psychologist 55 (1): 5–14. doi:10.1037/0003-066x.55.1.5

Seligman M., Rashid T., Parks A. (2006). "Positive Psychotherapy". American Psychologist 61 (8): 774–88. doi:10.1037/0003-066x.61.8.774

Slife, B. Barlow, S. & Williams, R. (2001). Critical issues in psychotherapy: translating new ideas into practice. London: SAGE. ISBN 0-7619-2080-3

Forensic Psychology

Forensic psychology is a branch of applied psychology which applies psychological principles to the criminal and civil justice systems. It is the intersection of psychology and the law, but forensic psychologists can perform many roles so the definition can vary. In many cases, people working within forensic psychology are not necessarily "forensic psychologists." These individuals might be clinical psychologists, school psychologists, neurologists or counsellors who lend their psychological expertise to provide testimony, analysis or recommendations in legal or criminal cases.

Forensic Psychology is very much rooted in empirical research, theory and practice, and is one of the fastest growing areas of applied psychology. Forensic psychologists work mainly in the prison and probation service, developing one to one or group interventions and treatment programmes for use with offenders, those on community orders and others under supervision. They work to address their offending behaviour or their psychological needs for example to manage depression, anger or anxiety.

Using expertise based on psychological theory and research, forensic psychologists work closely with other professionals and agencies, both in the assessment, treatment and management of individuals, and in the development of institutional policy and working practices.

Principles of Forensic Psychology

Forensic psychology is the application of psychological principles and methods to the study of criminal behaviour and legal processes. It draws on many different theoretical areas of psychology such as developmental psychology to explore the origins of aggressive behaviour, cognitive psychology to inform best practice in interviewing witnesses and social psychology to evaluate how small group dynamics may affect juror decision making.

While the term forensic psychology literally means psychology applied to courts of law, it now encompasses a vast area of applications representing the diverse fields of practice. It may be involved in the treatment of mentally disordered offenders,

assessing the likelihood of reoffending, providing expert testimony or advising on litigation cases.

It is important to recognise the role of a forensic psychologist as a research practitioner. The development of evidence based practice within the prison service is clear evidence of the increasing collaboration between researchers and practitioners such that practitioners work is increasingly grounded in scientific research and reciprocally practice concerns have a greater influence on research.

Psychological approaches to understanding crime: Theories of offending

There are many different psychological models of criminal behaviour ranging from early Freudian notions to later cognitive and social psychological models. The fundamental assumptions of psychological theories of criminality are:

- 1. The individual is the primary unit of analysis in psychological theories.
- 2. Personality is the major motivational element that drives behaviour within individuals.
- 3. Normality is generally defined by social consensus.
- 4. Crimes then would result from abnormal, dysfunctional, or inappropriate mental processes within the personality of the individual.
- 5. Criminal behaviour may be purposeful for the individual insofar as it addresses certain felt needs.
- 6. Defective, or abnormal, mental processes may have a variety of causes, i.e., a diseased mind, inappropriate learning or improper conditioning, the emulation of inappropriate role models, and adjustment to inner conflicts.

The last assumption of the psychological model would suggest that a variety of different causes or reasons exist for criminal behaviour and that general principles targeted at the individual would be effective for crime control.

However, there is a subset of a psychological criminal type, defined currently as antisocial personality disorder in the DSM 5 and previously defined as the sociopath or psychopath (APA, 2013). This type of criminal exhibits deviant behaviour early in

life and is associated with self-centeredness, a lack of empathy, and a tendency to see others as tools for their ends.

Controls for these individuals would be more extreme and general public policies may not be stringent enough to curb the behaviour in this small subset of criminals. Traditional imprisonment, fines, and other court sanctions are based on operant learning models of behaviour for crime control. Operant learning models are based on the utilitarian concepts that all people wish to maximize pleasure and minimize pain or discomfort.

Behavioural Approaches

Skinnerian based social psychological theories of reinforcement and punishment are influential in this model of criminal control although the idea of punishment for crime has a much longer history. Punishments are any sanctions designed to decrease a specific behaviour; fines, jail sentences, etc. are all forms of punishment.

However, Skinner himself recognized that punishment was generally ineffective in behaviour modification and that reinforcement worked better (Skinner, 1966). Because harsh forms of punishment do not appear to significantly decrease re-conviction rates, other psychological principles have been applied.

In terms of cognitive behavioural psychological principles, rehabilitation and relearning, retraining, or educational programs for offenders are forms of psychologically based methods to control crime. These methods are based on the cognitive behavioural methods of teaching an alternative functional response in place of a formally dysfunctional one as opposed to simple punishment. These programs can take place in prisons or outside of the prison and have long been demonstrated to be successful.

Forms of retraining, re-education, or re-entry program are based on psychological principles of criminality and reform. Many of these programs appear to be especially beneficial for drug and alcohol offenders. Likewise, recent efforts to curb bullying in schools are based on these methods.

In line with this, changing the environment of the offender such as providing more opportunities would be a psychological behavioural principle designed to cut crime.

Other psychological methods are policies aimed at maintaining a visible presence of law enforcement and methods to maintain self-awareness of people in tempting situations. Such methods are preventative.

It has been a well-known social psychological principle that situations that diminish self-consciousness and self-awareness lead individuals to being less restrained, less self-regulated, and more likely to act without considering the consequences of their actions. The simple act of placing mirrors in stores can increase self-awareness and decrease shop-lifting.

Likewise, the presence of visible law-enforcement can cut down on crime substantially. Making sanctions and the consequences for crime well-publicized and available to the public is another psychological method to control crime.

Various forms of criminal profiling are based heavily on psychological principles and represent an effort to either apprehend existing criminals or to identify persons at risk for certain behaviour. More recently there have been efforts to develop methods to identify individuals at risk for certain forms of deviant behaviour including criminal activities based on personality and social variables.

These psychological variables can be identified in the school or at home at an early age and include such disorders as learning disabilities, ADHD, depression, and others. Since many individuals with these problems often go on to demonstrate criminal behaviour or have legal problems later, efforts to identify and treat these issues are forms of psychological crime control policies.

Methods of crime control policies based on psychological principles target the individual and attempt to reform or prevent criminal behaviour from that perspective. Any policies requiring therapeutic intervention, retraining, or education are psychological in nature. Any policy designed at preventing crime by targeting individuals such as raising consciousness, promoting self awareness, or identifying individuals at risk are also psychological. Likewise, psychologists have long recognized that the best predictor of future behaviour is the individual's past behaviour. So policies that are specifically designed to deal with repeat offenders are also based on psychological principles of criminality.

Sociological Approaches

Sociological principles and psychological principles of criminality are intertwined and technically not independent. As with psychological theories there are numerous sociological formulations of the cause and control of criminality.

- 1. Attempting to connect the issues of the individual's criminality with the broader social structures and cultural values of society, familial, or peer-group.
- 2. How the contradictions of all of these interacting groups contribute to criminality.
- 3. The ways these structures cultures and contradictions have historically developed.
- 4. The current processes of change that these groups are undergoing.
- 5. Criminality is viewed from the point of view of the social construction of criminality and its social causes.

Traditional sociological theories proposed that crimes was a result of anomie, a term meaning "normlessness" or a feeling of a lack of social norms, a lack of being connected to society. The term was made popular by Émile Durkheim (1897). Durkheim originally used the term to explain suicide, but later sociologists used the term to describe the dissociation of the individual from the collective conscience or the criminality resulting from a lack of opportunity to achieve aspirations or by the learning of criminal values and behaviours. Therefore criminality results by the failure to properly socialize individuals and by unequal opportunities between groups. Durkheim believed that crime was an inescapable fact of society and advocated maintaining crime within reasonable boundaries.

A feature of sociological theories is that society "constructs" criminality. Therefore, certain types of human activity are harmful and are judged so by society as a whole. But it is also true that there are other behaviours recognized by society as "criminal" that do not result in harm to others and are therefore criminalized without sufficient ground, these are the so-called "victimless" crimes. Therefore according to this view if carried to its extreme 100% of the members of a society are lawbreakers at some

point. One of the sociological policy methods of crime control would be to advocate for decriminalization of these victimless crimes or at least a vast reduction in their penalties.

An important sociological control would be to increase legitimate opportunities for advancement and obtainment of goods and wealth in areas where these do not exist. Sociological controls targeted at this goal could originate at national as well as local levels of government and would include programs designed to guarantee equal opportunities to all individuals.

Social programmes ranging from job training, educational funding, urban renewal projects and so forth would be in line with sociological policies to control crime. Other related sociological controls for crime would consist of organizing and empowering community residents with projects like community crime watches, providing role models for children in schools and in other venues, providing parental support for working parents, and establishing community centres in downtrodden areas to allow people to learn and engage in positive activities.

Social programs aimed at socializing children properly and providing support for single family homes are also examples of sociological methods to control crime. Sociological policies to control crime would advocate stronger and harsher penalties for serious crimes such as murder, rape, are more effective law enforcement. Again, sociologists accept the realities that crime is a social phenomenon that will not disappear no matter how many interventions are enacted to control it.

Biological Approaches

Biological theories of criminality purport that criminal behaviour is the result of some flaw in the biological makeup of the individual.

- (1) Heredity (Genetics)
- (2) Neurotransmitter dysfunction/ chemical imbalance
- (3) Brain abnormalities that were caused by either of the above, improper development, or trauma.

Biological theorists would also endorse stricter penalties and better law enforcement techniques for crime control, but there are methods of crime control that are specific to the biological theories of criminality such as pharmacological, deep brain stimulation and psychosurgery.

Theories in Criminology: Why People Commit Crime

In criminology, examining why people commit crime is very important in the ongoing debate of how crime should be handled and prevented. Many theories have emerged over the years, and they continue to be explored, individually and in combination, as criminologists seek the best solutions in ultimately reducing types and levels of crime.

- **Rational choice theory:** People generally act in their self-interest and make decisions to commit crime after weighing the potential risks including getting caught and punished against the rewards.
- **Social disorganization theory:** A person's physical and social environments are primarily responsible for the behavioural choices that person makes. A community that has fraying social structures is more likely to have high crime rates. Such a community may have poor schools, vacant and vandalized buildings, high unemployment, and a mix of commercial and residential property.
- **Strain theory:** Most people have similar aspirations, but they don't all have the same opportunities or abilities. When people fail to achieve society's expectations through approved means such as hard work and delayed gratification, they may attempt to achieve success through crime.
- **Social learning theory:** People develop motivation and the skills to commit crime through the people they associate with.
- **Social control theory:** Most people would commit crime if not for the controls that society places on individuals through institutions such as schools, workplaces, churches, and families.
- **Labelling theory:** People in power decide what acts are crimes, and the act of labelling someone a criminal is what makes him a criminal. Once a person

is labelled a criminal, society takes away their opportunities, which may ultimately lead to more criminal behaviour.

- **Biology, genetics, and evolution:** Poor diet, mental illness, body chemistry and even evolutionary rewards for aggressive criminal conduct have been proposed as explanations for crime.

Effects of Crime on Victims

Traditionally many offences go unnoticed or unlabelled as real crime and are therefore not recorded. Within traditional definitions the extent of criminality is quite broad and much more 'normal' than people think. Prime et al (2001), revealed 33% of males and 9% of females born in 1953 had been convicted of at least one offense before the age of 46, and that 7% of males and 1% of females born in 1953 had received a custodial sentence before the age of 46, with 55% of convicted males and 80% of convicted females having criminal careers of less than one year. Similarly Flood-Page et al (2000) showed that 50% of 12-30 yr olds admitted at least 1 of 27 offences at some point, and that the most prolific 10% of offenders were responsible for nearly half of all crimes admitted by the sample. Women are generally more fearful of crime than men, while younger people are more afraid of becoming victims of violence or burglary than older age groups. (BCS 2010).

Risks of becoming a victim of violence

Men aged 16-24 have a 12.6% risk compared to 5.5% for men aged 25-34. Women aged 16-24 have a 7% risk compared to 2.8% risk for women aged 25-34 and women aged 75+ 0.2%. Factors most strongly associated with worry about becoming a crime victim were being female and people from an ethnic minority believed there was danger of an unprovoked attack. Dixon et al (2008) suggest that the impact of crime in terms of having been a victim or fearing becoming a victim goes beyond the immediate loss or pain, and may be long term. It can threaten peoples identity, reducing their social mobility and sense of well being, affecting their life choices and undermine their trust levels.

The harm of crime is unevenly distributed and is amplified by poverty and disadvantage, with repeat victimisation common. Pease and Farrell showed from BCS findings that 4% of all victims disproportionately experience 43% of crime-

being victimised once, for some individuals significantly increases the chance of being a victim again. Some of the characteristics of those likely to suffer repeat victimisation are; Living in a poor area, having a chaotic lifestyle and being in an abusive or volatile relationship. Dixon *et al* (2008) demonstrate that people in low income households are almost twice as likely to be mugged or burgled as those living in households with incomes of 30,000 or more. We are not always very sympathetic towards victims of crime. Often very deserving victims receive very little sympathy.

We all like to believe the world is a fair place and when we see someone suffer who has not done anything to deserve that it calls into question our belief in a just world. In order to make sense of the suffering we differentiate ourselves from the victim and convince ourselves that the victim somehow deserved their fate (Attribution). This attribution process was originally described by Lerner (1965) as the 'just world hypothesis.' In its simplest form it states that individuals have a need to believe that they live in a world where people get what they deserve and deserve what they get.

Victim degeneration is particularly likely in relation to specific crimes such as rape. For example a female victim of rape may be blamed for having dressed or behaved provocatively, or risked her own safety by drinking heavily or walking home alone at night.

There may be a gender difference though, Lerner and Miller suggest that women, regardless of their level of belief in a just world tend not to blame or derogate rape victims as much as men do because they empathise with the victim. The way we view victims particularly the vulnerable, the disadvantaged, and those who suffer repeat victimisation is important within a concept of social and restorative justice. It should also be remembered that offenders and their families are often victims too. Many offenders have been failed by their parents and by public services, or they may have mental health or addiction problems which have not been adequately treated. The vast majority of crime victims do not believe that prison reduces levels of offending, and that the government needs to invest more in tackling the causes of crime and providing treatment programmes for offenders.

Violence and Forensic Psychology

Violence is an extreme form of aggression, such as assault, rape or murder. Violence has many causes, including frustration, exposure to violent media, violence in the home or neighbourhood and a tendency to see other people's actions as hostile even when they're not. Certain situations also increase the risk of aggression, such as drinking, insults and other provocations and environmental factors like heat and overcrowding. The causes of violent behaviour in humans are often a topic of research in forensic psychology. Scientists do agree violence is inherent in humans. Among prehistoric humans, there is archaeological evidence for both contentions of violence and peacefulness as primary characteristics. Since violence is a matter of perception as well as a measurable phenomenon, psychologists have found variability in whether people perceive certain physical acts as 'violent'.

Understandings of violence are linked to a perceived aggressor-victim relationship: hence psychologists have shown that people may not recognise defensive use of force as violent, even in cases where the amount of force used is significantly greater than in the original aggression. The "violent male ape" image is often brought up in discussions of human violence.

Violence is often pursued as an antidote to shame or humiliation. The use of violence often is a source of pride and a defence of honour, especially among males who often believe violence defines manhood. Evolutionary psychology offers several explanations for human violence in various contexts, such as sexual jealousy in humans, child abuse and homicide. Goetz (2010) argues that humans are similar to most mammal species and use violence in specific situations. He writes that "Buss and Shackelford (1997) proposed seven adaptive problems our ancestors recurrently faced that might have been solved by aggression: co-opting the resources of others, defending against attack, inflicting costs on same-sex rivals, negotiating status and hierarchies, deterring rivals from future aggression, deterring mate from infidelity, and reducing resources expended on genetically unrelated children."

Psychopathy

Psychopathy is among the most difficult disorders to detect. The psychopath can appear normal, even charming. Underneath, they lack conscience and empathy, making them manipulative, volatile and often (but not always) criminal. Psychopathy is largely impervious to treatment. It is important to note that the vast majority of people with antisocial tendencies are not psychopaths. A common, yet understandable mistake is to assume that the terms psychopathy and psychotic are interrelated, they are not. A psychotic individual is essentially out of touch with reality, she or he is likely to be delusional and experience hallucinations, and is, therefore, behaviourally speaking, completely unaware of what they are doing and why they are doing it. Psychopathic behaviour on the other hand is rational; it represents an informed choice, a premeditated strategy to act in way that serves as an effective means to an end.

Offender Profiling

Offender profiling is grounded in the belief that it is possible to work out the characteristics of an offender by examining the characteristics of their offences. "Profiling generally refers to the process of using all the available information about a crime, a crime scene, and a victim in order to compose a profile of the unknown perpetrator." Profiling differs from conventional detection in its attempt to use information about how an offence was committed to make suggestions about the psychological characteristics of the offender. Profiling cannot tell police exactly who committed an offence, but it potentially can make predictions about the characteristics an offender is likely to possess. This can help police target their investigation more effectively and prioritise suspects once they have been identified.

FBI approach to profiling

- Data Assimilation (police reports, pathologists reports, crime scene photographs, witness reports)
- Crime Scene Classification- deciding if the crime scene falls into the organised or disorganised typology

- Crime Scene Reconstruction
- Profile Generation- (demographic features, such as social class, age, lifestyle, type of work, behavioural habits and personality habits)
- This approach has captured the public's imagination and media moguls, however, it is criticised for its lack of scientific evaluation and over-reliance on subjective intuition making it more of an art than a science.

Offender Profiling

Four main approaches to offender profiling were identified by Ainsworth (2001).

- **The geographical approach** – this looks at patterns in the location and timing of offences to make judgements about links between crimes and suggestions about where offenders live and work.
- **Investigative psychology** – this grew out of geographical profiling and uses established psychological theories and methods of analysis to predict offender characteristics from offending behaviour.
- **The typological approach** – this involves looking at the characteristics of crime scenes to assign offenders to different categories, each category of offender having different typical characteristics.
- **The clinical approach** – this approach uses insights from psychiatry and clinical psychology to aid investigation where an offender is thought to be suffering from a mental illness or other psychological abnormality.

There is considerable debate about which of these approaches is the most effective way of profiling offenders and whether psychological profiling has anything useful to offer at all. There is also an ongoing debate about whether offender profiling is an art or a science and the extent to which a scientific approach to offender profiling is possible.

Risk Assessment and Sex offenders

Risk assessment is a corner stone of effective offender management. It is crucial to identify the risks posed by offenders and the interventions that could be taken to manage or reduce those risks. This is relevant for all categories of offenders including sex offenders. One view is that risk assessment can identify who is likely to re-offend. A conflicting view is that there is an over-reliance on methods of unknown or limited value pretending a degree of scientific support and precision that has not been attained.

In the criminal justice system offenders pass through several stages of processing. At each stage risks of re-offending are assessed by professionals: pre-trial, prior to sentencing, to determine security levels in custody, prior to release and after breaches or critical incidents. These assessments can be either formal or informal. Risk assessment is fundamental to the criminal justice process. It aims to distinguish between offenders who are likely to re-offend and those who are at a lower risk of recidivism. Risk assessments are predictions of future behaviour. They have serious implications for both the offender and society. Risk prediction has a place in the criminal justice system. But in itself it carries the risk of error. The assessment of sexual offenders considers characteristics that increase or decrease risk. Prediction of sexual aggression in particular is an extremely difficult task due to the complex and multi-factorial nature of this type of crime.

Static and dynamic factors

Static risk factors include age, development history or offence history. Fixed characteristics, they are not amenable to change. While useful for evaluating long-term risk, due to their historical nature they cannot however be used to assess changes in levels of risk over time.

Dynamic factors are continuing factors linked to the likelihood of offending that are amenable to change following intervention. Dynamic factors can be further subdivided into stable and acute factors. Stable dynamic risk factors are relatively persistent characteristics of the offender, which are amenable to change over time. Examples would be responsibility, cognitive distortions and sexual arousal. Acute

dynamic factors are rapidly changing factors such as substance abuse, isolation and negative emotional states which increase risk.

Risk Assessment Tools

Stable Dynamic 2007 involves:

- 1 Introductory Interview
- **Section 1** –Social influences
- **Section 2** – Intimacy Deficits
 - a). capacity for relationship stability
 - b). emotional identification with children
 - c). hostile attitudes towards women
 - d). general social isolation / rejection / loneliness
 - e). lack of concern for others
- **Section 3** – General Self-regulation
 - a). Impulsive Acts
 - b). Poor Cognitive Problem Solving Skills
 - c). Negative Emotionality / Hostility
- **Section 4** – Sexual Self-regulation
 - a). Sexual Pre-occupation
 - b). Sex as Coping
 - c). Deviant Sexual Interests
- **Section 5** – Co-operation with Supervision
 - The Probation Officer has to assess whether the offender is working with them or against them.

Stable Dynamic Scoring System

Each of the thirteen parts is scored by the assessor on a 0, 1, 2 basis, 0 equating to low risk and 2 being high risk, and totalled accordingly.

Stable Acute Dynamic

Acute variables are factors associated with recidivism. They assess short term, timing of re-offending, and expression of current risky behaviour. Therefore acute risk factors should be assessed every time an offender attends a supervision session. The Stable Acute Dynamic risk predictor has the following factors and corresponding criteria.

- **Victim Access:** Consideration should be given to any opportunities for contact between victim and the offender.
- **Emotional Collapse:** Ascertain how the offender has been since the last supervision session. Whether the emotional state is appropriate, signs of depression / anxiety or substance abuse.
- **Collapse of Social Supports:** Question the offender about his daily routine and his social supports to assess if there have been any changes. Also it is useful to keep in regular contact with collaborators who are supportive of the offender and enquirers to verify information.
- **Hostility:** The supervisor should check for irrational or reckless defiance in the offender's interaction with others. What made him angry, how did he manage and who was involved?
- **Substance Misuse:** The offender should be questioned about his general wellbeing, if he is on medication, drinking or drug misuse habits. Information should be cross referenced with urinalysis screening.
- **Sexual Preoccupations:** Assessment of the offenders' sexual preoccupation needs to be made during each meeting to ascertain if he uses sex as a way of coping in times of upset, and if he has deviant sexual interests and fantasies.
- **Rejection of Supervision:** Is the offender working with the officer? Ability to comply with supervision and a willingness to engage and take constructive feedback is a good indication.

Methods of Risk Assessment

“Methods of risk assessment tend to fall into two broad categories, clinical and actuarial. Clinical assessments are based on professional training, theoretical knowledge and experience with offenders that are clinical judgement. Actuarial (or statistical) prediction, involves predicting an individual’s similarity to members of violent groups.

While actuarial measures have been shown to be superior in predicting recidivism compared with clinical judgement, most measures are heavily reliant on static factors alone and few consider dynamic changes in risk. Low frequency events are difficult to predict and low base rates of re-offending inevitably lead to errors in predictions. Low base rates lead to false-positive prediction where risk is overestimated and high risk offenders do not re-offend. Such assessments are usually primarily based on static risk factors and do not always consider dynamic changes in risk.

Analysis of sex offender outcomes studies suggests that contemporary treatment has a significant effect in reducing sexual recidivism and meta-analysis found that treatment dropout was a significant predictor of sexual recidivism. Actuarial estimates of risk should be adjusted based on treatment related information such as refusal to participate in treatment, treatment progress and programme completion.

In recognition of the importance of changes in risk, researchers and practitioners are increasingly focusing their attention on dynamic risk *and the factors that lead to sexual recidivism*. Beech, Erikson, Friendship, and Ditchfield, (2001); Serin, Maillous and Malcolm, (2001) have shown that considering and combining dynamic risk predictors such as sexual deviancy, pro-offending attitudes and other dynamic measures can increase the predictive accuracy of more static based risk instruments.

Static Risk Assessment

Risk prediction has been by far one of the most popular themes of sex offender research in the last few years. There are over 26 different static risk scales available for the prediction of sexual recidivism. Some of these are poorly validated; others have developed thorough and complex scoring procedures and have been tested on several separate samples (e.g. STATIC – 99; Hanson and Thornton, 2000).

Static risk scales are popular and important; their predictive ability is far superior to unstructured clinical judgement (Rice, 2000). However there is a danger that practitioners become over-reliant on them and forget that they perform better at predicting the behaviour of groups rather than they do at predicting the behaviour of individuals.

Several static factors have repeatedly been demonstrated to predict sexual recidivism. In a review of the literature, Craig, Browne and Stringer (2003) examined 26 studies on sexual offence recidivism and identified 17 static factors that were associated with sexual offences. These included:

- prior criminality
- prior sexual offences
- psychopathy
- age and time spent in custody
- paraphilias and deviant sexual interests

Hanson, Scott and Steffy (1995) found that static factors which predicted sexual recidivism among child sex offenders were prior-offence type and victim type; different from the predictors of non-sexual recidivism (low education, youth, violence). (Frisbie & Dondis, 1965; Proulx et al, 1997; Hanson et al, 1993), through Prently, Knight and Lee (1997) found that sex of the victim was not predictive of recidivism.

“Dynamic Risk Assessment” – Third Generation

Although the research is still in the early stage it has the potential to revolutionise practice in the assessment of both treatment and change following treatment. Pioneering research relates to dynamic risk assessment and is found in Beech (1998) using a cluster analysis, obtaining a two cluster solution representing “high deviance” and “low deviance” groups. High deviance men had high levels of social inadequacy, high personal distress, they minimised the experience of their victims, showed high sexual obsession and low levels of denial about offence behaviour.

Beech (1998) was able to demonstrate that this group of men had far more victims, were at greater risk of being reconvicted, were more likely to have abused outside the family and were more likely to have crossed over victim types. Allam (2000) using the Beech system identifying deviancy concluded that high deviance men were more likely to reoffend. This research defined potentially changeable or treatable characteristics associated with repeat sexual offending.

There seems to be less agreement on which dynamic risk factors account for the most variance in predicting sexual offence recidivism. Despite this Craig, Browne and Stringer (2003) identified 24 dynamic factors, 10 stable dynamic risk factors and 14 acute dynamic risk factors associated with sexual offence recidivism. Unemployment, substance abuse, criminal lifestyle or negative social influences and impulsivity (poor self-control and management) have been associated with sexual re-offending. Hanson et al (1993) found that dynamic factors relating to personality improved during treatment. The individual felt more in control of his life, more extraverted, less hostile, experienced less distress, less depressed mood and improved self esteem. These reported changes relate to stable dynamic factors and a change in perspective and coping skills rather than any significant change in personality. However techniques such as dialectical behaviour therapy and cognitive therapy have been shown to effect change in personality.

Poor treatment motivation has been associated with recidivism and deterioration in dynamic factors, such as emotional loneliness, deficits in empathy and relapse prevention skills, has been associated with treatment drop-out. In Hanson and Bussiere's (1998) meta-analytical review of 61 studies the strongest predictors of sexual recidivism were characteristics related to sexual deviance and to a lesser extent, general criminological variables. Sexual recidivism was unrelated to having a history of sexual abuse as a child, substance abuse and general psychological problems such as anxiety, depression and low self-esteem. These findings appear inconsistent with more recent findings. However what it does appear to suggest is that general psychological problems, such as low self-esteem, emotional identification with children and justification for sexual offending, and deviance coupled with static risk classifications, contribute to offenders risk for sexual recidivism (Beech, Friendship, Erikson and Hanson, 2002; Hanson and Harris, 2000, 2001). The literature seems to state that although personal distress is not a direct

predictor of sex offence recidivism, it may have an indirect effect if offenders rely on more deviant interests when distressed. Poor social support networks and social skills when released into the community can lead to increased feelings of anxiety, distress and recidivism.

Conclusion

In summary the three generations of risk assessment are now being realised through a combined approach using clinical judgement and actuarial assessments such as the static measures. Dynamic assessments have the ability to structure clinical judgement and measure change. Few actuarial measures consider dynamic factors. However such dynamic risk assessment tools, although they are empirically informed, need to be validated before their true potential can be realised. They have the ability to inform and revolutionise practice when used with a static measure and sound clinical judgement. Actuarial measures are increasingly used by the Prison and Probation Services in jurisdictions such as England, Wales, and Canada and more recently in Northern Ireland. The Probation Board of Northern Ireland (PBNi) has adopted the STATIC – 99, the Stable Dynamic and the Acute Dynamic 2000. The Irish Probation Service is preparing to follow suit with the introduction of the same tools. With the increasing development of actuarial risk assessments in probation practice practitioners will have the ability to gain profiles of sexual offenders in their own jurisdictions. Therefore they have the potential to predict more accurately recidivism and to provide valuable information in order to tailor treatment to meet the needs of the offender. Clinical judgement has the opportunity to be backed-up by empirical driven research; however it is important to build on this research by using actuarial predictors that cater for different sub-groups of offenders and issues. Neither clinical nor actuarial techniques singly have the ability to provide a robust assessment of risk. An integrated approach combining both actuarial and clinical judgement provides transparency and defensible effective practice, thereby allowing practice to be open to scrutiny and evaluation.

Child Abuse

Once an allegation of child abuse has been made it must be investigated to determine whether there is a basis for the allegation. Psychologists are frequently asked to evaluate children and adults to assess whether a pattern of abuse is evident, to identify personal, family and outside stressors that are contributing to the abuse pattern or creating a high risk situation for abuse to occur, and to develop treatment recommendations to eliminate the abuse that is identified. Recommendations may include removing a child from parental care, removing a parent or other adult from the household, supervised visitation, discontinuation of visitation, changing parental custody, treatment for the child or the abuser or both, and a plan for family reunification. Psychologists may complete child abuse investigations for state agencies, for private agencies or as a private practitioner contracted by the state, for a parent making allegations against another adult or parent, for a parent being accused of child abuse, for the court as part of a custody or visitation risk assessment, or as part of treatment of a child or adult.

However, psychologists cannot determine if a person is lying, and evidence of possible abuse does not mean there is abuse. Divorced or separated parents may make false accusations, and troubled children may make an accusation and later retract it.

Psychologists are obligated to clarify the limits of prediction based on clinical judgment and psychological testing, and should not present their opinion as fact. Child abuse investigations usually involve clinical interviews with all involved parties, and collecting information from all appropriate sources. Psychological tests may be employed to assess mental functioning, identify possible psychological disorders or problems, or identify abuse risk factors. Frequently, the findings are presented in court, and the court determines whether there is sufficient data to determine if abuse took place, and who did it.

Witnesses

Justice crucially relies on reliable testimony from eye witnesses and expert witnesses and from scientific evidence. If this testimony is not reliable, the innocent may be wrongfully imprisoned and the guilty may go free. Jurors and police officers

attach considerable importance to the evidence of eye witnesses, despite generally accepted knowledge that there have been many cases of mistaken identification. With the rapid development in DNA technology it has become easier to identify genuine perpetrators. In spite of misidentification, eyewitness testimony plays a very important part in the apprehension of criminals and is probably the most common form of evidence offered by the prosecution.

Memory in relation to eye witness testimony

Psychological research has demonstrated that memory processes are extremely susceptible to influence and according to Loftus (2003) are more likely to produce a synthesis of experiences. Developments in cognitive psychology since the 1980's suggest that perception and memory are active, constructive processes, and that people's perception of the world around them is crucially related to their understanding of that world. Kapardis (2003) suggests that variables which can influence the reliability of eye witness testimony can be classified into four categories

- 1) Event characteristics
- 2) Witness Characteristics
- 3) Perpetrator variables
- 4) Interrogational variables

Event Characteristics

- **Passage of time**- recall is subject to deterioration over time, although there can be remarkable exceptions
- **Frequency** –the more times an event occurs the more likely people will remember it but if asked to remember a specific occasion from a series of recurring events, recall accuracy decreases the more frequently the events have occurred.
- **Duration**-The longer a witness has to view a crime the more accurate their testimony is likely to be, though stress may lead to an overestimate of duration.

- **Illumination-** The amount of light at the crime scene is important. Witness accuracy is better during daytime than towards end of daylight and at night.
- **Weapon-** presence of a weapon is stressful and increases physiological arousal. Cognitive efficiency is said to decline if arousal level increases beyond an optimal level, because the witness cannot attend to all cues or determine which are relevant. Weapon focus-studies have shown that when witnesses are faced with a weapon, they tend to focus on the weapon, reducing their ability to identify the perpetrator.
- **Flashbulb memory-** Brown and Kulik suggest we remember significant and unexpected events vividly and in some detail. Others e.g. Christianson (1992) suggest flashbulb memories may not be so accurate- when questioned on the spaceship challenger explosion, recollection of place, activity and time contained only 30% accurate answers and 42% inaccurate answers. However when Wright (1993) questioned people who had been at Sheffield football stadium when 95 supporters died, their recall was influenced by their emotional investment in the event. This suggests we may reconstruct our memories of important events to support a particular viewpoint, and this strengthens our recall of specific features. Witnessing a traumatic event can increase recall assurance, but not necessarily accuracy.
- **Witness Characteristics**
- **Personality factors**
- **Mood/Emotion**
- **Drugs**
- **Age**
- **Gender**
- **Stereotype**
- **Confidence**
- **Perpetrator Variables**

Most research focuses on facial features, but body shape and movement can also be influencing factors. Gender can be ascertained by witnesses on basis of body movement. Estimates of height are influenced by the height of the witness or post event information about the perpetrators occupation. If witnesses were small they overestimated the height of others and if the perpetrators occupation is high status, this resulted in taller estimates (Christensen, Sweeney and Ochalek 1983). Identification across races is less accurate than own race identification.(Bothwell, Brigham, Pigot (1987)

Interrogation Variables

Post event information presented to witnesses can contaminate their evidence and render it unreliable. When we see something we process certain details, which are then held together by our existing mental schemata which can introduce bias. Misinformation can become part of the recall and trick us into reconstructing our memory of the event witnessed.

Line up identity parades

Wells et al (1998) proposed four general principles to protect innocent suspects.

- 1) Use of the blind technique- person who conducts the line up should not be aware which member of the line-up or photo spread is the suspect.
- 2) Eye witness should be told the person organising the line up does not know which person is the suspect in order to ensure neutrality.
- 3) The suspect should not stand out in the line up or spread as being different
- 4) A clear statement should be taken from the eye witness at the time of the identification as to their level of confidence about their selection.

When Wells (1993) told witnesses that the suspect may not be in the line-up and showed some a line-up with the suspect and others a line-up without the suspect, he found 54% of those who identified the suspect correctly said they definitely would have identified someone else even if the suspect had not been there. A possible way of distinguishing between good and poor eyewitnesses is the 10-12 second rule. Eyewitnesses who identify someone from a line-up quickly tend to be more accurate

Child Witnesses

Children form a specific category of eyewitness particularly in cases of alleged sexual abuse where a child may be the only witness to offences which could have occurred some time ago. Concerns have been expressed about children's ability to give evidence in court, the likely credibility of such testimony and the need to preserve defendants right to a fair trial. Children's evidence has traditionally been seen as unreliable by the courts, with concerns about their suggestibility, poor memory and with very young children their inability to recognise the difference between right and wrong.

Miscarriages of justice and a growing awareness of the extent of child sexual abuse led to the development of a different view of potential child witnesses and the Hedderman report (1998) concluded that with appropriate support and a different approach to interviewing children could be credible witnesses in court. Some developments in this area include the introduction of live links, videotaped interviews, The Memorandum of good practice (1992), research in the area of suggestibility and Achieving Best Evidence (2002)

Considerable advances have been made in the way child witnesses are viewed. However areas for concern remain. Of particular concern is the possible use of coaching in the pre-interview phase and during cross examination via live link. There is also insufficient training of interviewers, and no cohesive national system for the effective preparation of child witnesses through the court process.

Anti-social behaviour in children

Anti-social behaviour is that which lacks consideration for others and may cause damage to the society, whether intentionally or through negligence. This is opposed to pro-social behaviour, which is behaviour that helps or benefits the society. Anti-social behaviour is any sort of behaviour that goes against the norms that society has placed. Many different types of extreme anti-social behaviours have been documented and observed including aggression to those around them, cruelty, violence, scam, theft, arson and vandalism. Other lesser traits that could be considered anti-social are noncompliance, lying, intimidating, manipulative,

and other activities such as drug and alcohol abuse. Antisocial behaviour can be broken down into two components:

- Presence of antisocial (i.e., angry, aggressive, or disobedient) behaviour
- Absence of pro-social (i.e., communicative, affirming, or cooperative) behaviour.

Most children exhibit some antisocial behaviour during their development, and different children demonstrate varying levels of pro-social and anti-social behaviour. Some children may exhibit high levels of both antisocial and pro-social behaviours; for example, the popular but rebellious child. Some, however, may exhibit low levels of both types of behaviours; for example, the withdrawn, thoughtful child. High levels of antisocial behaviour are considered a clinical disorder. Young children may exhibit hostility towards authority, and be diagnosed with oppositional-defiant disorder. Older children may lie, steal, or engage in violent behaviours, and be diagnosed with conduct disorder.

Mental health professionals agree, that rising rates of serious school disciplinary problems, delinquency, and violent crime indicate, that antisocial behaviour in general is increasing. 30 to 70% of childhood psychiatric admissions are for disruptive behaviour disorders, and diagnoses of behaviour disorders are increasing overall. A small percentage of antisocial children grow up to become adults with antisocial personality disorder, and a greater proportion suffers from the social, academic, and occupational failures resulting from their antisocial behaviour.

Causes and characteristics of Antisocial Behaviour

Antisocial behaviour develops and is shaped in the context of coercive social interactions within the family, community, and educational environment. It is also influenced by the child's temperament and irritability, cognitive ability, the level of involvement with deviant peers, exposure to violence, and deficit of cooperative problem-solving skills. Antisocial behaviour is frequently accompanied by other behavioural and developmental problems such as hyperactivity, depression, learning disabilities, and impulsivity.

Multiple risk factors for the development and persistence of antisocial behaviours include genetic, neurobiological and environmental stressors beginning at the prenatal stage and often continuing throughout the childhood years. Genetic factors are thought to contribute substantially to the development of antisocial behaviours. Genetic factors, including abnormalities in the structure of the prefrontal cortex of the brain, may play a role in an inherited predisposition to antisocial behaviours.

Neurobiological risks include maternal drug use during pregnancy, birth complications, low birth weight, prenatal brain damage, traumatic head injury, and chronic illness.

High-risk factors in the family setting include the following:

- parental history of antisocial behaviours
- parental alcohol and drug abuse
- chaotic and unstable home life
- absence of good parenting skills
- use of coercive and corporal punishment
- parental disruption due to divorce, death, or other separation
- parental psychiatric disorders, especially maternal depression
- economic distress due to poverty and unemployment
- Heavy exposure to media violence through television, movies, Internet sites, video games, and even cartoons has long been associated with an increase in the likelihood that a child will become desensitized to violence and behave in aggressive and antisocial ways.

However, research relating the use of violent video games with antisocial behaviour is inconsistent and varies in design and quality, with findings of both increased and decreased aggression after exposure to violent video games. Companions and peers are influential in the development of antisocial behaviours. Some studies of boys with antisocial behaviours have found that companions are mutually reinforcing

with their talk of rule breaking in ways that predict later delinquency and substance abuse. Factors that contribute to a particular child's antisocial behaviour vary, but usually they include some form of family problems (e.g., marital discord, harsh or inconsistent disciplinary practices or actual child abuse, frequent changes in primary caregiver or in housing, learning or cognitive disabilities, or health problems).

Attention deficit hyperactivity disorder is highly correlated with antisocial behaviour. A child may exhibit antisocial behaviour in response to a specific stressor for a limited period of time, but this is not considered a psychiatric condition.

Children and adolescents with antisocial behaviour disorders have an increased risk of accidents, school failure, early alcohol and substance use, suicide, and criminal behaviour. The elements of a moderate to severely antisocial personality are established as early as kindergarten or nursery. Antisocial children score high on traits of impulsiveness, but low on anxiety and reward-dependence, that is, the degree to which they value, and are motivated by, approval from others. Underneath their tough exterior antisocial children have low self-esteem. A salient characteristic of antisocial children and adolescents is that they appear to have no feelings. Besides showing no care for others' feelings or remorse for hurting others, they tend to demonstrate none of their own feelings except anger and hostility, and even these are communicated by their aggressive acts and not necessarily expressed through affect.

One analysis of antisocial behaviour is that it is a defence mechanism that helps the child to avoid painful feelings, or else to avoid the anxiety caused by lack of control over the environment. Antisocial behaviour may also be a direct attempt to alter the environment. Social learning theory suggests that negative behaviours are reinforced during childhood by parents, caregivers, or peers.

A child's negative behaviour initially serves to stop the parent from behaving in ways that are aversive to the child (the parent may be fighting with a partner, yelling at a sibling, or even crying). The child will apply the learned behaviour at school, and a vicious cycle sets in: he or she is rejected, becomes angry and attempts to force his will or assert his pride, and is then further rejected by the very peers from whom he might learn more positive behaviours. As the child matures, "mutual avoidance" sets in with the parent(s) or caregivers, as each party avoids the negative behaviours of

the other. Consequently, the child receives little care or supervision and, especially during adolescence, is free to join peers who have similarly learned antisocial means of expression.

Treatment

The most important goals of treating antisocial behaviour are to measure and describe the individual child's or adolescent's actual problem behaviours and to effectively teach positive behaviours that should be adopted instead. In severe cases, medication will be administered to control behaviour, but it should not be used as substitute for therapy. Children who experience explosive rage respond well to medication. Ideally, an interdisciplinary team of teachers, social workers, and guidance counsellors will work with parents or caregivers to provide universal or "wrap-around" services to help the child in all aspects of his or her life: home, school, work, and social contexts.

In many cases, parents themselves need intensive training on modelling and reinforcing appropriate behaviours in their child, as well as in providing appropriate discipline to prevent inappropriate behaviour. The most effective methods are systemic therapies which address communication skills among the whole family or within a peer group of other antisocial children or adolescents. These probably work best because they entail actually developing (or redeveloping) positive relationships between the children, adolescent or other people.

Methods used in social skills training include modelling, role playing, corrective feedback, and token reinforcement systems. Regardless of the method used, the child's level of cognitive and emotional development often determines the success of treatment. Adolescents capable of learning communication and problem-solving skills are more likely to improve their relations with others.

Unfortunately, conduct disorders, which are the primary form of diagnosed antisocial behaviour, are highly resistant to treatment. Few institutions can afford the comprehensiveness and intensity of services required to support and change a child's whole system of behaviour; in most cases, for various reasons, treatment is terminated usually by the client long before it is completed. Special education teachers and counsellors have a better chance at instituting long-term

treatment programmes, that is, if the student stays in the same school for a period of years.

Research studies show that children who are given social skills instruction decrease their antisocial behaviour, especially when the instruction is combined with some form of supportive peer -group or family therapy. But the long-term effectiveness of any form of therapy for antisocial behaviour has not been demonstrated. The fact that peer groups have such a strong influence on behaviour suggests that schools that employ collaborative learning and the mainstreaming of antisocial students with regular students may prove most beneficial to the antisocial child.

Family and School Based Prevention

Enhanced parent-teacher communications and the availability of school psychologists and counsellors trained in family intervention within the school setting are basic requirements for successful intervention and treatment of childhood antisocial behaviours. School-based programs from early childhood onward that teach conflict resolution, emotional literacy, and anger management skills have been shown to interrupt the development of antisocial behaviour in low-risk students. Students who may be at higher risk because of difficult family and environmental circumstances will benefit from more individualized prevention efforts, including counselling, academic support, social-skills training, and behaviour contracting.

Academic settings with the capacity to deliver professional parental support and provide feedback in a motivating way can help parents to develop effective parenting skills that may interrupt further progression of antisocial behaviour patterns in their children. Access to written and video information on parenting skills and information about community family resources, as well as promotion of parent-support groups, are effective intervention strategies for changing family dynamics that shape antisocial behaviour in the children. Older students who already exhibit a persistent pattern of antisocial behaviour can be helped with intensive individualized services that may involve community mental health agencies and other outside intervention.

Community-based programs, including youth centres and recreational programs with trained therapists, can provide additional support for at-risk children. Healthy nutrition and prenatal care, a safe and secure family and social environment, early bonding with an emotionally mature and healthy parent, role models for pro-social behaviours, non-coercive methods of parenting, peer relationships with pro-social individuals, and early intervention when problems first appear are all means of assuring development of pro-social behaviours and reducing and extinguishing antisocial behaviours in children.

Parents may hesitate to seek help for children with antisocial behaviour patterns out of fear of the child being negatively labelled or misdiagnosed. Almost all children will engage in some form of antisocial behaviour at various stages of development. Skilled parents will be able to help the child recognize that certain behaviours are unacceptable. However if these conduct disturbances persist and worsen, they should be taken seriously as precursors to more serious problems. Early intervention is important for the sake of the child and the entire family system.

Efforts to prevent antisocial behaviour are mostly directed at adolescents. The nature of a prevention intervention is based on its underlying theoretical approach and the age group of the individuals being targeted. Interventions that target the prenatal and early childhood environment focus on maternal nutrition, maternal health, smoking reduction, and family problem-solving skills. Interventions that target the family environment seek to facilitate the development of non-coercive discipline, strategies for improving social and educational development, and strategies for improving parental involvement in school and extracurricular activities. Interventions that target the school environment focus on supporting academic success, modifying school environments to inhibit aggressive behaviour, increasing academic organization, and teaching positive peer relations.

Treatment efforts have largely been based on cognitive-behavioural training, which involves attempts to modify moral reasoning, increase one's ability to take the perspective of another, and to increase frustration tolerance and the ability to resolve interpersonal dilemmas with pro-social solutions. Such treatment also seeks to modify family interactions and create improved parental management and a more positive family atmosphere.

Bibliography

- Adler, J. R. (Ed.). (2004). Forensic Psychology: Concepts, debates and practice. Cullompton: Willan.
- Bartol, C. R., & Bartol, A. M. (1999). History of Forensic Psychology. In A. K. Hess & Irving B. Weiner (Eds.), Handbook of Forensic Psychology (2nd edn). London: John Wiley and Sons.
- Bennett, P. (2007). Abnormal Clinical Psychology; An Introductory Textbook (Second edition). Maidenhead: Open University Press
- Blackburn, R. (1996). What is forensic psychology? Legal and Criminological Psychology. 1996 Feb; Vol 1(Part 1) 3-16.
- Coolican, H. (2007). Applied Psychology. 2nd Edition. London: Hodder Arnold.
- Dalby, J. T. (1997) Applications of Psychology in the Law Practice: A guide to relevant issues, practices and theories. Chicago: American Bar Association. ISBN 0-8493-0811-9
- Davis, J. A. (2001). Stalking crimes and victim protection. CRC Press. 538 pages. ISBN 0-8493-0811-9.
- Duntley, J. D., & Shackelford, T. K. (2006). Toward an evolutionary forensic psychology. Social Biology, 51, 161-165.
- Eysenck, M.W. (2000) Psychology: A Students Handbook. New York; Psychology Press
- Gudjonsson, G. (1991). Forensic psychology - the first century. Journal of forensic psychiatry, 2(2), 129.
- Gudjonsson, G. Haward, L. Forensic Psychology. A guide to practice. (1998) ISBN 0-415-13291-6 (pbk.), ISBN 0-415-13290-8
- Hayes, N. (2010) Understanding Applied Psychology. London: Hodder Education.
- Myers, D. (2002) Exploring Psychology, fifth edition, New York; Worth publishers
- Myers, D. (2008). Exploring Psychology. Worth Publishers. ISBN 1-57259-0963.
- Ogloff, J. R. P., & Finkelman, D. (1999). Psychology and Law: An Overview. In R. Roesch, S. D. Hart, & J. R. P. Ogloff (Eds.), Psychology and Law the State of the Discipline . New York: Springer. ISBN 0-306-45950-7

- O'Mahony, B. (2013). So, You Want to Be a Forensic Psychologist? Create Space. ISBN 9781482011814
- Roesch, R., & Zapf, P. A. (Eds.). (2012). Forensic assessments in criminal and civil law: A handbook for lawyers. NY: Oxford University Press. ISBN 9780199766857
- Ribner, N.G. (2002). California School of Professional Psychology Handbook of Juvenile Forensic Psychology. Jossey-Bass. ISBN 0-7879-5948-0

Organisational Psychology

Organisational psychology is the scientific study of employees, workplaces, and organizations. Industrial and organizational psychologists contribute to an organization's success by improving the performance, satisfaction, safety, health and well-being of its employees. An organisational psychologist conducts research on employee behaviours and attitudes, and how these can be improved through hiring practices, training programs, feedback, and management systems. Industrial organisational psychologists also help organizations transition among periods of change and development.

Occupational psychologists are concerned with individuals and the jobs that they do while organisational psychologists work at the level of the organization itself, dealing with questions of groups, management, and the various social factors which can influence organizational life.

Some large organisations employ their own organisational psychologists who specialise in areas such as management training, team working, and organisational change, but as a general rule, organisational psychologists work from outside the organisation. They come in as consultants, either independently or from consultancy firms. Some organisational psychologists also have academic posts with Universities, which gives them a good base to conduct research.

Organisational psychologists used to begin their careers with a similar type of training to occupational psychologists but specialising in organisational theory and research during their higher degree, rather than on psychometrics and selection issues. In recent years the training has become more distinct and separate for organisational psychologists as the needs of constantly changing organisations has highlighted the need for understanding the social psychological aspect of organisational life.

Organisational psychologists are familiar with a wide range of issues concerning organisational life. This ranges from an understanding of the complexities surrounding management structures and leadership, to the understanding of the processes of organisational change and the resolution of organisational conflicts, to detailed knowledge of group processes and decision making. Their knowledge spans

several different levels, ranging from the level of individual cognitive processes and how issues affecting organisations are understood by people working in them, to the level of organisational culture, distinctive history, practices and customs which make each organisation unique.

Employee Selection

Organisational psychologists often work with HR specialists to design (a) recruitment processes and (b) personnel selection systems. Personnel recruitment is the process of identifying qualified candidates in the workforce and getting them to apply for jobs within an organization. Personnel recruitment processes include developing job announcements, placing ads, defining key qualifications for applicants, and screening out unqualified applicants.

Personnel selection is the process used to hire or promote individuals. Although the term can apply to all aspects of the process, recruitment, selection, hiring, acculturation, etc. the most common meaning focuses on the selection of workers. In this respect, selected prospects are separated from rejected applicants with the intention of choosing the person who will be the most successful and make the most valuable contributions to the organization.

Personnel selection systems employ evidence-based practices to determine the most qualified candidates. Selection involves both the newly hired and individuals who can be promoted from within the organization. Common selection tools include ability tests (e.g., cognitive, physical, or psychomotor), knowledge tests, personality tests, structured interviews, the systematic collection of biographical data, and work samples. Organisational psychologists must evaluate evidence regarding the extent to which selection tools predict job performance, evidence that bears on the validity of selection tools.

Organisational psychologists not only help in the selection and assessment of personnel for jobs, but also assist in the selection of students for admission to colleges, universities, and graduate and professional schools as well as the assessment of student achievement, student aptitude, and the performance of teachers and schools. Increasingly, they are working for educational assessment

and testing organizations and divisions. A meta-analysis of selection methods in personnel psychology found that general mental ability was the best overall predictor of job and training performance.

Training

Training is the systematic acquisition of skills, concepts, or attitudes that results in improved performance in another environment. Most people hired for a job are not already versed in all the tasks required to perform the job effectively. Evidence indicates that training is effective and that training expenditure is paid off in terms of higher net sales and gross profitability per employee. Training can be beneficial for the organization and for employees in terms of increasing their value to their organization as well as their employability in the broader marketplace.

Many organizations use training and development as a way to attract and retain their most successful employees. Training programs often include formative evaluation to assess the impact of the training as the training proceeds. Formative evaluations can be used to locate problems in training procedures and help Organisational psychologists make corrective adjustments while the training is ongoing. A training program is likely to include a summative evaluation at its conclusion in order to ensure that trainees have met the training objectives and can perform the target work tasks at an acceptable level.

The basic foundation for training programs is learning. Learning outcomes can be organized into three broad categories: cognitive, skill-based, and affective outcomes. Cognitive is a type of learning outcome that includes declarative knowledge or the knowledge of rules, facts, and principles. An example is police officers acquire declarative knowledge about laws and court procedures. Skill-based is a learning outcome that concerns procedural knowledge and the development of motor and technical skills. An example is motor skills that involve the coordination of physical movements such as using a special tool whereas technical skills might include understanding a certain software program, or exhibiting effective customer relations behaviours. Affective is a type of learning outcome that includes attitudes or beliefs that predispose a person to behave in a certain way. Attitudes can be developed or changed through training programs. Examples of these attitudes are organizational commitment and appreciation of diversity.

Before training design issues are considered, a careful needs analysis is required to develop a systematic understanding of where training is needed, what needs to be taught or trained, and who will be trained. Training needs analysis involves a three step process that includes organizational analysis, task analysis and person analysis.

Organizational analysis examines organizational goals, available resources, and the organizational environment to determine where training should be directed. This analysis identifies the training needs of different departments or subunits and also takes into account the climate of the organization and its subunits. Task analysis uses the results from job analysis to determine what is needed for successful job performance and then determines what the content of training should be. It can consist of developing task statements, determining homogeneous task clusters, and identifying KSAOs (knowledge, skills, abilities and other characteristics) required for the job.

With organizations increasingly trying to identify "core competencies" that are required for all jobs, task analysis can also include an assessment of competencies. Person analysis identifies which individuals within an organization should receive training and what kind of instruction they need. Employee needs can be assessed using a variety of methods that identify weaknesses that training and development can address. The needs analysis makes it possible to identify the training program's objectives, which in turn, represents the information for both the trainer and trainee about what is to be learned for the benefit of the organization.

Challenges which Organisational psychologists face

- To identify the abilities required to perform increasingly complex jobs.
- To provide job opportunities for unskilled workers.
- To assist supervisors in the management of an ethnically diverse workforce.
- To retain workers displaced by changing economic, technological, and political forces.
- To help organizations remain competitive in the international marketplace.

- To conduct the necessary research to determine the effectiveness of training programs.

Performance Appraisal

Performance appraisal or performance evaluation is the process of measuring an individual's or a group's work behaviours and outcomes against the expectations of the job. Appraisal is frequently used in promotion decisions, to help design and validate personnel selection procedures, and for performance management.

Performance management is the process of providing performance feedback relative to expectations and improvement information (e.g., coaching, mentoring). It also includes documenting and tracking performance information for organization-level evaluation purposes.

An occupational psychologist would typically use information from the job analysis to determine a job's performance dimensions, and then construct a rating scale to describe each level of performance for the job. Often, the psychologist would be responsible for training organizational personnel how to use the performance appraisal instrument, including ways to minimize bias when using the rating scale, and how to provide effective performance feedback. Additionally, the organisational psychologist may consult with the organization on ways to use the performance appraisal information for broader performance management initiatives.

Individual Assessment

Psychologists perform individual assessments in order to evaluate differences among candidates for employment as well as differences among employees. The constructs measured pertain to job performance. With candidates for employment, individual assessment is often part of the personnel selection process. These assessments can include written tests, physical tests, psychomotor tests, personality tests, work samples, and assessment centres. Psychometrics is the science of measuring psychological variables, such as knowledge, skills, and abilities. Organisational psychologists are generally well-trained in psychometric psychology.

Employee Motivation

Understanding what motivates an organization's employees is central to the study of organisational psychology. Motivation is a person's internal disposition to be concerned with approach positive incentives and avoid negative incentives. While motivation can often be used as a tool to help predict behaviour, it varies greatly among individuals and must often be combined with ability and environmental factors to actually influence behaviour and performance. It is important for organizations to understand and to structure the work environment to encourage productive behaviours and discourage those that are unproductive

Motivation involves three psychological processes:

- Arousal
- Direction
- Intensity.

Arousal initiates action. Direction refers to the path employees take in accomplishing the goals they set for themselves. Intensity is the vigour and amount of energy employees put into this goal-directed work performance. The level of intensity is based on the importance and difficulty of the goal.

These psychological processes result in four outcomes. First, motivation serves to direct attention, focusing on particular issues, people, tasks, etc. It also serves to stimulate an employee to put in effort. Motivation results in persistence, preventing one from deviating from the goal-seeking behaviour and results in task strategies, which are patterns of behaviour produced to reach a particular goal.

Groups and Teams

There is a distinction between a group and a team. People in groups often act differently from when they are on their own and this applies just as much in organisational life as it does in any other area of day to day living. Most organisations have come to recognise that this can be a positive force, that people like to work co-operatively, and that providing opportunities for them to do so often helps them to remain motivated and interested in their work. If a team is working

well, the members can inspire one another to work better. Organisational psychologists are involved in team working at many levels, ranging from research into what makes teams effective, to the development and implementation of team-working strategies in the organisation as a whole.

Team- working is useful to organisations, because an effective team can be far more productive than the same people working as individuals. However, being with other people in a group can trigger a number of psychological processes such as pressure for conformity, compliance and co-operation.

Groupthink

All groups of people have a natural tendency to assume that their way of looking at the world is the only possible one and groupthink is an example of what happens when that is carried to extremes. Groupthink has been shown to be damaging to organisations and that decisions tend to be based on an entirely unrealistic perception of the situation generated by the group which dismisses outside information and operates entirely on the basis of its own assumptions. A recent example can be seen in the global banking crisis 2008, where the major investment banks were so carried away with their risky investment behaviour that they brought the world's entire financial system into crisis. Bankers concerned were entirely taken up with their own beliefs, so much so that they failed to make any real world checks on what was actually happening.

Symptoms of Groupthink

- An illusion of invulnerability
- A tendency to rationalise away unpopular solutions
- Stereotyping and deriding opponents rather than arguing a case logically
- Self censorship- those with doubts keep quiet rather than speaking up
- Unrealistic impression of unanimity among members
- Members acting as mind guards and censoring undesirable information and opinions
- Illusion of morality and that the group's actions are intrinsically right.

There are a number of safeguards which an organisation can put in place to ensure that groupthink does not happen and this is an area where the organisational psychologist's understanding of group processes and other aspects of group decision making comes in useful. Organisations are full of groups: committees, working groups and informal 'canteen cultures'. People are intrinsically social, so knowing how social influences act on people can contribute a great deal to helping organisations running effectively.

Teams and Team-working

A team is more than just a group. A team is a group of people with complimentary knowledge and skills who have been brought together for a specific purpose. There are several different types of teams, but the main way that a team is different from a group is that it is much more task focused. This too has consequences. Teams tend to be quite explicit about what they consider appropriate conduct for the team itself and are much less concerned with non team activities than groups.

Effective working teams foster pride in the organisation, enhance employee beliefs in its values and energise people at work. West (1995) argued that what makes a team distinctive is that its members share common values.

Dimensions of Team Vision

- Clarity
- Motivating value
- Goal attainability
- Shared vision
- Ability to develop future potential

Other approaches to team building emphasise the social process of social identification or 'them and us'. Effective team-working harnesses the psychological process of social identification and strengthens team member's sense of commitment to one another and their awareness of the positive contribution they can make to the organisation.

Social identity mechanisms include the importance of classification, social comparison and also pride in the group and are useful motivators of people. Organisational psychologists implementing team working tend to draw on these approaches and other aspects such as effective team skills and the establishment of appropriate training for team-working including interpersonal and liaison skills. Most people's experience is in working as individuals and they sometimes need explicit training in effective team working skills.

Group Behaviour

Group behaviour is the interaction between individuals of a collective and the processes such as opinions, attitudes, growth, feedback loops, and adaptations that occur and change as a result of this interaction. The interactions serve to fill some need satisfaction of an individual who is part of the collective and helps to provide a basis for his interaction with specific members of the group.

A specific area of research in group behaviour is the dynamics of teams. Team effectiveness refers to the system of getting people in a company or institution to work together effectively. The idea behind team effectiveness is that a group of people working together can achieve much more than if the individuals of the team were working on their own.

Team Effectiveness

Organizations support the use of teams, because teams can accomplish a much greater amount of work in a short period of time than can be accomplished by an individual contributor, and because the collective results of a group of contributors can produce higher quality deliverables.

Five elements that are contributors to team effectiveness:

- **(1) Team composition**
- **(2) Task design**
- **(3) Organizational resources**
- **(4) Team rewards**
- **(5) Team goals.**

Team Composition

The composition of teams is initially decided during the selection of individual contributors that are to be assigned to specific teams and has a direct bearing on the resulting effectiveness of those teams. Aspects of team composition that should be considered during the team selection process include team member: knowledge, skills and abilities (KSAs), personalities, and attitudes.

Team Composition

Highly skilled members are more effective than teams built around those with lesser skills, and teams that include a diversity of skills have improved team performance. Additionally, increased average cognitive ability of team members has been shown to consistently correlate to increased work group effectiveness. Organizations should seek to assign teams with team members that have a mix of KSAs. Teams that are composed of members that have the same KSAs may prove to be ineffective in meeting the team goals, no matter how talented the individual members are. Personalities and attitudes of the individuals that are selected as team members are other aspects that should be taken into consideration when composing teams, since these individual traits have been found to be good indicators of team effectiveness. Differing personalities of individual team members can affect the team climate in a negative way as members may clash and reduce team performance.

Task Design

A fundamental question in team task design is whether or not a task is even appropriate for a team. Those tasks that require predominantly independent work are best left to individuals, and team tasks should include those tasks that consist primarily of interdependent work. When a given task is appropriate for a team, task design can play a key role in team effectiveness (Sundstrom, et al., 2000).

The Job Characteristics Theory of motivation identifies core job dimensions that provide motivation for individuals and include: skill variety, task identity, task significance, autonomy and feedback (Hackman & Oldham, 1980).

These dimensions map well to the team environment. Individual contributors that perform team tasks that are challenging, interesting, and engaging are more likely to

be motivated to exert greater effort and perform better than those team members that are working on those tasks that do not have these characteristics.

Organisational Resources

During the chartering of new teams, organizational resources are first identified. Examples of enabling resources include facilities, equipment, information, training and leadership. Also identified during team chartering are team-specific resources e.g., budgetary resources and human resources.

Team-specific human resources represent the individual contributors that are selected for each team as team members. Intra-team processes such as task design and task assignment should be sufficient for effective utilization by the team specific resources.

Team Rewards

Organizational reward systems are a driver for strengthening and enhancing individual team member efforts that contribute towards reaching collective team goals. The first element for reward systems design is the concept that for a collective assessment to be appropriate for individual team members, the group's tasks must be highly interdependent. If this is not the case, individual assessment is more appropriate than team assessment.

A second design element is the compatibility between individual-level reward systems and team-level reward systems. For example, it would be an unfair situation to reward the entire team for a job well done if only one team member did the great majority of the work. That team member would most likely view teams and team work in a negative fashion and not want to participate in a team setting in the future.

A final design element is the creation of an organizational culture that supports and rewards employees who believe in the value of teamwork and who maintain a positive mental attitude towards team-based rewards (Haines and Taggar, 2006).

Team Goals

Goals for individual contributors have been shown to be motivating when they contain three elements: (Lock & Latham, 1990).

- (1) difficulty
- (2) acceptance
- (3) specificity

In the team setting, goal difficulty is related to group belief that the team can accomplish the tasks required to meet the assigned goal. Goal acceptance and specificity is also applicable to the team setting. When team members individually and collectively commit to team goals, team effectiveness is increased and is a function of increased supportive team behaviours (Aube & Rousseau, 2005).

It is also important to be aware of the interplay between the goals of individual contributors that participate on teams and the goals of the teams themselves. The selection of team goals must be done in coordination with the selection of goals for individuals. Individual goals must be in line with team goals to be effective (Mitchell & Silver, 1990).

Job Satisfaction and Commitment

Job satisfaction reflects an employee's overall assessment of their job, particularly their emotions, behaviours, and attitudes about their work experience. Job satisfaction has theoretical and practical utility for the field of psychology and has been linked to important job outcomes including attitudinal variables, absenteeism, employee turnover, and job performance. Job satisfaction is strongly correlated with attitudinal variables such as job involvement, organizational commitment, job tensions, frustration, and feelings of anxiety.

Job satisfaction also has a weak correlation with employee's absentee behaviours and turnover from an organization with employees more likely to miss work or find other jobs if they are not satisfied. Although a positive relationship exists between job

satisfaction and performance, it is moderated by the use of rewards at an organization and the strength of employee's attitudes about their job.

Productive behaviour

Productive behaviour is defined as employee behaviour that contributes positively to the goals and objectives of an organization. For successful transition from being an outsider to a full-fledged member of an organization, an employee typically needs job-related training as well as more general information about the culture of the organization. In financial terms, productive behaviour represents the point at which an organization begins to achieve some return on the investment it has made in a new employee.

Industrial–organizational psychologists are typically more focused on productive behaviour rather than simple job or task performance because of the ability to account for extra-role performance in addition to in-role performance. While in-role performance tells managers or researchers how well the employee performs the required technical aspects of the job, extra-role performance includes behaviours not necessarily required as part of the job but still contribute to organizational effectiveness. By taking both in-role and extra-role performance into account, industrial–organizational psychologists are able to assess employees' effectiveness (how well they do what they were hired to do), efficiency (their relative outputs to relative inputs), and their productivity by how much they help the organization reach its goals.

Industrial–organizational psychologists frequently evaluate three different forms of productive behaviour in organizations: job performance; organizational citizenship behaviour; and innovation. Job performance represents behaviours employees engage in while at work which contribute to organizational goals. These behaviours are formally evaluated by an organization as part of an employee's responsibilities. In order to understand and ultimately predict job performance, it is important to be precise when defining the term.

Job performance is about behaviours that are within the control of the employee and not about results (effectiveness), the costs involved in achieving results (productivity), the results that can be achieved in a period of time (efficiency), or the

value an organization places on a given level of performance, effectiveness, productivity or efficiency (utility). To assess job performance, reliable and valid measures must be established. While there are many sources of error with performance ratings, error can be reduced through rater training and through the use of behaviourally-anchored rating scales. Such scales can be used to define the behaviours that constitute poor, average, and superior performance.

Additional factors that complicate the measurement of job performance include the instability of job performance over time due to forces such as changing performance criteria, the structure of the job itself and the restriction of variation in individual performance by organizational forces. These factors include errors in job measurement techniques, acceptance and the justification of poor performance and lack of importance of individual performance. The determinants of job performance consist of factors having to do with the individual worker as well as environmental factors in the workplace.

According to “Campbell's Model of The Determinants of Job Performance”, it is as a result of the interaction between declarative knowledge (knowledge of facts or things), procedural knowledge (knowledge of what needs to be done and how to do it), and motivation (reflective of an employee's choices regarding whether to expend effort, the level of effort to expend, and whether to persist with the level of effort chosen). The interplay between these factors show that an employee may, for example, have a low level of declarative knowledge, but may still have a high level of performance if the employee has high levels of procedural knowledge and motivation.

Regardless of the job, three determinants stand out as predictors of performance:

- (1) general mental ability (especially for jobs higher in complexity);
- (2) job experience (although there is a law of diminishing returns);
- (3) Personality trait of conscientiousness (people who are dependable and achievement-oriented, who plan well).

These determinants appear to influence performance largely through the acquisition and usage of job knowledge and the motivation to do well. An expanding area of research in job performance determinants includes emotional intelligence.

Counterproductive work behaviour

Counterproductive work behaviour is employee behaviour that goes against the goals of an organization. These behaviours can be intentional or unintentional and result from a wide range of underlying causes and motivations. The forms of counterproductive behaviour with the most empirical examination are ineffective job performance, absenteeism, job turnover and accidents. Less common but potentially more detrimental forms of counterproductive behaviour have also been investigated including theft, violence, substance use, and sexual harassment.

Occupational Stress

Organisational psychology has contributed significantly to the study of occupational stress and its effect on occupational health, since early research in the area began. Occupational stress is concerned with physical and psychosocial working conditions that can elicit negative responses from employees. Stressful working conditions are referred to as stressors that can lead to three types of strains:

- 1) Behavioural (e.g., absenteeism or poor performance)
- 2) Physical (e.g., headaches or coronary heart disease)
- 3) Psychological (e.g., anxiety or depressed mood).

Occupational stress can have implications for organizational performance because employee well-being relates to employee performance on the job. A number of models have been developed to explain how job stressors might affect employee health and organizational performance

Organizational Culture

Organizational culture can be described as a set of assumptions shared by the individuals in an organization that directs interpretation and action by defining

appropriate behaviour for various situations. There are three levels of organizational culture:

- Artefacts
- Shared values
- Basic beliefs and assumptions.

Artefacts comprise the physical components of the organization that relay cultural meaning. Shared values are individuals' preferences regarding certain aspects of the organization's culture (e.g., loyalty, customer service). Basic beliefs and assumptions include individuals' impressions about the trustworthiness and supportiveness of an organization, and are often deeply ingrained within the organization's culture.

In addition to an overall culture, organizations also have subcultures. Examples of subcultures include corporate culture, departmental culture, local culture, and issue-related culture. While there is no single "type" of organizational culture, some researchers have developed models to describe different organizational cultures.

Organizational culture has been shown to have an impact on important organizational outcomes such as performance, attraction, recruitment, retention, employee satisfaction, and employee well-being. Also, organizations with an adaptive culture tend to perform better than organization's with an un-adaptive culture.

Leadership and Management

In organisational psychology, leadership can be defined as a process of influencing others to agree on a shared purpose, and to work towards shared objectives. A distinction should be made between leadership and management. Managers process administrative tasks and organize work environments. Although leaders may be required to undertake managerial duties as well, leaders typically focus on inspiring followers and creating a shared organizational culture and values. Managers deal with complexity, while leaders deal with initiating and adapting to change. Managers undertake the tasks of planning, budgeting, organizing, staffing, controlling and problem solving. In contrast, leaders undertake the tasks of setting a direction or vision, aligning people to shared goals, communicating, and motivating.

Approaches to studying leadership in organisational psychology can be broadly classified into three categories:

- Leader-focused approaches
- Contingency-focused approaches
- Follower-focused approaches

Leader-Focused Approaches

Leader-focused approaches look to organizational leaders to determine the characteristics of effective leadership. According to the trait approach, more effective leaders possess certain traits that less effective leaders lack. More recently, this approach is being used to predict leader emergence. The following traits have been identified as those that predict leader emergence when there is no formal leader: high intelligence, high needs for dominance, high self-motivation, and socially perceptive. A leader-focused approach is the behavioural approach which focuses on the behaviours that distinguish effective from ineffective leaders. Another leader-focused approach is power and influence. To be most effective a leader should be able to influence others to behave in ways that are in line with the organization's mission and goals.

How influential a leader can be depends on their social power or their potential to influence their subordinates. There are six bases of power: coercive, reward, legitimate, expert, referent, and informational power. A leader can use several different tactics to influence others within an organization. These common tactics include: rational persuasion, inspirational appeal, consultation, ingratiation, exchange, personal appeal, coalition, legitimating, and pressure.

Contingency-Focused Approaches

Of the three approaches to leadership, contingency-focused approaches have been the most prevalent in recent years. Contingency-focused theories base a leader's effectiveness on their ability to assess a situation and adapt their behaviour accordingly. These theories assume that an effective leader can accurately "read" a situation and skilfully employ a leadership style that meets the needs of the individuals involved and the task at hand.

Fiedler's Contingency Theory holds that a leader's effectiveness depends on the interaction between their characteristics and the characteristics of the situation.

Path–Goal Theory asserts that the role of the leader is to help his or her subordinates achieve their goals. To effectively do this, leaders must skilfully select from four different leadership styles to meet the situational factors. The situational factors are a product of the characteristics of subordinates and the environment.

The Leader-Member Exchange (LMX) Model focuses on how leader–subordinate relationships develop. Generally speaking, when a subordinate performs well or when there are positive exchanges between a leader and a subordinate, their relationship is strengthened, performance and job satisfaction are enhanced, and the subordinate will feel more commitment to the leader and the organization as a whole.

In addition to the contingency-focused approaches, there has been a high degree of interest paid to three novel approaches that have recently emerged. The first is transformational leadership, which posits that there are certain leadership traits that inspire subordinates to perform beyond their capabilities. The second is transactional leadership, which is most concerned with keeping subordinates in-line with deadlines and organizational policy. This type of leader fills more of a managerial role and lacks qualities necessary to inspire subordinates and induce meaningful change. The third is authentic leadership which is centred on empathy and a leader's values or character. If the leader understands their followers, they can inspire subordinates by cultivating a personal connection and leading them to share in the vision and goals of the team.

Follower-Focused Approaches

Follower-focused approaches look at the processes by which leaders motivate followers, and lead teams to achieve shared goals. Because leaders are held responsible for their followers' ability to achieve the organization's goals, their ability to motivate their followers is a critical factor of leadership effectiveness. Similarly, the area of team leadership draws heavily from the research in teams and team effectiveness in organisational psychology. Because organizational employees are frequently structured in the form of teams, leaders need to be aware of the potential benefits and pitfalls of working in teams, how teams develop, how to satisfy team

members' needs, and ultimately how to bring about team effectiveness and performance.

An emerging area of research in the area of team leadership is in leading virtual teams, where people in the team are geographically-distributed across various distances and sometimes even countries. While technological advances have enabled the leadership process to take place in such virtual contexts, they present new challenges for leaders as well, such as the need to use technology to build relationships with followers, and influencing followers when faced with limited or no face-to-face interaction.

Organisational Change and Development

Industrial-organizational psychologists have displayed a great deal of consideration for the problems of organizational change and systematic ways to bring about planned change. This effort, called organizational development (OD), involves techniques such as:

- sensitivity training
- role playing
- group discussion
- job enrichment
- survey feedback
- team building

Resistance to Change

Implementing change is not easy and people are often highly resistant to it. Employees resisting change can be a major problem for the organisation which relies on the goodwill and co-operation of people working within it. Not all resistance is bad and sometimes can be justified in the sense that some changes really can result in lowering of quality and the resistance shown by employees is to alert management to the damaging consequences of what it is that they are doing.

Those who oppose organisational change are not always wrong. Sometimes they can see the consequences more clearly than management can. Often resistance to change happens for other factors. Organisational psychologists are often employed to identify those reasons, and suggest solutions for them. One common reason for resistance to change is simply lack of communication. If people don't know what is going on, then rumour and misinformation spread and quickly acquire the status of fact.

People are not passive: they don't simply accept what is happening to them without trying to understand what is going on. Employees in an organisation are quick to detect the unusual and if nobody tells them what is going on, they will speculate about it. So establishing effective communication is an important part of implementing successful organisational change. Another source of resistance to change is helplessness and passivity. Being helpless is stressful and when under stress people exaggerate the negative aspects of their thinking. They are likely to resist the changes because they expect the worst. On the other hand if they are involved in the change process in some way, such as being consulted and given the opportunity to make suggestions they then have some sense of ownership of the change and that can make all the difference to whether they resist it, or whether they try to make it work.

Mistrust of change and the people who are causing the change to happen can also be a factor in resistance to change. Organisational psychologists who adopt this role know how important it is that they should give employees an opportunity to know who they are, what they are doing, and also how their expertise can be a positive factor in the change process. People from outside who don't get to know the organisation and its culture and implement change in an arbitrary and dictatorial fashion, are unlikely to be successful.

The Psychological Contract

A psychological contract is an implicit unspoken agreement between employees and the organisation that each will fulfil their obligations and duties towards the other. Sometimes that psychological contract can involve assumptions that the organisation is no longer able to fulfil, and when that becomes apparent the consequences can be profound.

It was acceptable in the not too distant past to regard a large organisation as providing them with a job for life. If they worked hard then the organisation would respond by providing them with job security. More recently the competitive environment of many organisations means that they are no longer able to sustain that assumption and this can lead to reduced motivation and commitment on the part of their workforce. As psychological research into the process continues, organisational psychologists have developed a clearer understanding of how these problems can be addressed, and of the ways that organisations can overcome them.

The psychological contract at work does not need to be based on the idea of jobs for life, and increasingly organisations are recognising this. A great deal of research and on the part of the organisational psychologist is focused around ways of building organisational commitment, even in a relatively short-term workforce. By highlighting other aspects of the organisations commitment to its employees such as taking seriously employees career portfolios and helping them to develop skills which will be useful to them in the future, it is possible for the organisation to develop a positive psychological contract with its employees based on openness and trust, but which does not contain uneconomic or unmanageable assumptions.

Managing organisational change involves a certain amount of re-evaluating assumptions. Lewin described it as a three way model. The first stage consists of 'unfreezing', challenging peoples established ideas, recognising that the organisation has different needs which have to be addressed, and combating resistance to change through argument and explanation. The second stage is the change process itself, which involves adjusting the tasks, structures and technology in the organisation, and also changing the people who are doing the work, by giving them different responsibilities and appropriate retraining. The third stage is that of 'refreezing' and consolidating the changes which have taken place, by allowing the changes to work for a period of time, modifying as required and evaluating its effectiveness.

Continuous Innovation

One of the alternatives to major organisational change is the idea of continuous innovation. This idea came into Western organisations from Japan where the practice is known as kaizen-continuous development through small refinements and improvements- is common. Kaizen involves the entire workforce in finding ways that working practices can be improved. The organisation as a whole is constantly changing and does not face the major upheavals of the Western style approach of keeping things the same for many years and then changing everything at once.

The idea that continuous organisational innovation is preferable to massive restructuring appears to have taken hold in many organisations, although not all. Many organisations in the Western world have applied the principles of kaizen, although their cultural and status differences often mean that they seem to have problems involving the workforce in quite the same ways.

Innovation

West (1990) produced a model of the innovation process. It forms a cycle from recognition of the problems which need to be solved to the initiation of a change process in terms of identifying what needs to be done and putting into place the necessary resources to do it, to the implementation of that process, to a period of stabilization and evaluation. The evaluation process identifies problems which need to be addressed by more innovation and so the whole cycle continues. Each stage in the cycle is improved or enhanced by certain qualities of management. Having a clear vision for example, improves the process of recognising and identifying changes which need to be made. An organisation in which people feel that they can make contributions or challenge ideas safely will help in initiating actual changes and make sure that they are set up properly.

Having group and team norms in which innovation is recognised as a positive rather than a negative way helps when the changes are actually implemented in the organisation. Organisational climates, in which employees value excellence and high quality performance helps the stabilization and evaluation stage of the cycle. Understanding organisational change and helping management develop effective

programmes for implementing it is an important part of the organisational psychologist's work.

The Learning Organisation

Starkey (1996) proposed the idea of the learning organisation which develops a culture of learning and responding to their environments. Because it becomes a deeply rooted part of the organisation, necessary changes just happen, they don't have to be forced or implemented deliberately. One characteristics of learning organisations is they tend to be person centred, valuing their staff as assets and valuing expertise. They also tend to have fluid relationships, in that the people working in them can be flexible in the roles that they adopt, and the work that they do, and they are often very results oriented.

Such organisations are often experimental and creative, ready to explore new ways of doing things and to see whether they will work or not, because they know that they can readjust and change something that isn't working. The most effective organisations are those which listen to all of their employees, because people at the lower levels often see much more clearly where things are going wrong. However, as in many organisations, middle level bureaucracy often prevents information from getting from the bottom levels to the top.

Organisational Psychology Future Trends

Teachout and Vequist (2008) identified driving forces affecting future trends in organisations:

- **(1) Changes in the market conditions**
- **(2) Competition for market share and talent**
- **(3) Changes in customer demands**
- **(4) Changes in technology and innovation,**
- **(5) Increase in costs, especially in energy and health sectors**
- **(6) Globalization.**

They also discussed three trends in the field as a result of these forces, people, process, and technology.

Human Capital or People

In terms of human capital or people consulting, there are major forces for future trends:

- (1) Lack of competencies in STEM and communication fields.
- (2) Ageing workforce.
- (3) Increasing and aggressive competition for talent.
- (4) Increase in project or contract-based workforce instead of hiring permanent employees
- (5) Globalization.

As a result, trends, such as major talent management, selection and recruiting, workplace education and training, and planning for next generation, have emerged. In addition, change management also becomes important in organizations in order to innovate and implement new technology, tools, and systems to cope with changes in the business.

Process

Because of an increase in competition, it becomes important to identify and improve key processes that meet customer values and demands as well as processes that are faster and cheaper.

Technology

In terms of technology, there is an increased need to automate processes or data so that employees can focus on actually doing work and business rather than doing the manual labour. The organisational psychologist can add value to these technologies by providing training, communication, and change management as well as to incorporate these technologies into organizational culture. Regardless of how

advanced technology is, organisational consultants are still needed to make sure that these advanced technologies have positive effects on employees and organizations in both technical and social aspects.

Bibliography

- Anderson, N.; Ones, D.S.; Sinangil, H.K. & Viswesvaran, C. (Eds.). (2002). *Handbook of industrial, work and organizational psychology*, Volume 1: Personnel psychology. Thousand Oaks, CA: Sage Publications Ltd.
- Anderson, N.; Ones, D.S.; Sinangil, H.K. & Viswesvaran, C. (Eds.). (2002). *Handbook of industrial, work and organizational psychology*, Volume 2: Organizational psychology. Thousand Oaks, CA: Sage Publications Ltd.
- Aube, C. & Rousseau, V. (2005). Team goal commitment and team effectiveness: The role of task interdependence and supportive behaviors. *Group Dynamics: Theory, Research, and Practice*, 9, 189–204.
- Barrick, M.R.; Stewart, S.L.; Neubert, M.J. & Mount, M.K. (1998). Relating member ability and personality to Work-team processes and team effectiveness. *Journal of Applied Psychology*, 83, 377–91.
- Borman, W.C.; Ilgen, D.R. & Klimoski, R.J. (Eds.). (2003). *Handbook of psychology: Vol 12 Industrial and organizational psychology*. Hoboken, NJ: John Wiley & Sons.
- Dematteo, J.S.; Eby, L.T. & Sundstrom, E. (1998). Team-based rewards: Current empirical evidence and directions for future research. *Research in Organizational Behavior*, 20, 141–83.
- Dunnette, M.D. (Ed.). (1976). *Handbook of industrial and organizational psychology*. Chicago: Rand McNally.
- Guzzo, R.A. & Shea, G.P. (1992). Group Performance and intergroup relations in organizations. *Handbook of industrial and organizational psychology* (Vol. 3, pp. 269–313).
- Hackman, J.R.; Brousseau, K.R. & Weiss, J.A. (1976). The interaction of task design and group performance strategies in determining group effectiveness. *Organizational Behavior and Human Performance*, 16, 350–65.
- Hackman, J.R. & Oldham, G.R. (1980). *Work redesign*. Reading, MA: Addison-Wesley.
- Haines, V.Y. & Taggar, S. (2006). Antecedents of team reward attitude. *Group Dynamics: Theory, Research, and Practice*, 10, 194–205.
- Koppes, L.L. (Ed.). (2007). *Historical perspectives in industrial and organizational psychology*. Mahwah, NJ: Lawrence Erlbaum.
- Lant, T.K. "Organizational Cognition and Interpretation," in Baum, (Ed)., *The Blackwell Companion to Organizations*. Oxford: Blackwell Publishers.

- Lock, E.A. & Latham, G.P. (1990). *A theory of goal setting and task performance*. Englewood Cliffs, NJ: Prentice-Hall.
- Luthans, F., & Kreitner, R. (1985). *Organizational behavior modification and beyond: An operant and social learning approach* (2nd ed.). Glenview, IL: Scott, Foresman.
- Mitchell, T.R. & Silver, W.R. (1990). Individual and group goals when workers are interdependent. Effects on task strategy and performance. *Journal of Applied Psychology*, 75, 185–193.
- Rogelberg, S.G. (Ed.). (2002). *Handbook of research methods in industrial and organizational psychology*. Malden, MA: Blackwell.
- Salas, E.; Stagl, K. & Burke, C. (2004). 25 years of team effectiveness in organizations: Research themes and emerging needs, in C. Cooper & I. Robertson (eds), *International Review of Industrial and Organizational Psychology*, Vol. 19 (pp. 47–91). Chichester, UK: John Wiley & Sons.
- Sundstrom, E.; De Meuse, K.P. & Futrell, D. (1990). Work teams: applications and effectiveness. *American Psychologist*, 45(2), 120–33.
- Sundstrom, E.; McIntyre, M.; Halfhill, T. & Richards, H. (2000). Work Groups: From the Hawthorne Studies to Work Teams of the 1990s and Beyond. *Group Dynamics: Theory, Research, and Practice* (Vol 4, No 1. 44–47).
- Van Vianen, A.E.M. & De Dreu, C.K.W. (2001). Personality in teams: Its relationship to social cohesion, task cohesion, and team performance. *European Journal of Work and Organizational Psychology*, 10(2), 97–120.
- Wageman, R. & Baker, G. (1997). Incentives and cooperation: The joint effects of task and reward interdependence on group performance. *Journal of Organizational Behavior*, 18, 139–58.
- Whitney, K. (1994). Improving group task performance: The role of group goals and group efficacy. *Human Performance*, 7, 55–78.

Educational Psychology

Educational psychology is the study of how humans learn in educational settings, the effectiveness of educational interventions, the psychology of teaching and the social psychology of schools as organisations. It is concerned with how students feel, interact, learn, develop and behave often focusing on subgroups such as those subject to specific disabilities.

It involves the application to education of psychological theories, research and techniques, with the aim of establishing a body of knowledge about the psychological and educational development of children within the context of home, school and community. The knowledge comes from a number of areas within psychology;

- Child development
- Development of learning and understanding (cognitive processes) in children
- Studies of emotional and behavioural difficulties in children and young people
- Testing and assessment in areas such as intelligence and personality
- Increasingly studies of the way in which systems and organisations operate and what makes them effective have become influential within educational psychology.

There has also been increased recognition that education takes place in a social context and that a child's development can be influenced by factors at various levels such as parent, child, family, peer relationships, socio-economic, social and political factors, all ecological influences on development.

Educational Psychologists

Educational psychologists work in schools, colleges, nurseries, special schools and units and work in consultation with parents, teachers and other educational staff. They use observation and assessment with individual or with groups of children in relation to learning, behaviour or emotional difficulties. They may carry out joint school and family work and provide training and workshops for teachers and other

professional's example a whole school approach to combat bullying. Educational psychologists may be engaged in action research and school projects. Traditionally, educational psychologists have played a key role in assessment of children with special educational needs. Some children with complex needs may require additional support in school or placement in a special school or unit. These children may have a statement of special educational needs document outlining the special provision to be made for that child. The educational psychologist will write a report contributing to the statement, outlining the child's educational needs.

Increasingly educational psychologists are becoming part of multi-professional teams. They work closely with other agencies, such as social workers, community services for young offenders and health services such as speech and language therapists. Many educational psychology services have a critical incident support team of specially trained educational psychologists who respond to a crisis or traumatic incident involving or likely to affect children at school, such as the death of a child.

Role of education in children's development

Children develop rapidly during their early years and positive or negative experiences have implications for children's well-being, school readiness and later success in life. Early childhood is the period of human development from the prenatal stage through the transition into the early primary grades. During a child's early years, there are four main critical domains of development: Physical: Cognitive: Linguistic and Socio-emotional.

Early Childhood Development links the young child's cognitive, social, emotional, and physical processes with the care and services provided by families, communities, and the nation to support their development. Poverty, nutritional deficiencies and inadequate learning opportunities are among the leading reasons that at least 200 million children in the developing world are not reaching their developmental potential. A child's early years are a window of opportunity to lay a strong foundation for lifetime. By the time a child enters school they should be: healthy and well-nourished: securely attached to caregivers and able to interact positively with extended family members, peers and teachers: able to communicate

in their native language with peers and adults and ready to learn throughout primary school.

Early care and education

Early care and education means care and education for children aged 0–6 years. It is not limited to any one place or time of the day. Young children develop, learn and are nurtured in many places: in their own homes with their parents and families, in the homes of their grandparents, other relatives and childminders, and in centre-based services such as crèches and playgroups.

For young children, care and education should be inseparable. From the very start, children's care should be attentive to their capacity for learning and development, while their early education should be based on play and should include a strong focus on social skills and emotional development. Children's need for nurture, caring relationships and learning-through-play extends well beyond their early years.

High quality early care and education matters

For children: Quality care and education in the early years helps children to flourish and make the most of their lives. There is a large body of evidence that demonstrates the long-term beneficial effect of quality care and education for young children's development.

For the economy: A strong economy depends on people's skills, creativity, motivation and knowledge. Investment in young children has high economic and social returns, because its impact on people's skills and dispositions lasts a lifetime.

For society: Quality care and education for young children helps make society fairer through reducing social and economic disadvantage and strengthening equality.

High quality care and education services should be available and affordable for all young children as all children can benefit. In addition, some children and families need extra supports and services to overcome barriers that they face. Early identification of additional needs and early response to those needs are essential to minimise the long-term negative effects of disadvantage in early childhood.

Major theoretical approaches

The discipline of educational psychology borrows from a number of theoretical backgrounds. Behaviourist theories relate to observable aspects of changes in children's behaviour. Cognitive theories relate to thinking processes and memory and constructivist theories are concerned with 'thinking about thinking', or understanding mental constructs.

Behaviourists Theories

Behaviourist theories, influenced by the work of Skinner (1950's), explain learning in terms of observable behaviours based on the influence of environmental stimuli. Learning is seen as a relatively enduring change in observable behaviour that occurs as a result of experience, as distinct from genetic, biological factors, illness or injury. The principle of reinforcement is widely used. In the classroom teachers may use reinforcement to motivate and encourage learning or to increase attention and time on task. Reinforcements range from simple praise, to star charts to letters sent home to parents. Having developed the appropriate behaviour in a child, the teacher may use a schedule of reinforcement, for example not rewarding every time, but gradually removing the reinforcement until the behaviour becomes self sustaining or the child is motivated from within (intrinsic motivation).

Teachers try to ignore attention seeking behaviour, and use a technique called 'extinction'. In psychology, the term extinction is used to describe the weakening of a conditioned response over time. Extinction can occur in both classical and operant conditioning. In classical conditioning, it occurs when the conditioned stimulus is presented alone so that it no longer precedes the unconditioned stimulus. Eventually, the conditioned response will cease. In operant conditioning, extinction can occur when a response is no longer reinforced. Stimulus response behavioural approaches were not able to deal effectively with thinking. In particular they dealt poorly with the way language develops in children.

Behaviourist approaches have been confined generally to the more 'observable' aspects of behaviour, and therefore are more relevant to classroom behaviour and

its management than to the internal processes involved in the retention of information and how that information may be subsequently used.

Cognitive theories of learning

Social learning theory (Bandura) is interested in the extent to which learning is affected through observation, and provides a bridge between behaviourist and cognitive approaches within psychology. Social learning theorists view learning as a change in mental processes that creates the capacity to demonstrate different behaviours.

Bandura's four factors central in observational learning:

- 1) Attention
- 2) Retention: Retaining information
- 3) Reproducing information or behaviour
- 4) Motivation to reproduce information or behaviour

Teachers can model desired behaviours and reinforce those learners who display desired behaviour, ensuring that other student's attention is drawn to these outcomes. Bandura's later theories include the process of self-regulation, self management and self efficacy. Self-regulation involves setting one's own standards and being able to observe one's own behaviour reflectively. Self management includes training and encouraging students to set their own goals, self evaluate their progress and reinforce them for work successfully completed. Self-efficacy is a belief in one's abilities to organise actions to meet objectives and solve problems.

As with all theories of human behaviour, social learning theory has strengths and weaknesses. In particular it is not able to explain why learners imitate some models and not others. Pure cognitive theories are concerned with the internal processes involved in thinking and remembering. These theories explain learning by focusing on changes in mental processes and constructs that occur as a result of people's efforts to make sense of the world.

Piaget's Theory of Cognitive Development

Jean Piaget (1896 - 1980) was employed at the Binet Institute in the 1920s, where his job was to develop French versions of questions on English intelligence tests. He became intrigued with the reasons children gave for their wrong answers on the questions that required logical thinking. He believed that these incorrect answers revealed important differences between the thinking of adults and children.

Piaget was the first psychologist to make a systematic study of cognitive development. His contributions include a theory of cognitive child development, detailed observational studies of cognition in children, and a series of simple but ingenious tests to reveal different cognitive abilities. Before Piaget's work, the common assumption in psychology was that children are merely less competent thinkers than adults. Piaget showed that young children think in strikingly different ways compared to adults.

According to Piaget, children are born with a very basic mental structure (genetically inherited and evolved) on which all subsequent learning and knowledge is based. Piaget's Theory differs from others in several ways:

- It is concerned with children, rather than all learners.
- It focuses on development, rather than learning, so it does not address learning of information or specific behaviours.
- It proposes discrete stages of development, marked by qualitative differences, rather than a gradual increase in number and complexity of behaviours, concepts, ideas, etc.

The goal of the theory is to explain the mechanisms and processes by which the infant, and then the child, develops into an individual who can reason and think using hypotheses. To Piaget, cognitive development was a progressive reorganization of mental processes as a result of biological maturation and environmental experience. Children construct an understanding of the world around them, and then experience discrepancies between what they already know and what they discover in their environment.

Three Basic Components of Piaget's Cognitive Theory:

1) Schemas: A schema is the basic building block of intelligent behaviour, a form of organizing information that a person uses to interpret the things he or she sees, hears, smell, and touches. A schema can be thought of as a unit of knowledge, relating to one aspect of the world including objects, actions, and abstract (theoretical) concepts. We use schemas to understand and to respond to situations. We store them and apply them when needed.

2) Processes that enable the transition from one stage to another are equilibrium, assimilation and accommodation. A child is considered to be in a state of equilibrium or in a state of cognitive balance when capable of explaining what he or she is perceiving (schema) at the time. Assimilation and accommodation are processes of adjustment to changes in the environment and are defined as adaptation, the continuous process of using the environment to learn. According to Piaget, adaptation is the most important principle of human functioning.

3) Stages of Development

Sensori-motor: During this stage senses, reflexes, and motor abilities develop rapidly. Intelligence is first displayed when reflex movements become more refined. Understanding of the world involves only perceptions and objects with which the infant has directly experienced. Actions discovered first by accident are repeated and applied to new situations to obtain the same results. Toward the end of the sensory-motor stage, the ability to form primitive mental images develops as the infant acquires object permanence. Until then, an infant does not realize that objects can exist apart from him or herself.

Preoperational: The child in the preoperational stage is not yet able to think logically. With the acquisition of language, the child is able to represent the world through mental images and symbols, but in this stage, these symbols depend on his own perception and his intuition. The preoperational child is completely egocentric. Although he is beginning to take greater interest in objects and people around him, he sees them from only one point of view: his own. This stage may be the age of curiosity; preschoolers are always questioning and investigating new things. Since they know the world only from their limited experience, they make up explanations

when they don't have one. It is during the preoperational stage that children's' thought differs the most from adult thoughts.

Concrete operational: The stage of concrete operations begins when the child is able to perform mental operations. Piaget defines a mental operation as an interiorized action, an action performed in the mind. Mental operations permit the child to think about physical actions that he or she previously performed. The preoperational child could count from one to ten, but the actual understanding that one stands for one object only appears in the stage of concrete operations. The primary characteristic of concrete operational thought is its reversibility. The child can mentally reverse the direction of his or her thought. A child at this stage is able to do simple mathematical operations. Operations are labelled "concrete" because they apply only to those objects that are physically present. Conservation is the major acquisition of the concrete operational stage. Piaget defines conservation as the ability to see that objects or quantities remain the same despite a change in their physical appearance. Children learn to conserve such quantities as number, area, weight, mass and volume; though they may not achieve all concepts at the same time.

Formal operational: The child in the concrete operational stage deals with the present, the here and now; the child who can use formal operational thought can think about the future, the abstract, the hypothetical. Piaget's final stage coincides with the beginning of adolescence, and marks the start of abstract thought and deductive reasoning. Thought is more flexible, rational, and systematic. The individual can now conceive all the possible ways they can solve a problem, and can approach a problem from several points of view. The adolescent can think about thoughts and operate on operations, not just concrete objects. He or she can think about such abstract concepts as space and time. The adolescent develops an inner value system and a sense of moral judgment. He or she now has the necessary "mental tools" for living his life.

Educational Implications

Piaget did not explicitly relate his theory to education, although later researchers have explained how features of his theory can be applied to teaching and learning. Piaget has been extremely influential in developing educational policy and teaching. Because the theory is based upon biological maturation and stages the notion that 'readiness' is important. Readiness concerns when certain information or concepts should be taught. According to Piaget's theory children should not be taught certain concepts until they have reached the appropriate stage of cognitive development. Within the classroom learning should be student centred and accomplished through active discovery learning. The role of the teacher is to facilitate learning, rather than direct tuition. Therefore teachers should encourage the following within the classroom:

- Focus on the process of learning, rather than the end product of it.
- Using active methods that require rediscovering or reconstructing "truths".
- Using collaborative, as well as individual activities (so children can learn from each other).
- Devising situations that present useful problems.
- Evaluate the level of the child's development, so suitable tasks can be set.

Evaluation of Piaget's Theory

Strengths

The influence of Piaget's ideas in developmental psychology has been enormous. He changed how people viewed the child's world and their methods of studying children. He was an inspiration to many who came after and took up his ideas. Piaget's ideas have generated a huge amount of research which has increased our understanding of cognitive development. His ideas have been of practical use in understanding and communicating with children, particularly in the field of education.

Limitations

Vygotsky and Bruner do not refer to stages at all, and see development as continuous. Others have queried the age ranges of the stages. Some studies have shown that progress to the formal operational stage is not guaranteed. For example,

Keating (1979) reported that 40-60% of college students fail at formal operation tasks, and Dasen (1994) states that only one-third of adults ever reach the formal operational stage. Because Piaget concentrated on the universal stages of cognitive development and biological maturation, he failed to consider the effect that the social setting and culture may have on cognitive development (Vygotsky).

Piaget's methods of observation and clinical interviews are more open to biased interpretation than other methods. Because he conducted the observations alone data are based on his own subjective interpretation of events. It would have been more reliable if Piaget conducted the observations with other researchers and compared results afterwards to check if they are similar. Several studies have shown Piaget underestimated the abilities of children because his tests were sometimes confusing or difficult to understand.

The concept of schema is incompatible with the theories of Bruner and Vygotsky. Behaviourism would also refute Piaget's schema theory because it cannot be directly observed as it is an internal process. Therefore, they would claim it cannot be objectively measured. Piaget carried out his studies with a handful of participants (small sample size) and all from the same area, so accordingly the results of these studies cannot be generalized to children from different cultures.

Constructivist Theories

Constructivism is a theory to explain how knowledge is constructed when information comes into contact with existing knowledge that had been developed by experiences. It has its roots in cognitive psychology and biology and an approach to education that lays emphasis on the ways knowledge is created in order to adapt to the world. Von Glasersfeld describes constructivism as "a theory of knowledge with roots in philosophy, psychology, and cybernetics". Cybernetics is the science of communication and control theory that is concerned especially with the comparative study of automatic control systems such as the nervous system and brain and mechanical-electrical communication systems. Constructivism has implications for the theory of instruction. Discovery, hands-on, experiential, collaborative, project and task-based learning, are a number of applications that base teaching and learning on constructivism.

Intelligence

Although theories of intelligence have been discussed by philosophers since Plato, intelligence testing is an invention of educational psychology, and is coincident with the development of that discipline. Continuing debates about the nature of intelligence revolve on whether intelligence can be characterized by a single factor known as general intelligence, multiple factors e.g., Gardner's theory of multiple intelligences, or whether it can be measured at all.

In practice, standardized instruments such as the Stanford-Binet IQ test are widely used in economically developed countries to identify children in need of individualized educational treatment. Children classified as gifted are often provided with accelerated programmes. Children with identified deficits may be provided with enhanced education in specific skills such as phonological awareness.

In addition to basic abilities, individual personality traits are also important with people higher in conscientiousness and hope, attaining superior academic achievements. While there are several different theories of intelligence, psychologists do not agree on a universal definition of intelligence or on exactly which qualities it encompasses.

Some researchers have suggested that intelligence is a single, general ability; while others believe that intelligence encompasses a range of aptitudes, skills and talents. British psychologist Charles Spearman (1863-1945) described a concept he referred to as general intelligence, or the *g factor*. He concluded that intelligence is a general cognitive ability that could be measured and numerically expressed. Psychologist Louis Thurstone (1887-1955) offered a differing theory of intelligence. Instead of viewing intelligence as a single general ability, his theory focused on seven different "primary mental abilities.

- Verbal comprehension
- Reasoning
- Perceptual speed
- Numerical ability

- Word fluency
- Associative memory
- Spatial visualization

Howard Gardner - Multiple Intelligences:

One of the more recent ideas to emerge is Howard Gardner's theory of multiple intelligences. Instead of focusing on the analysis of test scores, Gardner proposed that numerical expressions of human intelligence are not a full and accurate depiction of people's abilities. His theory describes eight distinct intelligences that are based on skills and abilities that are valued within different cultures

The eight intelligences Gardner described are:

- Visual-spatial Intelligence
- Verbal-linguistic Intelligence
- Bodily-kinesthetic Intelligence
- Logical-mathematical Intelligence
- Interpersonal Intelligence
- Musical Intelligence
- Intra personal Intelligence
- Naturalistic Intelligence

Triarchic Theory of Intelligence: Robert Sternberg

Psychologist Robert Sternberg defined intelligence as "mental activity directed toward purposive adaptation to, selection and shaping of, real-world environments relevant to one's life." While he agreed with Gardner that intelligence is much broader than a single, general ability, he instead suggested some of Gardner's intelligences are better viewed as individual talents. Sternberg proposed what he refers to as 'successful intelligence,' which is comprised of three different factors:

- Analytical intelligence: Refers to problem-solving abilities.

- **Creative intelligence:** This aspect of intelligence involves the ability to deal with new situations using past experiences and current skills.
- **Practical intelligence:** This element refers to the ability to adapt to a changing environment.

Raising Educational Achievement

Promoting educational achievement and attainment is not just a school issue. Many factors beyond the classroom can affect whether children and youth succeed in school. Whereas within-school standards, practices, staffing, and curricula clearly are vital to raising the academic achievement of the nation's children and youth, addressing non-school factors could augment efforts being made in schools.

Motivation- Behaviourist Approach

Reinforcement increase learning so they can act as motivators. However, this behavioural theoretical approach does not explain intrinsic motivation, new learning without any observable reinforcement. Some evidence suggests that the use of reinforcements can reduce interest in intrinsically motivated tasks- children may begin to expect rewards as a condition of learning

Motivation: Cognitive Approaches

- 1) **Expectancy x value theory.** According to this theory a learner's motivation is determined by how much they value the goal and whether they expect to succeed.
- 2) **Self efficacy** is the measure of the belief in one's own ability to complete tasks and reach goals. Influenced by past performance, history of success, and observing good models. It can be increased by encouraging pupils to set challenging but achievable goals.
- 3) **Goal setting.** Research has distinguished learning goals from performance goals. Learning goals focus on mastery of a task or increasing understanding. Performance goals are concerned with competence and

how it compares with the competence of others. Learning goals are most effective and lead to sustained interest. Pupils who adopt a learning goals approach attribute success to internal controllable causes. Research indicates that individuals may have either an entity view of intelligence or an incremental view. An entity view is the belief that ability is fixed and stable, and therefore not within one's control. Such people are likely to adopt performance goals. The incremental view is that ability can be improved with effort. People with these beliefs are likely to adopt learning goals.

- 4) **Attribution Theory** attempts to describe how learners explain their successes and failures that is what they attribute these successes and failures to. Attributions can be explained on three dimensions. The first is the location of the cause (locus) which can be an internal locus-within the learner (eg ability and effort) or an external locus outside the learner (factors over which they have no control example luck and task difficulty). The second is stability, the extent to which the cause can change. Effort is considered unstable since it can change, whereas ability is considered stable. The third is the extent to which the learner is in control of the learning situation, or accepts responsibility for their performance- they may be in control of the effort invested, but not the task difficulty.
- 5) **Self- determination theory** considers how learners decide to act on their environment, how they make choices and decisions. It is concerned with innate psychological needs, competency, autonomy and relatedness. The need to master ones environment (develop competence) is considered intrinsic, internally driven and has its roots in basic survival. Autonomy relates to one's ability to be independent and alter ones environment. Relatedness is the need to feel accepted by others in one's social environment and is concerned with ones feelings of worth and respect.

Teacher behaviour, attitudes and expectations

One major area of research has been into factors which make for effective teaching and happy classrooms. Interest is in the factors which influence the way in which teachers generally affect the social and academic development of their pupils. Teachers with high personal teaching efficacy take responsibility for the success or

failure of their own instruction. They praise competence and avoid the use of rewards to control behaviour. Low personal efficacy teachers are more likely to blame other factors for low achievement such as low intelligence or home factors. They also have lower expectation. Low efficacy contributes to teacher stress and burnout. Considerable research has identified a number of essential teaching skills including attitudes, organisation and communication skills.

Positive teacher attitudes are fundamental to effective teaching and teacher characteristics such as efficiency, enthusiasm, caring and high expectations promote motivation in pupils and lead to higher achievement. Effective communication is an important factor in student achievement. There are four aspects to effective communication.

- Using precise language
- Keeping instruction thematic and to the point (connected discourse)
- Providing clear transition signals when moving from one idea to the next.
- Alerting students to important information (Emphasis)

(Eggen and Kaush 2007)

Young children accept praise even when overdone while older children assess the validity of the praise and what they believe it communicates about their ability. Younger children enjoy praise in front of the class while it is best given quietly and individually to adolescents. Anxious students and those from low socio-economic backgrounds tend to react more positively to praise than more confident pupils or those from advantaged backgrounds.

Teacher expectations

Teachers often treat pupils they perceive to be high achievers differently from those they perceive to be low achievers. They may provide more emotional support by interacting more often and positively. Teachers may make more eye contact and stand closer and make more effort for high achievers. They often give the high achievers more praise, longer feedback and ask them more questions. Differential treatment may influence the learner's beliefs and expectations. Children of all ages are aware of the different expectations teachers have of them.

Peer Influences

Peers influence children's development in two ways by communicating attitudes and values and forming friendships or excluding children from friendships. Peer influences can be positive or negative. Researchers have found that a pupil's choice of friends can predict his or her grades, level of disruptive behaviour and teachers ratings of involvement in school.

Individual differences and disabilities

Each person has an individual profile of characteristics, abilities and challenges that result from predisposition, learning and development. These manifest as individual difference in;

- Intelligence
- Creativity
- Cognitive style
- Motivation
- Capacity to process information, communicates, and relate to others.

The most prevalent disabilities found among school age children are attention deficit hyperactivity disorder (ADHD), learning disability, dyslexia and speech disorder. Less common disabilities include, hearing impairment, cerebral palsy, epilepsy and blindness.

Special Educational Needs and Inclusion

There are many reasons why a child may have special educational requirements. Sometimes a child may appear to be slow to learn, but actually is not. They may have another problem such as a hearing impairment which is making it difficult for them to learn in the normal way. Educational psychologists are familiar with a wide range of psychometric tests which help them to identify these different kinds of problems. They use general intelligence tests but also use more specific tests designed to find out exactly where any kind of special deficit or problem lie.

The tests they use are not available to the general public as they require specialised training to use and each has its own specialised context and requirements. Assessing special educational needs is not only about identifying children who need additional support because they are finding learning difficult for some reason. It also

includes finding enhanced or more demanding education for those who have a higher than average intelligence or are gifted and talented.

Educational assessment can be particularly useful when a child is underachieving as a result of stereotyping or other social pressures. When intelligence tests show that a child is brighter than previously thought, this changes the teachers expectations and through that the child's experience in the classroom and beyond. Most special educational needs do not require a child to attend a special school and include integration of children with special needs into mainstream school. Physical disabilities will require alterations to accommodate wheelchairs, handrails etc. Other types of physical or sensory disabilities may require ecological changes to accommodate children with hearing/visual impairments. Initial adjustments may present some challenges, but the school as a whole usually benefits once the adjustments have been made. Some special educational needs operate on the cognitive rather than the sensory level that is they are to do with how the brain processes the information it receives, rather than with how it receives the information in the first place.

Dyslexia

Dyslexia disorder takes various forms. Processing visual information and distinguishing between letters leads to problems with reading and writing. The problem for the educational psychologist though is that not all children with reading problems have dyslexia. Educational psychologists need to be able to distinguish between children who have reading problems because of environmental and social factors and those who have specific information processing deficits. This is where psychometric tests are particularly useful. The diagnosis of the particular type of dyslexia and its severity, affects the recommendations an educational psychologist will make for how the school and parents should tackle the problem.

The task is not made any easier by the way society has latched on to the label 'dyslexia'. As a result the child is often labelled dyslexic incorrectly. This type of label and amateur diagnosis is damaging and can easily become a self fulfilling prophecy. If parents and teachers believe that a child is not capable of reading and writing properly they don't put the effort into teaching and encouraging the child and the child too comes to believe that they too are not capable.

Bullying

School bullying is a far more common problem than many schools like to admit. In recent years many initiatives have been developed to address this problem. Children who are subjected to bullying at school can become emotionally damaged and such an experience almost always results in educational underachievement.

School bullying can range from physical violence and intimidation to subtle but vicious verbal harassment. Children who are constantly ridiculed because of their appearance or personal difference are just as much victims of bullying as those who live in fear of being beaten up outside the school gates.

Bullying cannot be tackled at an individual level. Successful interventions involve the school as a whole addressing the problem with the aim of developing an anti-bullying culture amongst all of the children. Once bullying is recognised as something to be despised rather than admired, the bully has lost their reason for engaging in bullying activities. At the same time interventions with individual children are also needed. Those who have been bullied often need counselling to deal with the emotional consequences while those who have perpetrated the bullying need help to identify and challenge their emotional needs which led to their bullying in the first place.

Problem Behaviours in School

- Bullying/ Aggressive behaviour
- Distracting; Attention seeking behaviour
- Anti-social behaviour
- Withdrawn anxious behaviour- may be related to factors such as domestic difficulties, abuse or bullying.

Family, School and Community - Home, Early Learning and School

The home situation, family attitudes, values and culture can influence a child's academic and social progress at school. Certain parenting styles promote more healthy personal development than others. Researchers have identified four patterns of parenting and the child's characteristics associated with them.

- **Authoritative parents** are consistent, firm but caring. Their children are confident, have high self esteem and usually do well at school.

- **Authoritarian parents** stress conformity and are detached. Their children can be withdrawn, lack social skills and be defiant.
- **Permissive parents** have limited expectations, set few boundaries and make few demands. Their children are often immature, poorly motivated and lack self control.
- **Uninvolved parents** show little interest in their children with few expectations. Their children often lack self control and long term goals

Family, School and Community: Gender and Ethnic Differences in Education

A growing trend is that girls do better at school than boys. Across all ethnic groups, girls outperform boys. UK Census (2010) figures show that minority ethnic groups from Afro-Caribbean, Pakistan, and Bangladesh do least well and from these groups Afro- Caribbean boys are most likely to be excluded from school. Interestingly Afro- Caribbean pupils, who do not perform well in secondary school, had been higher achievers at earlier stages of schooling. The reasons for different educational outcomes are complex, involving language, cultural and socio-economic factors and length of time in the educational system. Research indicates that economic disadvantage has the most significant effect on educational achievement.

Educational Psychologists and Evaluation Programmes

Educational psychologists have expertise in developing programmes to evaluate educational interventions, with dual qualifications in education and psychology and trained in research methods and evaluation issues in the educational context. Evaluation can take several forms. Educational psychologists evaluate changes that have been implemented and their effects but also have to evaluate potential changes before they take place, and spot consequences and issues that will need specific attention. Their reports form an important contribution to educational policy at local, national and international level. Dealing with problems at a multiplicity of levels is one of the distinctive skills of an educational psychologist.

It takes longer to train as a fully qualified educational psychologist than it does to become a medical doctor and even then educational psychologists must continuously renew and refresh their professional skills and knowledge throughout their working lives.

Bibliography

Bennett, P. (2007) *Abnormal Clinical Psychology; An Introductory Textbook* (Second edition). Maidenhead: Open University Press

Case, R. (1985). *Intellectual development: Birth to adulthood*. New York: Academic Press.

Coolican, H. (2007). *Applied Psychology*. (2nd Edition). London: Hodder Arnold.

Elliot, A.J. (1999). Approach and avoidance motivation and achievement goals. *Educational Psychologist*, 34, 169–89.

Emmer, E.T., Stough, L. M. (2001). Classroom management: A critical part of educational psychology with implications for teacher education. *Educational Psychologist*, 36, 103–12.

Eysenck, M.W. (2000) *Psychology: A Students Handbook*. New York; Psychology Press

Farrell, P. (2010). School psychology: Learning lessons from history and moving forward. *School Psychology International*, 31(6), 581-598.

Gardner, Howard. (1983) *Frames of Mind: The Theory of Multiple Intelligences*. New York: Basic Books.

Hayes, N. (2010) *Understanding Applied Psychology*. London: Hodder Education.

McGoey, K.E. & DuPaul, G.J. (2000) Token reinforcement and response cost procedures: Reducing the disruptive behavior of preschool children with attention-deficit/hyperactivity disorder. *School Psychology Quarterly*, 15, 330–43.

Myers, D. (2002) *Exploring Psychology*, fifth edition, New York; Worth publishers

Myers, D. (2008). *Exploring Psychology*. Worth Publishers. ISBN 1-57259-096-3.

Seifert, K. & Sutton, R. (2009) Educational Psychology: Second Edition. Global Text Project, pp. 33–37.

Smeyers, P. Depaepe, M. (2012). The Lure of Psychology for Education and Educational Research. "The Journal of Educational Philosophy", 46, 315-331.

Snowman, J. (1997). Educational Psychology: What Do We Teach, What Should We Teach? "Educational Psychology", 9, 151-169

Spearman, C. (1904). "General intelligence" objectively determined and measured. American Journal of Psychology, 15, 201–93.

Thorndike, E.L. (1912). Education: A first book. New York: MacMillan.

Woolfolk, A. Winne, P. Perry, N. (2006). Educational Psychology (3rd Canadian ed). Toronto, Canada: Pearson.

Zimmerman, B., Schunk, D. (2003). Educational psychology: A century of contributions. Mahwah, NJ, US: Erlbaum.

Health Psychology

Health psychology is the study of psychological and behavioural processes in health, illness and healthcare. It is concerned with understanding how psychological, behavioural and cultural factors are involved in physical health and illness, in addition to the biological causes that are well understood by medical science. Health psychology is concerned with all aspects of health and illness across the life span. Psychological factors can affect health directly such as stress causing the release of the hormone cortisol which damages the body over time, and indirectly via a person's own behaviour choices which can harm or protect health such as smoking or taking exercise.

Health psychologists take a bio-psychosocial approach. This means that they understand health to be the product not only of biological processes but also of psychological processes (e.g. stress, thoughts and beliefs, behaviours such as smoking and exercise) and social processes (e.g. socioeconomic status, culture and ethnicity).

In 1948, the World Health Organization (WHO) defined health as "a complete state of physical, mental, and social well-being and not merely the absence of disease or infirmity". This definition was very forward looking for its time, but is the core of health psychologists' conception of health today. Rather than defining health as the absence of illness, health is recognized as a state involving balance among physical, mental, and social well-being. Many use the term "wellness" to refer to this optimum state of health.

Health Psychologists

Health psychologists focus on health promotion and maintenance, which includes such issues as how to get children to develop good health habits, how to promote regular exercise, and how to design a media campaign to get people to improve their diets, stop smoking, drink in moderation etc. They also study the psychological aspects of the prevention and treatment of illness and teach people in high-stress occupations how to manage stress effectively so that it will not adversely affect their health.

Health psychologists also work with people who are already ill to help them adjust more successfully to their illness or to learn to follow their treatment regimen. They focus on the aetiology and correlates of health, illness, and dysfunction. Aetiology refers to the origins or causes of illness, and health psychologists are especially interested in the behavioural and social factors that contribute to health or illness and dysfunction. Such factors include health habits such as alcohol consumption, smoking, exercise, and ways of coping with stress.

Health psychologists also analyze and attempt to improve health care systems and the formulation of health policy. They study the impact of health institutions and health professionals on people's behaviour and develop recommendations for improving health care.

Personality and Health

The way people react, respond, relate, and retaliate to situations is what makes up their personality. Various psychological studies have been conducted over the years to understand and pinpoint exactly what a healthy personality is. These studies have resulted in a number of theories.

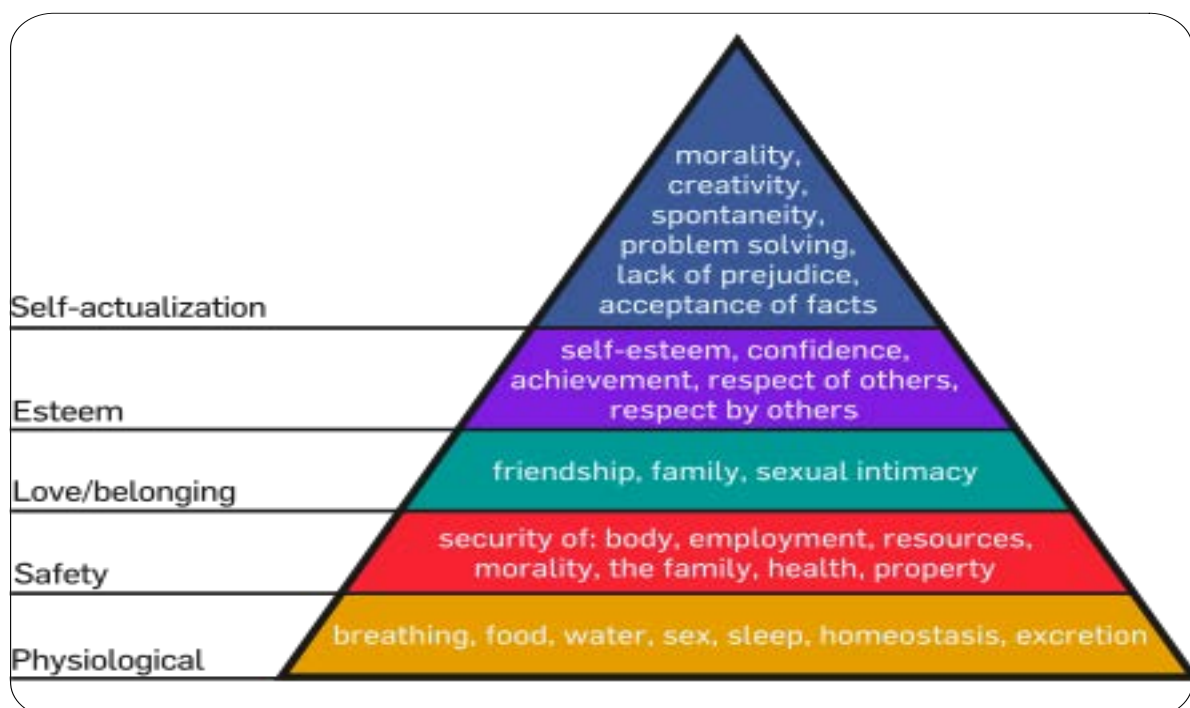
Carl Jung's theory of an individuated person emphasizes higher forces of nature and their role-play in a healthy personality. The theory of self-transcendence by Viktor Frankl relates to finding meaning in our past and our actions in order to have a healthy mental state. The importance of social adjustment is reflected in the theory by Erich Fromm. Carl Rogers's theory of the fully functional person sheds light on one's ability to take their own decisions and be spontaneous. The mature person theory by Gordon Allport, stresses that such a personality is developed by moving forward and not by dwelling on the past.

Another important theory on self-growth and healthy personality is Abraham Maslow's self-actualization theory- realization of one's full potential. This hierarchy is most often displayed as a pyramid. The lowest levels of the pyramid are made up of the most basic needs, while the more complex needs are located at the top of the pyramid. Needs at the bottom of the pyramid are basic physical requirements including the need for food, water, sleep, and warmth. Once these lower-level needs have been met, people can move on to the next level of needs, which are safety and

security. As people progress up the pyramid, needs become increasingly psychological and social. The need for love, friendship, and intimacy become important. Further up the pyramid, the need for personal esteem and feelings of accomplishment take priority.

Like Carl Rogers, Maslow emphasized the importance of self-actualization, which is a process of growing and developing as a person in order to achieve individual potential. Abraham Maslow believed that these needs are similar to instincts and play a major role in motivating behaviour.

Physiological, security, social, and esteem needs are deficiency needs (also known as *D-needs*), meaning that these needs arise due to deprivation. Satisfying these lower-level needs is important in order to avoid unpleasant feelings or consequences.



Over the years, the development of these theories has led psychologists to sum up the human personality into five important traits also known as OCEAN. It is one of the most common and famous theories of all for personality analysis.

The **OCEAN theory** comprises five main spheres:

- Openness
- Conscientiousness
- Extraversion
- Agreeableness
- Neuroticism.

Out of these five, the first four are positive traits. Neuroticism, in its own, is a negative trait. However, the opposite of it, emotional stability, is a trait of a healthy personality.

Openness

A healthy personality reflects openness and eagerness towards things old or new. It covers new experiences, new ideas, thoughts, letting go of older conventions and accepting the changing times. It deals with creativeness, a strong imagination, adventures and risks. Curiousness is also a part of their nature and they are eager to gain more knowledge.

Individuals who are open do not have preconceived notions about people or situations and have an open mind towards contemporary ideas. They aim for a higher quality in life and improve their own productivity, be it at home or work and are constantly striving to better their styles and techniques. They believe that a progressive outlook is important for personal improvement.

Conscientiousness

This trait describes the characteristics of self-organization and efficiency. A healthy personality is generally goal-oriented and has a perspective of what they want in life. Such personalities are competent and competitive. They are able to judge themselves and others with a clear and analytical mind. They do not have false notions about their capacities and they can handle failure well.

A person with a healthy personality does not over-criticize himself, yet is always striving to better his own self. Such people are committed to the work they do and are generally self-sufficient. They make the best out of situations and themselves. They do not complain, nor indulge in blaming and take acceptance of their own faults and behaviour and are always working on them. They are consistent in their work and do not get bored easily. They have a high level of tolerance when it comes to pressure and are always working hard, striving to succeed in all endeavours.

Extraversion

This personality is warm and welcoming to new people. Such people are at ease with making new acquaintances and are relaxed while having conversations. They are outgoing and friendly by nature and have a large group of friends. They are comfortable with people of different interests and have a curiosity about others. They have an appealing and magnetic personality, which more often than not influences others and have a positive attitude and easygoing charm, which helps them build more contacts and keeps them in a great social environment. They tend to make others feel good and positive about themselves and generally accept others as they are.

Agreeableness

Agreeableness generally refers to the level of social trust and regard that a person displays. A healthy personality, however, has a balanced outlook towards the matters of trust and intimacy. Such personalities do not trust others too easily, but they also do not doubt people for no apparent reason. They are generally helpful to others and even strangers. However, they are street smart and do not divulge personal information to unknown people. They are modest to people in need and do not hesitate to help. Yet, they do judge the situation and try to understand whether the person truly needs the help they asked for. They are straightforward in their communication and honest in making an opinion. However, they also take care not to hurt other person's sentiments and are tactful in their approach. In times of conflict, they prefer to work out with calm words and avoid arguments or quarrels.

Emotional stability as opposed to neuroticism

Neuroticism is a long-term disposition to negative emotions, such as distress, anger, frustration, hatred, jealousy, etc. It is not a part of a healthy personality which is formed by the opposite of neuroticism, i.e. emotional stability.

Emotional stability refers to the level of control a person has over their own emotions. A healthy personality is devoid of unreasonable and unwanted negative emotions towards others and even oneself. Such people have a positive self-regard and a realistic self-judgment. They keep feelings of anger, jealousy, and hatred at bay and do not indulge in self-loathing or pity. They are not impulsive and take rational, well-judged decisions. They tend to protect their health, self-esteem, and well-being despite any problems of their life.

Personality Traits

Type A personalities are competitive, high achievers and have a high sense of time urgency. As a result of these combined traits Type A's are usually found to be busy working on their own projects. Type A's may have felt insecure at one point of their lives and decided to fight the insecurity by changing their lives and making achievements as fast as they can.

Type B personalities are the opposite of type A's. They are relaxed, laid back and not easily stressed. While type B can be achievers too still they won't be as competitive as Type A's. Type B can delay work and do it in the last moment, some of them can turn into procrastinators which is something that a type A can never do.

Type C personalities love details and can spend a lot of time trying to find out how things work and this makes them very suitable for technical jobs. Type C is not assertive, and they can suppress their own desires even if there is something that they dislike. Lack of assertiveness can result in stress and sometimes in depression. Type Cs are vulnerable to depression compared to type A and type B.

Type D personalities have a negative outlook towards life and are pessimistic. A small event that is not even noticed by type B can ruin type D's day. Type D might become socially withdrawn as a result of fear of rejection even if they like to be

around people. Type D's are known for suppressing their emotions and this makes them the most vulnerable type to depression.

Personality and Health

Personality factors relate to health in **five main ways**:

1. Personality may influence stress.
2. Personality may affect coping mechanism options and effectiveness.
3. Personality may influence the amount of social support and social relationships.
4. Personality may affect individual's health habits, preventing steps to modify behaviour, and adherence to medical regimes.
5. Personality may shape personal accounts of symptoms and pain and the expression of such symptoms to others (i.e. friends, family, medical professionals).

Personality Factors that Lead to Healthy Behaviours

Optimism

Optimism is the very expectation that good things will occur and bad things will not, describing bad events as the result of external, unstable, and specific causes. Individuals with optimistic thinking and high self-esteem leads to fewer infections, quicker post-operative recovery, decreased risk of post-partum depression, and a longer life by way of decreased morbidity due to cancer and cardiovascular illness.

Extraversion

Outgoing and social individuals have high levels of energy, often assume leadership roles, and seek challenges. Spiro et al. (1990) found that self-reported extraverts had fewer physiological and physical symptoms.

Internal Locus of Control is the perception of one's control over events and what happens in their life plays a significant role in mood and healthy behaviour. Greater perceptions of internal control lead to decreased incidence of depression.

Personality Factors that Lead to Unhealthy Behaviours

Pessimism –there are two trains of thought for pessimism:

- 1) The very expectation that bad things will occur and good things will not.
- 2) Describing bad events as the result of external and universal causes.

A pessimistic outlook in life may lead to stressful anxiety. The biochemical imbalance may hinder protective functions, thereby causing greater risk at developing Parkinson's disease, dementia, cancer, and immunologic disorders.

Type A Personality

This personality type is characterized by: time urgency, impatience, anxiety, little time for relaxation, poor sleep patterns, anger, aggressiveness and hostility and compulsive/neurotic tendencies. Studies suggest individuals with Type A personalities have much greater risk for cardiovascular disease, however, more recent lines of research indicates minute or no correlation. Nonetheless, Type A's report greater symptoms of minor illness.

External Locus of Control – Individuals who feel external sources control their actions, rather than being internal-borne; see success as a matter of chance. They are more receptive to supervision. Given the lack of manipulating their control internally, externals often fail to exercise, diet, and seek medical treatment.

Culture and Health

All cultures have systems of health beliefs to explain what causes illness, how it can be cured or treated, and who should be involved in the process. The extent to which patients perceive patient education as having cultural relevance for them can have a profound effect on their reception to information provided and their willingness to use it. Western industrialized societies which see disease as a result of natural scientific phenomena, advocate medical treatments that combat microorganisms or use sophisticated technology to diagnose and treat disease. Other societies believe that illness is the result of supernatural phenomena and promote prayer or other spiritual interventions that counter the presumed disfavour of powerful forces.

There are several important cultural beliefs among Asians and Pacific Islanders. The extended family has significant influence, and the oldest male in the family is often the decision maker and spokesperson. The interests and honour of the family are more important than those of individual family members. Older family members are respected, and their authority is often unquestioned. Among Asian cultures, maintaining harmony is an important value; therefore, there is a strong emphasis on avoiding conflict and direct confrontation. Due to respect for authority, disagreement with the recommendations of health care professionals is avoided. However, lack of disagreement does not indicate that the patient and family agree with or will follow treatment recommendations.

Among Chinese patients, because the behaviour of the individual reflects on the family, mental illness or any behaviour that indicates lack of self-control may produce shame and guilt. Chinese patients may be reluctant to discuss symptoms of mental illness or depression.

Many African-Americans participate in a culture that centres on the importance of family and church. There are extended bonds with grandparents, aunts, uncles, cousins, or individuals who are not biologically related but who play an important role in the family system. Usually, a key family member is consulted for important health-related decisions. The church is an important support system for many African-Americans.

Some sub-populations of cultures, such as those from India and Pakistan, are reluctant to accept a diagnosis of severe emotional illness or mental retardation because it severely reduces the chances of other members of the family getting married.

In Vietnamese culture, mystical beliefs explain physical and mental illness. Health is viewed as the result of a harmonious balance between the *poles of hot and cold* that govern bodily functions. Vietnamese don't readily accept Western mental health counselling and interventions, particularly when self-disclosure is expected. However, it is possible to accept assistance if trust has been gained.

Each ethnic group brings its own perspectives and values to the health care system, and many health care beliefs and health practices differ from those of the traditional

Western health care culture. The expectation of many health care professionals has been that patients will conform to mainstream values. Such expectations have frequently created barriers to care that have been compounded by differences in language and education between patients and providers from different backgrounds.

Cultural differences affect patients' attitudes about medical care and their ability to understand, manage, and cope with the course of an illness, the meaning of a diagnosis, and the consequences of medical treatment. Patients and their families bring culture specific ideas and values related to concepts of health and illness, reporting of symptoms, expectations for how health care will be delivered, and beliefs concerning medication and treatments. In addition, culture specific values influence patient roles and expectations, how much information about illness and treatment is desired, how death and dying will be managed, bereavement patterns, gender and family roles, and processes for decision making.

Understanding and Changing Health Behaviours

A number of health behaviours are known to have a negative impact on health; smoking, excessive alcohol consumption, poor diet, lack of exercise and risky sexual practices. Smoking is currently the most influential behaviour on health and is estimated that half of all lifetime smokers will die prematurely because of their habit, although the risks do decline if smoking is given up. Following the health risks of smoking in magnitude are the risks of being obese.

Excessive alcohol consumption has become more problematic; one in six deaths on the roads is alcohol related and one in six people attending A&E has alcohol related injuries or problems. Alcohol is related to liver disease, cardiovascular problems and cancer.

The UK record with regard to sexual health is no better, highest teenage pregnancy rates and the rates of STIs doubled in the previous decade. Despite the obvious risks, many people continue to engage in unhealthy behaviours.

Among the younger age groups (up to 19 yrs) more females than males smoke, but in the older age group this pattern is reversed. In the UK, government surveys show that almost three quarters of smokers say that they would like to give up, and each year over half a million people access stop smoking services.

The percentage of obese people in the UK increased dramatically over the latter part of the 20th century, with 23% of the adult population and 17% of children categorised as obese in 2010. Analysis of lifestyle changes over this time period suggests the increase is primarily due to people having a more sedentary lifestyle. ONS surveys documents that more than one in three UK adults exceeds the safe drinking guidelines each week.

Rates of binge drinking are higher in the younger age groups, and range for girls is approaching rates for boys. High and increasing rates of sexually transmitted infections and unplanned pregnancies are a direct result of the significant number of people who engage in risky sexual behaviour. In the UK the average age of first sexual encounters is age 16. Approximately 40% of young people aged 15-16 years, 29% of those aged 14-15 years, and 14% of those aged 13-14 years are sexually active and almost half report risky sexual behaviour of not using condoms or other forms of contraception.

One key area of health psychology research is the study of what motivates people to engage in healthy and unhealthy behaviour. Health psychologists help people adopt healthier behaviours, including motivating people to give up smoking, drink alcohol sensibly, take more exercise, eat a healthier diet and engage in safe sexual behaviours. Health behaviours like any other behaviour draw heavily on general psychological theories and models of behaviour to understand health behaviour.

Behavioural Model Classical Conditioning

Classical conditioning can be used to explain some of our health behaviours and why it can be difficult to change these behaviours, as our environment may cue our unhealthy behaviours. Often people turn to eating as an act of comfort. In these instances, food that has repeatedly been paired with affection in the past comes to trigger the same feelings of comfort. The pleasure of smoking becomes paired with many other daily activities. Repeated reminders of the circumstances in which they used to have a cigarette example after a meal, might explain why so many people find it hard to break bad health habits.

Health psychologists use the understanding of how classical conditioning affects behaviour to design interventions to help people change their behaviour. Two commonly used interventions which rely on classical conditioning to break bad health habits are

- **Stimulus control** – to control the environmental stimuli which cue the behaviour example smokers advised to avoid situations they associate with smoking or those who overeat advised to remove snack foods, to avoid eating out or spending too long shopping for food.
- **Response substitution**- finding more suitable alternatives for problem behaviours that are automatically cued for example people who smoke because they were cued by needing to do something with their hands can be encouraged to carry dummy cigarettes or those who seek oral gratification can be encouraged to use chewing gum and overeaters encouraged to keep a stock of health low fat snacks.

Behavioural Model Operant Conditioning

Operant conditioning is dependent on the environmental response to the behaviour, rather than environmental cues. Operant conditioning processes explain how our environment rewards and punishes us for our behaviour. For example, a teenager who starts to smoke may gain social approval from their peers and may avoid being teased for refusing a cigarette. This combination of positive reinforcement for the smoking behaviour and punishment for not smoking leads to the establishment of the behaviour.

Health psychologists can also use operant conditioning principles to help change behaviour. Charges levied by health care providers for missed appointments for example can be seen as an intervention using the operative conditioning principle of punishment. Generally though punishments are negative consequences and not as powerful as rewards and positive outcomes in changing behaviour.

Social Learning Theory

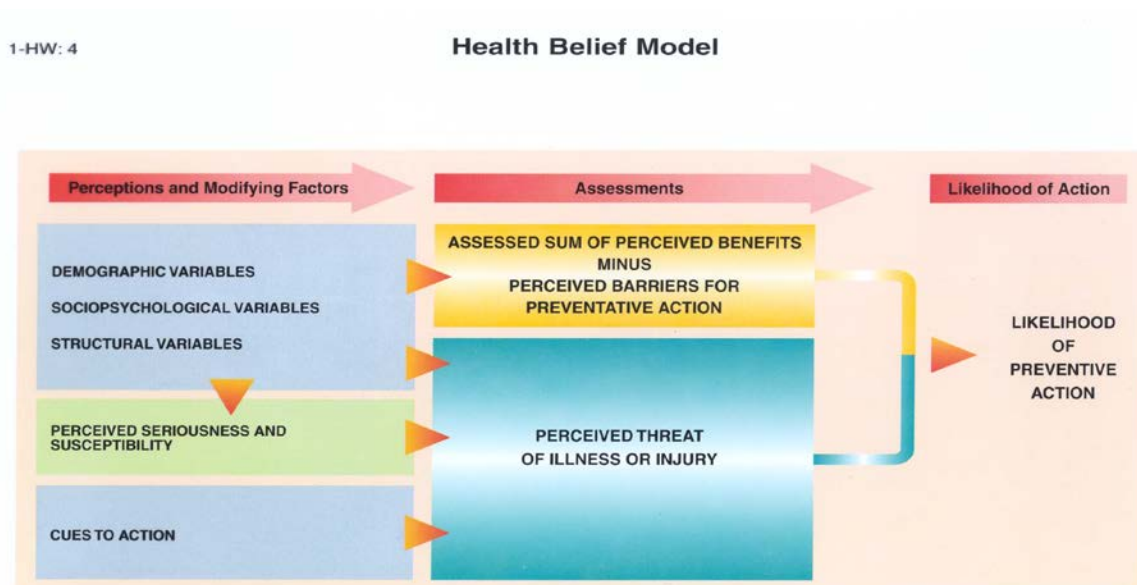
Social learning theory is important in explaining various health behaviours. Young people who see adults smoking are far more likely to smoke themselves, especially if they see the behaviour associated with other desirable features. Likewise we can provide good examples to children that may encourage them to act in a healthy manner. The involvement of celebrities endorsing health behaviours works on the social learning principle that people will take more notice of the message if they admire the person giving it and aspire to be like them.

Cognitive Theories of Health Behaviour

Another way in which health psychologists can understand factors which might determine health behaviours is to describe **the thought processes (cognitive)** which occur in a person's mind as they think about health behaviours. Some commonly used cognitive models of health behaviour are;

- The health belief model
- Theory of planned behaviour
- Trans-theoretical model

The Health Belief Model



The Health Belief Model (HBM) is one of the first theories of health behaviour. It is a conceptual framework that describes a person's health behaviour as an expression of health beliefs. It was developed in the 1950s by a group of U.S. Public Health Service social psychologists who wanted to explain why so few people were participating in programs to prevent and detect disease. The health belief model proposes that a person's health-related behaviour depends on the person's perception of four critical areas:

- **Severity of a potential illness,**
- **Person's susceptibility to that illness,**
- **Benefits of taking a preventive action**
- **Barriers to taking that action.**

The model states that health-seeking behaviour is influenced by a person's perception of a threat posed by a health problem and the value associated with actions aimed at reducing the threat. HBM addresses the relationship between a person's beliefs and behaviours. It provides a way to understand and predict how clients will behave in relation to their health and how they will comply with health care therapies.

Major Concepts and Definitions of the Health Belief Model

There are six major concepts in the HBM:

- 1. Perceived Susceptibility
- 2. Perceived severity
- 3. Perceived benefits
- 4. Perceived costs
- 5. Motivation
- 6. Enabling or modifying factors

Perceived Susceptibility: refers to a person's perception that a health problem is personally relevant or that a diagnosis of illness is accurate.

Perceived severity: even when one recognizes personal susceptibility, action will not occur unless the individual perceives the severity to be high enough to have serious organic or social complications.

Perceived benefits: refers to the patient's belief that a given treatment will cure the illness or help to prevent it.

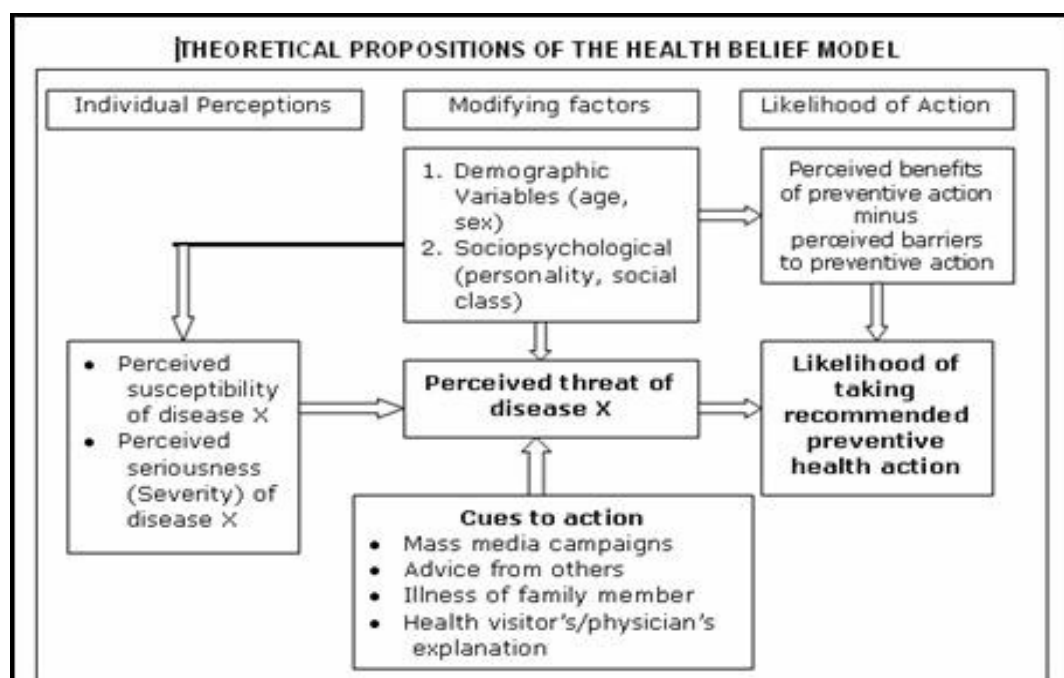
Perceived costs: refers to the complexity, duration, and accessibility and accessibility of the treatment.

Motivation: includes the desire to comply with a treatment and the belief that people should do what.

Modifying factors: include personality variables, patient satisfaction, and socio-demographic factors.

Criticisms of HBM

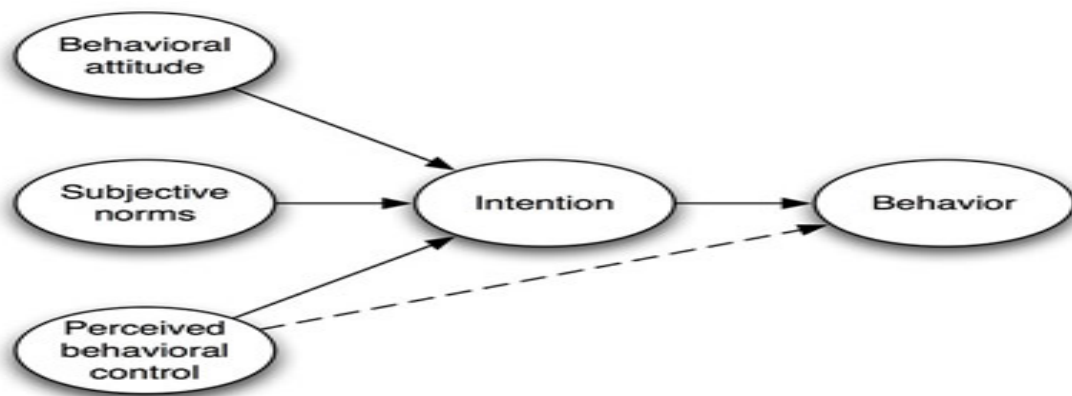
Is health behaviour that rational? Its emphasis on the individual ignores social and economic factors. There is an absence of a role for emotional factors such as fear and denial. Alternative factors may predict health behaviour, such as outcome expectancy whether the person feels they will be healthier as a result of their behaviour and self-efficacy, the person's belief in their ability to carry out preventative behaviour.



Theory of Planned Behaviour Cognitive Model

Developed by Ajzen in 1991, the theory of planned behaviour has its origins in more general social psychology models, but is one of the most commonly used models of health behaviour. It is derived from an earlier formulation called the theory of reasoned action and has certain advantages over the health belief model in that the social environment is given prominence in its ability to influence our behaviour. It still shares some of the disadvantages of all cognitive models, however, in that it also assumes that people make rational and considered decisions about their health.

Theory of Planned Behaviour



One of the most predictive persuasion theories, it has been applied to studies of the relations among beliefs, attitudes, behavioural intentions and behaviours in various fields such as advertising public relations, advertising campaigns and healthcare. The theory states that attitude toward behaviour, subjective norms, and perceived behavioural control, together shape an individual's behavioural intentions and behaviours.

Theory of Planned Behaviour Concepts of Key Variables

Behavioural Beliefs and Attitude toward Behaviour

Behavioural belief is an individual's belief about consequences of particular behaviour. The concept is based on the subjective probability that the behaviour will produce a given outcome. **Attitude toward behaviour** is an individual's positive or negative evaluation of self-performance of the particular behaviour. The concept is the degree to which performance of the behaviour is positively or negatively valued. It is determined by the total set of accessible behavioural beliefs linking the behaviour to various outcomes and other attributes.

Normative Beliefs and Subjective Norms

Normative belief is an individual's perception of social normative pressures, or relevant others' beliefs that he or she should or should not perform such behaviour. **Subjective norm** is an individual's perception about the particular behaviour, which is influenced by the judgment of significant others e.g., parents, spouse, friends, teachers.

Control Beliefs and Perceived Behavioural Control

Perceived behavioural control is an individual's perceived ease or difficulty of performing the particular behaviour (Ajzen, 1991). It is assumed that perceived behavioural control is determined by the total set of accessible control beliefs.

Control belief is an individual's beliefs about the presence of factors that may facilitate or impede performance of the behaviour (Ajzen, 2001). The concept of perceived behavioural control is conceptually related to self-efficacy.

Behavioural intention and Behaviour

Behavioural intention is an indication of an individual's readiness to perform a given behaviour. It is assumed to be an immediate antecedent of behaviour (Ajzen, 2002). It is based on attitude toward the behaviour, subjective norm, and perceived behavioural control, with each predictor weighted for its importance in relation to the behaviour and population of interest.

Behaviour is an individual's observable response in a given situation with respect to a given target. Ajzen said behaviour is a function of compatible intentions and perceptions of behavioural control in that perceived behavioural control is expected to moderate the effect of intention on behaviour, such that a favourable intention produces the behaviour only when perceived behavioural control is strong.

The theory of planned behaviour has been particularly successful in predicting behaviours such as smoking, alcohol consumption and exercise. The perceived behavioural control and a related concept of self efficacy, has been particularly useful in the prediction of health behaviours. Studies have shown that factors within the theory of planned behaviour can explain about 60% of the variability in our intentions.

There are some criticisms of the theory of planned behaviour. As this model was developed as a general model of behaviour, it does not have any specific reference to health values like the health belief model does. The model considers only cognitive determinants of attitudes and beliefs. One of the most promising extra variables is that of anticipated regret which relates to the strength of emotional disappointment which may occur if the intended behaviour is not completed.

The theory of planned behaviour and the health belief models also only relate to the motivational stage or intention formation stage and do not address what can be termed the action stage which relates to the translation of intention into behaviour. Research suggests even when intention is high people do not always follow through with the intended behaviour.

Further analysis by Webb and Sheeran (2006) demonstrates that in various studies which have successfully increased intention, the impact on behaviour has been more modest. Much research has investigated the intention- behaviour gap, and one of the promising strands appears to be that of implementation intentions.

Theory of Planned Behaviour: Implementation intentions

Implementation intentions

An implementation intention requires the person to make a specific plan as to when and where they will carry out the behaviour. Studies showed that implementation intention can help people work towards the attainment of their goal, and over time, it can help make the process an automatic behaviour. It has a good rate of success for a range of health behaviours such as improved diets and increased levels of exercise.

Changing Motivation and Behaviours

Motivation is defined as the process that initiates, guides and maintains goal-oriented behaviours. Motivation is what causes us to act. It involves the biological, emotional, social and cognitive forces that activate behaviour.

Components of Motivation

There are three major components to motivation: activation, persistence and intensity.

- **Activation** involves the decision to initiate behaviour.
- **Persistence** is the continued effort toward a goal even though obstacles may exist.
- **Intensity** is the concentration and vigour that goes into pursuing a goal.

Extrinsic Vs. Intrinsic Motivation

Different types of motivation are described as being either extrinsic or intrinsic. **Extrinsic motivations** are those that arise from outside of the individual and often involve rewards. **Intrinsic motivations** are those that arise from within the individual.

Key to Facilitating Successful Behaviour Change

- Building self-efficacy while recognising autonomy
- Identifying and facilitating readiness to change
- Facilitating motivation to change
- Helping to prevent and manage relapses
- Fostering a good working alliance
- Using evidence-based procedures
- Providing relevant information and advice
- Allowing sufficient time for change

Building Self-efficacy with useful Goal-setting

A client's sense of self-efficacy in making behaviour change can be greatly aided by setting useful and useable goals to build and maintain motivation.

Goals should be clear plans for concrete actions. Goals should be expressed as behaviours the client intends to do, which will distinguish them from wishful thinking, good intentions or desirable outcomes.

Goals should be realistically challenging. If goals are too hard, the sense of self-efficacy will be lost; if they are too easy they won't inspire much effort.

Goals should incorporate the client's interests. It is difficult to be motivated to work on something that is not genuinely interesting. Exercise routines may be made more interesting by, for example, listening to a book on CD at the same time. Healthy eating and drinking can and should be very interesting.

Goals should conform to the client's values. Different people may well have different values, as do different societies and cultures.

Goals should have verifiable outcomes. Verifiable outcomes will allow clients to see themselves as being successful at achieving the goals they have set. This in turn will build self-efficacy so that they will be more likely to keep achieving the goals. Verifiable outcomes provide observable evidence of achievement, as opposed to desirable outcomes which are something that is hoped for.

Goals should depend on the client's own efforts. It is important that achieving goals does not depend on the actions or reactions of things outside of the client's control. This is the aspect of goal-setting many health professionals get wrong. For example, a good goal is to eat sensibly, because that's under the person's control; a poor goal would be to lose 10 kg, because that's not under the person's control.

Goals should be achieved reasonably soon. Distant goals tend to be weaker motivators, while closer goals tend to be stronger motivators. Daunting goals can be broken into manageable steps so that they are seen as a series of sub-goals.

Goals should be set with the involvement of the client. Collaborative goal-setting is the beginning of all successful behaviour change programs and how we show practical respect for our client's autonomy.

Trans-theoretical Model of Change

The Trans-theoretical Model or Wheel of Change; proposed by the psychologists James Prochaska and Carlo Di-Clemente (1982) helps people make changes and considers how it can be used for structuring therapy intervention. The model is particularly helpful in situations where a client is trying to break a habitual/ addictive behaviour which is creating repeated problems for them. It can be applied to a range of habitual problems, including:

- Smoking
- Misuse of alcohol/ drugs
- Eating problems
- Other addictive behaviours

Trans-theoretical Model of Change



Adapted from Prochaska and Di Clemente's cycle of change model.

Prochaska and Di Clemente's model has been set out in a number of different ways to illustrate the stages that a person often goes through on the path to change.

Pre-Contemplation: Here the client is not thinking at all about changing their behaviour. After Pre-Contemplation, at some point the client then moves into Stage 1 of the model.

Stage 1 – Contemplation: Here the client is in **ambivalence** – i.e. they can see some benefits in changing but also are aware of or experiencing the benefits of not changing, so as yet they haven't started to change and are at a stage of indecision.

Stage 2 – Decision: The client makes a decision to change. Usually this occurs after some specific triggering event, which increases their motivation to change – for example, if smoking cigarettes or abusing alcohol is the problem behaviour, then an event such as a relative or friend experiencing serious health problems from smoking or drinking might trigger the client to decide to cut down their own smoking/ drinking.

Stage 3- Action: The client now begins to act. This may be by stopping the problem behaviour altogether (e.g. by ceasing smoking or drinking alcohol) or by reducing it.

Stage 4 – Maintenance: If things are going well, then the client maintains their progress in stopping or cutting down the problem or addictive behaviour.

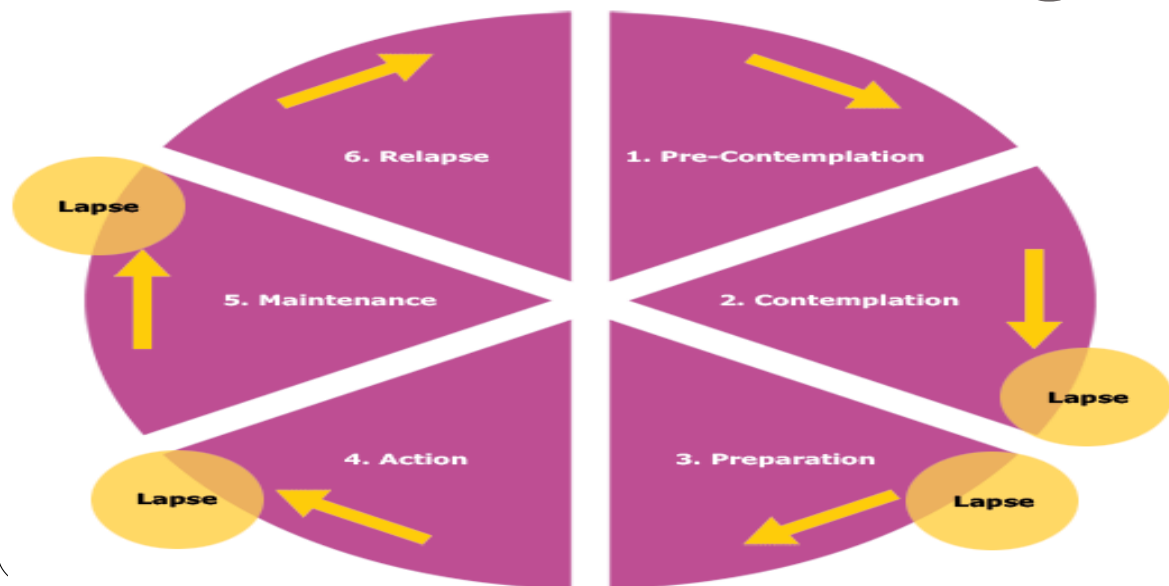
Permanent Exit – If the client is able permanently to avoid returning to the problem behaviour then they can be said to have permanently exited from the cycle. Usually they may be said to be controlling or managing the problem rather than that it has disappeared. For example, they might still get cravings to smoke or drink alcohol, but so long as they avoid actually smoking or drinking in practice they will avoid the harmful physical effects associated with smoking or alcohol. However, in most cases before they achieve permanent exit, the client will experience Stage 5:

Stage 5: Lapse: The client slips back temporarily into the problem behaviour. Perhaps they are particularly stressed one night and they have a cigarette or drink alcohol.

Prochaska and DiClemente represent the stages 1-5 as a wheel or cycle which people generally go round several times before they are able to exit permanently. The model is therefore **sometimes referred to as "The Wheel of Change"**, but should not be confused with the 'Wheel of Life', with which most coaches are familiar as a common tool for initial assessment of different areas of a person's life.

The 'lapse' stage in Prochaska and DiClemente's model is sometimes called 'relapse'. This distinction can therefore be used to highlight to the client that if they have a slip-up or lapse, they have a choice. They can either get back on track, recognise their progress and try to learn from the experience of lapsing as to what they might do differently the next time to avoid lapsing again in a similar situation or lose heart and see the lapse as a sign that they will never achieve change in which case the lapse may become a permanent relapse. If the client does relapse, then the therapist can encourage them to respond to the situation practically. Rather than see the lapse as a sign of failure of will power, just see it as a natural stage in the process of change and encourage the client to see that they have a choice about whether to get back on track.

Trans-theoretical Model of Change



How Prochaska and DiClemente's Model can be used

A therapist can use the model when working with a client either by sharing it with the client or else as a framework to work with behind the scenes. The client can be shown the model of change, asked to locate what stage they feel they are currently at, what stages they have moved through, and to elaborate on circumstances and their thoughts about this.

Often, seeing the model of change and the stages enables a client to feel that their perceived problem is not as extraordinary as they may initially think and that they are actually following quite normal stages in working through their problem. Explaining to a client that a relapse is normal and does not have to lead to failure can assist the client in dealing with potential feelings of guilt, shame or inadequacy at not progressing faster.

Seeing the stages of the model set out and explained clearly can also help a client to feel that the situation is not hopeless or beyond their control. Instead, it is a situation where they can progress if they are patient, set realistic achievable goals and don't

panic when they lapse, but try to adopt a mentality of learning from experience without judging themselves.

The model also takes the pressure off the therapist to solve all the client's problems immediately. Instead they have a clear framework within which they can encourage the client to locate their problem behaviour and select strategies. At any stage in the coaching process where the client appears to be faltering in progress, the therapist can go back to the model and reassess with the client what stage they are at and what may be appropriate strategies for them to adopt.

Different strategies are appropriate for different stages of the model.

Stage	Appropriate Strategies
Pre-Contemplation: Client not considering trying to achieve change	For someone at this stage, appropriate information as to why change may be helpful for the client, provided in a non authoritarian manner by way of simple information, may be of use.
Stage 1 - Contemplation: Client sees some benefits in changing but is also experiencing or aware of benefits in not changing	Encourage the client to: 1. Analyse the arguments for and against change (e.g. to complete a list highlighting and weighing up both the advantages and the disadvantages of making the changes they are thinking about) 2. Reflect on different options for change and the likely effect of them. 3. Consider whether there are any very small ways they could begin to take steps in the direction of change, which seem reasonable and achievable to them.

Stage	Appropriate Strategies
Stage 2 - Deciding to try to achieve change	Encourage client to: 1. Plan change carefully rather than make a rush decision. 2. Break the plan down into achievable goals. 3. Write down commitment to change. 4. Think about where they can get support for following their plans.
Stage 3 – Acting to achieve change	Encourage client to: 1. Follow their plan, monitor and review progress. 2. Reward and congratulate themselves on successes (even small successes). 3. Remind themselves of the benefits that will ensue if they achieve goals and acknowledge & identify those benefits as they happen (even if only partially achieved) 4. Pace themselves at a level where they will be able to sustain motivation & if possible allow themselves some time to relax when they are not focusing on their plan – Recognise they have a life outside the plan. 5. Learn from things which don't turn out as they expect. 6. Make use of appropriate support. 7. If they lapse, try not to return back to where they started from but instead recognise the progress they have made,

Stage	Appropriate Strategies
Stage 4 - Maintaining change	Encourage client to: 1. Recognise that development is an ongoing process. 2. Maintain and review plans until absolutely sure they are no longer required. 3. Again, if they lapse, try not to return back to where they started from but instead recognise the progress they have made and implement a new plan, learning from the lapse. 4. Think about whether there is a way they can help others make positive changes in the light of their experience.

Stress and its Relationship to Health

Psychologists quantify stress in a number of ways. One of the first approaches to stress concentrates on the physiological changes which occur. Taking this response approach the extent of the stress experienced can be measured by the strength of the individual's physiological changes. These changes are produced by activation of the sympathetic nervous system and the secretion of the hormones adrenaline and cortisol. A number of physiological changes can be measured, such as increased heart rate and blood pressure, levels of sweating and changes in immunological factors or hormonal activity.

A different approach to the measurement of stress is to assess the number of times someone experiences events or situations that most people report as being stressful. These can be major life events (natural disaster, bereavement, redundancy, divorce) or minor (argument, losing keys). Listing such events on a questionnaire to provide a score representing the experience of stressful events over a certain timeframe, although comprehensive enough to cover all relevant sources of stress for all people can be difficult. Another difficulty with this life events approach is that it assumes that an event causes as much stress for one person as it does another, but people differ widely in the meaning attached to events.

Another approach to understanding stress is to take an approach which recognises individual differences in how we respond to situations. This is called the Transactional model.

The Transactional model of stress proposed by Lazarus and Folkman (1984) takes an approach that stress is 'in the eye of the beholder'. Taking this approach no event would be seen as stressful in itself, instead any appraised as stressful depending on how it is interpreted and how well the person feels that they can cope. Lazarus and Folkman (1984) theorised that the interpretation of an event as stressful is dependent on two appraisals:

- 1) **Meaning attached to the event:** benign, a threat, harmful, or a challenge.
- 2) **Perception of our ability to cope** and the **resources** we have to meet the requirements of the event.

Stress occurs when a person's perceived or real ability to cope is exceeded by the perceived or real demands of the event. Different people and different types of personalities will vary in their perception of events and in their perceived ability to cope with events. The transactional approach requires a subjective measurement of stress. Subjective stress questionnaires have been developed (Perceived stress scale Cohen, Kamarck and Mermelstein) and researches have also been able to use structured interviews to explore relevant sources of stress (Brown and Harris). Coping checklists have also been developed such as the COPE scale (Carver, Scheier and Weintraub) which covers 14 different styles of coping.

Link between Stress and Ill Health:

Cannon (1932) coined the term flight or fight response to describe the physical response of the body to stress. Early studies demonstrated that sustained periods of stress were accompanied by an increased susceptibility to illness. The term allostatic load (coined in the late 20th C) was used to describe wear and tear to the body caused by stress response and the impact of lifestyle habits such as smoking and poor diet (McEwen 1998).

Although the short term physical changes experienced during the stress response have a number of benefits in terms of mobilising the body for action, each stress response causes a degree of allostatic load, as it places the body in a higher level of functioning.

Excessive reaction to stress creates additional allostatic load and damage. Allostatic load is also produced if the body does not quickly revert back to normal once the stressful event has passed, or if recovery of physical systems is not synchronised appropriately. Cortisol is the hormone implicated in helping the body switch off the stress response. However if this is not in proportion to the levels of activation, then the immune system can be pushed to levels below optimum functioning.

Stress may also lead to illness due to a reduction in care behaviours and an increase in riskier behaviours such as smoking, eating, alcohol consumption and drug abuse in people reporting high stress levels. The cardiovascular system is noticeably affected by the stress response. Researchers have found higher levels of heart

attack, stroke and sudden cardiac death in populations exposed to major and severe stressors, such as natural disasters, war or accidents.

Within the brain subtle changes are caused by repeated or prolonged stress responses which make people more likely to develop depression (Checkley 1996). Long term effects of stress on the immune system lead to increased levels of coughs, colds, infections (Cohen, Tyrrell and Smith 1994) as well as delays in wound healing (Glaser 2005). Effects of stress can also be seen more widely in those with increased susceptibility to type 2 diabetes, obesity and autoimmune disorders (Sapolsky 2004).

The relationship between job demands, control and stress was first demonstrated by Karasek (1979) whose studies showed that employees with the highest level of job demands, but low levels of control in terms of decision making had higher levels of stress, disturbed sleep, anxiety and exhaustion. Based on this research, Karasek proposed a model of job stress which suggests that there is an optimum level of demands, with both very low levels and very high levels causing stress. Later models integrated the stress-buffering effects of social support. A systematic review of the evidence collected since Karasek's model was proposed has tended to support the association of three factors- extreme demands, low control and low support with rates of illness and staff absence.

Understanding the factors that make situations stressful has important implications for reducing stress levels. Research suggests that levels of stress among health care professionals are higher than other occupational groups and a great deal of work has been conducted on the issue of staff burnout within medical professions and settings.

Occupational health psychologists can help reduce the stressful nature of the work environment. In part this can be achieved by reducing the demands of the physical environment, ensuring noise levels are reasonable, temperature is comfortable and lighting appropriate. Providing workers with some sense of control over their working environment such as allowing them to decide the order in which they complete their tasks can help reduce stress levels. Rotating staff between tasks can help to keep interest levels high, and avoid the problem of too low a level of demand and

boredom. Increasing opportunities for workers to interact with each other and take advantage of social support can also help reduce stress.

A study carried out by Michie, Wren and Williams (2004) found that making changes in the work environment of hospital cleaners to increase control and increase support from other workers resulted in lower sickness rates. Health psychologists also work generally to enable people to manage the stresses within their lives. Keeping a diary of aspects of their life that they find stressful is encouraged. Analysis of a stress diary may identify events or circumstances which might be possible to avoid. Alternatively people can be provided with skills to prevent some sources of stress in certain situations such as time management and communication skills workshops. Another tactic is to try to change how people appraise events and their coping skills.

The transactional model would suggest that our experience of stress is determined in part by what we perceive as stressful. Certain cognitive styles such as always looking at the negative side can mean that more of life is perceived as stressful, whereas a more optimistic style is associated with reduced experience of stress. Other approaches try to help people reduce the physical response to stress such as increased heart rate, blood pressure and breathing rates. This may be achieved by relaxation training, progressive muscle relaxation, mediation or biofeedback.

Health psychologist's research on stress continues to explore the links between stress and illness and more importantly to investigate methods of reducing stress in daily life and helping people to cope better with the stress they experience.

Preventing Illness and Health Promotion

Health Psychologists try to help people to lead a healthy life by developing and running programmes which can help people to make changes in their lives such as stopping smoking, reducing the amount of alcohol they drink, eating more healthily, and taking regular exercise. Campaigns informed by health psychology have targeted tobacco use.

Practitioners emphasize education and effective communication as a part of illness prevention because many people do not recognize, or minimize, the risk of illness present in their lives. Health psychologists help to promote health and well-being by preventing illness. Some illnesses can be treated better if they are caught early.

Health Psychologists have worked to understand why some people do not go for screening or immunisations and are finding ways to encourage people to have health checks and screening for illnesses such as cancer or heart disease. They are also finding ways to try to help people to avoid risky behaviours that may affect their health and well-being, such as unprotected sex and to prevent future ill health.

Health Psychologists - The Effects of Disease

Health psychologists investigate how disease affects individuals' psychological well-being. An individual who becomes seriously ill or injured faces many different practical stressors. The stressors include problems meeting medical and other bills; problems obtaining proper care when home from the hospital; obstacles to caring for dependents; having one's sense of self-reliance compromised; or gaining a new, unwanted identity as a sick person. These stressors can lead to depression and reduced self-esteem.

Health psychology also concerns itself with bettering the lives of individuals with terminal illness. When there is little hope of recovery, therapists can improve the quality of life of the patient by helping the patient recover at least some of his or her psychological well-being. Health psychologists are also concerned with identifying the best ways for providing therapeutic services for the bereaved.

Health Psychologists-Critical Analysis of Health Policy

Health psychologists explore how health policy can influence inequities, inequalities, and social injustice. These avenues of research expand the scope of health psychology beyond the level of individual health to an examination of the social and economic determinants of health both within and between regions and nations. The individualism of mainstream health psychology has been critiqued and deconstructed by critical health psychologists using newer qualitative methods and frameworks for investigating health experience and behaviour.

Health Psychologists - Conducting Research

Health Psychologists have advanced skills in a variety of research methods, which enables them to conduct research, provide expert advice or collaborate on a study, for example studying the links between stress and health. They carry out research to answer questions such as:

- What influences healthy eating?
- How is stress linked to heart disease?
- What are the emotional effects of genetic testing?
- How can we change people's health behaviour to improve their health?

Health Psychologists-Teaching & Communication

Health psychologists can also be responsible for training other health professionals, for example on how to deliver an intervention to help promote healthy eating or stopping smoking, or deliver training in communication skills such as how to break bad news, or support behaviour change. This can also enhance practitioner patient relationships and adherence to treatment.

Applications of Health Psychology

Improving Doctor–Patient Communication

Health psychologists attempt to aid the process of communication between Doctors and patients during medical consultations. There are many problems in this process, with patients showing a considerable lack of understanding of many medical terms, particularly anatomical terms. One main area of research on this topic involves "doctor centred" or "patient centred" consultations. Doctor centred consultations are generally directive, with the patient answering questions and playing less of a role in decision-making. Although this style is preferred by elderly people and others, many people dislike the sense of hierarchy or ignorance that it inspires.

Patient centred consultations focus on the patient's needs, involve the doctor listening to the patient completely before making a decision, and involve the patient in the process of choosing treatment and finding a diagnosis.

Improving Adherence to Medical Advice

Getting people to follow medical advice and adhere to their treatment regimens is a difficult task for health psychologists. People often forget to take their medication or consciously opt not to take their prescribed medications because of side effects. Estimated adherence rates are difficult to measure; there is, however, evidence that adherence could be improved by tailoring treatment programs to individuals' daily lives.

Managing Pain

Health psychology attempts to find treatments to reduce and eliminate pain, as well as understand pain anomalies such as analgesia causalgia, neuralgia, and phantom limb pain. Although the task of measuring and describing pain has been problematic, the development of the McGill Pain Questionnaire has helped make progress in this area. Treatments for pain involve patient administered analgesia, acupuncture, biofeedback, and cognitive behaviour therapy.

Community approaches within Health Psychology

Community psychology studies the individuals' contexts within communities and the wider society, and the relationships of the individual to communities and society. Community psychologists aim to understand the quality of life of individuals, communities, and society to enhance quality of life through collaborative research and action.

Community psychology employs various perspectives within and outside of psychology to address issues of communities, the relationships within them, and related people's attitudes and behaviour. Rappaport (1977) discusses the perspective of community psychology as an ecological perspective on the person and their environment (often related to work environments) being the focus of study and action instead of attempting to change the personality of individual or the environment when an individual is seen as having a problem. Community psychology grew out of the community mental health movement, but evolved dramatically as early practitioners incorporated their understandings of political structures and other community contexts into perspectives on client services.

Prevention and Health Promotion

Community psychology emphasizes principles and strategies of preventing social, emotional and behavioural problems and wellness and health promotion at the individual and community levels, borrowed from Public health and Preventive medicine, rather than a passive, "waiting-mode," treatment-based medical model. Universal, selective, primary, or secondary prevention (early identification and intervention) are particularly emphasized.

Empowerment

One of the goals of community psychology involves empowerment of individuals and communities that have been marginalized by society. One definition for the term is "an intentional, ongoing process centred in the local community, involving mutual respect, critical reflection, caring, and group participation, through which people lacking an equal share of resources gain greater access to and control over those resources" (Cornell Empowerment Group). Rappaport's (1984) definition includes: "Empowerment is viewed as a process: the mechanism by which people, organizations, and communities gain mastery over their lives."

While empowerment has had an important place in community psychology research and literature, some have criticized its use. Riger (1993), for example, points to the paradoxical nature of empowerment being a masculine, individualistic construct being used in community research.

Social Justice

A core value of community psychology is seeking social justice through research and action. Community psychologists are often advocates for equality and policies that allow for the wellbeing of all people, particularly marginalized populations.

Diversity

Another value of community psychology involves embracing diversity. Rappaport includes diversity as a defining aspect of the field, calling research to be done for the benefit of diverse populations in gaining equality and justice. This value is seen through much of the research done with communities regardless of ethnicity, culture, sexual orientation, disability status, socio-economic status, gender and age.

Individual Wellness

Individual wellness is the physical and psychological wellbeing of all people. Research in community psychology focuses on methods to increase individual wellness, particularly through prevention and second-order change.

Citizen Participation

Citizen participation refers to the ability of individuals to have a voice in decision-making, defining and addressing problems, and the dissemination of information gathered on them. This is the basis for the usage of participatory action research in community psychology, where community members are often involved in the research process by sharing their unique knowledge and experience with the research team and working as co-researchers.

Collaboration and Community Strengths

Collaboration with community members to construct research and action projects makes community psychology an exceptionally applied field. By allowing communities to use their knowledge to contribute to projects in a collaborative, fair and equal manner, the process of research can itself be empowering to citizens. This requires an ongoing relationship between the researcher and the community from before the research begins to after the research is over.

Psychological Sense of Community

Psychological sense of community was introduced in 1974 by Seymour Sarason. In 1986 a major step was taken by David McMillan and David Chavis with the publication of their "Theory of Sense of Community" and in 1990 the "Sense of Community Index". Originally designed primarily in reference to neighbourhoods, the Sense of Community Index (SCI) can be adapted to study other communities as well, including the workplace, schools, religious communities and communities of interest.

Empirical Grounding

Community psychology grounds all advocacy and social justice action in empiricism. This empirical grounding is what separates community psychology from a social movement or grassroots organization. Methods from psychology have been adapted for use in the field that acknowledge value-driven, subjective research involving community members. The methods used in community psychology are therefore tailored to each individual research question.

Bibliography

- Banyard, P. (2002). Psychology in practice: Health. London, England: Hodder & Stoughton Educational.
- Belar, C. D., Mendonca McIntyre, T. & Matarazzo, J. D. (2003). Health psychology. In D. K. Freedheim & I. Weiner (Eds.), Handbook of Psychology. Vol.1: History of Psychology. New York: Wiley
- Bennett, P (2007) Abnormal Clinical Psychology; An Introductory Textbook (Second edition). Maidenhead: Open University Press
- Cohen, L.M.; McChargue, D.E.; & Collins, Jr. F.L. (Eds.). (2003). *The Health Psychology Handbook: Practical issues for the Behavioral Medicine Specialist*. Thousand Oaks, CA: Sage Publications.
- Coolican, H. (2007). Applied Psychology. (2nd Edition). London: Hodder Arnold.
- David F. Marks, Michael Murray, Brian Evans & Emeé Vida Estacio (2011) Health Psychology. Theory-Research-Practice (3rd Ed.) Sage Publications. ISBN 1-84860-622-2(hbk) 978-1848606227.
- Eysenck, M.W. (2000) Psychology: A Students Handbook. New York; Psychology Press
- Hayes, N. (2010) Understanding Applied Psychology. London: Hodder Education.
- Johnston, M. (1994). Health psychology: Current trends. *The Psychologist*, 7,114–118.
- Johnston, M., Weinman, J. & Chater, A. (2011). A healthy contribution. *The Psychologist*, 24(12), 890-892.
- Michie, S.; & Abraham, C. (Eds.). (2004). Health psychology in practice. London. BPS Blackwells.
- Myers, D. (2002) Exploring Psychology, fifth edition, New York; Worth publishers
- Myers, D. (2008). Exploring Psychology. Worth Publishers. ISBN 1-57259-0963.
- Ogden, J. (2007). Health Psychology: A Textbook (4th ed.). Berkshire, England: Open University Press.
- Ogden, J. (2012). Health Psychology: A Textbook (5th ed.). Maidenhead, UK: Open University Press.

- Prochaska, J.O. & DiClemente, C. C. (1982) "Transtheoretical therapy: Toward a more integrative model of change" from 'Psychotherapy: Theory, Research, and Practice', 19, 276-288.
- Quick, J.C.; & Tetrick, L.E. (Eds.). (2003). Handbook of Occupational Health Psychology. Washington, DC: American Psychological Association.
- Taylor, S.E. (1990). Health psychology. American Psychologist, 45, 40–50.
- The British Psychological Society. (2011). Health Psychology in applied settings: A guide for employers.

Theories of Human Growth and Development

Developmental Psychology

Contents

Page

194: Introduction to Developmental Psychology
195: Freud's Stages of Psychosexual Development
198: Erik Erikson's Theory of Psychosocial Development
200: Learning Theories (Behaviourist)
200: Social Child Development Theories
204: Cognitive Theories of Development
205: Piaget's Theory and Stages of Cognitive Development
206: Kohlberg's Theory of Moral Development
209: Erik Erikson's Stages of Development
211: Physical Developmental Milestones
213: Cognitive Developmental Milestones
216: Social Emotional Developmental Milestones
218: Early Childhood
219: Adolescence
220: Early Adulthood: Emerging Adulthood: Middle Adulthood
221: Old Age
221: Parenting Variables and Parenting Styles
222: Parenting Roles: Mother and Father Factors
223: Bowlby's Attachment Theory
224: Nature V's Nurture
229: Bibliography

Theories of Human Growth and Development

Developmental Psychology

Developmental psychology is the branch of psychology and the scientific study of how people grow and change over the course of a lifetime. Originally concerned with infants and children it expanded to include adolescence, adult development, ageing, and the entire lifespan. Beginning with Sigmund Freud (1856–1939) and Jean Piaget (1896–1980), the early focus of developmental psychology was on the maturation of children. Within the last three decades, researchers who study human development have expanded their focus to examine change across a broad range of topics including psycho-physiological processes; cognitive development involving areas such as problem solving, moral and conceptual understanding; language acquisition; social, personality, emotional development, self-concept and identity formation.

The scientific study of human growth and development is important not only to psychology, but also to biology, sociology, anthropology, education, history and health care. Most important, however, are its practical applications. By better understanding how and why people change and grow, the knowledge can be applied to help people to reach their full potential.

There have been a number of important debates and issues throughout the history of developmental psychology. Some of the major questions posed by psychologists and researchers are centred on the relative contributions of genetics versus environment and the **‘Nature V’s Nurture’ debate**. Does genetic inheritance play a larger role in influencing development and behaviour, or does the environment have a stronger effect? Today, most psychologists recognize that both elements play an essential role, but the debate continues.

A second important consideration in developmental psychology involves the relative importance of early experiences versus those that occur later in life. Are we more affected by events that occur in early childhood, or do later events play an equally important role?

A third and major issue is that of continuity. Does change occur smoothly over time, or through a series of predetermined steps? Most theories of development fall under three broad areas: Psychoanalytical theories: Learning theories: Cognitive theories.

Psychoanalytic theories are those influenced by the work of Sigmund Freud (1856–1939), who believed in the importance of the unconscious mind and childhood experiences. Freud's contribution to developmental theory was his proposal that development occurs through a series of psychosexual stages

Theorist Erik Erikson (1902-1994) expanded upon Freud's ideas by proposing an 8 stage theory of psychosocial development. Erikson's theory focused on conflicts that arise at different stages of development and, unlike Freud's theory, Erikson described development throughout the lifespan.

Learning theories focus on how the environment impacts behaviour. Important learning processes include classical conditioning, operant conditioning and social learning. In each case, behaviour is shaped by the interaction between the individual and the environment.

Cognitive theories focus on the development of mental processes, skills, and abilities. Examples of cognitive theories include Jean Piaget's (1896-1980) theory of cognitive development.

Freud's Stages of Psychosexual Development

Proposed by psychoanalyst Sigmund Freud (1856–1939), the theory of psychosexual development describes how personality develops during childhood. While the theory is well-known in psychology, it is also one of the most controversial. Freud believed that personality develops through a series of childhood stages in which the pleasure-seeking energies of the id become focused on certain erogenous areas. This psychosexual energy or libido (sexual drives or instincts) is described as the driving force behind behaviour.

These are called psychosexual stages because each stage represents the fixation of libido on a different area of the body. As a person grows physically certain areas of their body become important as sources of potential frustration (erogenous zones), pleasure or both.

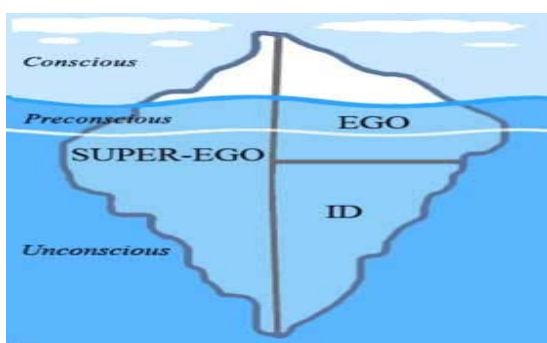
Freud believed that life was built round tension and pleasure. He also believed that all tension was due to the build up of **libido** (sexual energy) and that all pleasure came from its discharge.

In describing human personality development as psychosexual Freud meant to convey that what develops is the way in which sexual energy accumulates and is discharged as we mature biologically. Freud used the term 'sexual' in a very general way to mean all pleasurable actions and thoughts.

Freud stressed that the first five years of life are crucial to the formation of adult personality. The id must be controlled in order to satisfy social demands; this sets up a conflict between frustrated wishes and social norms.

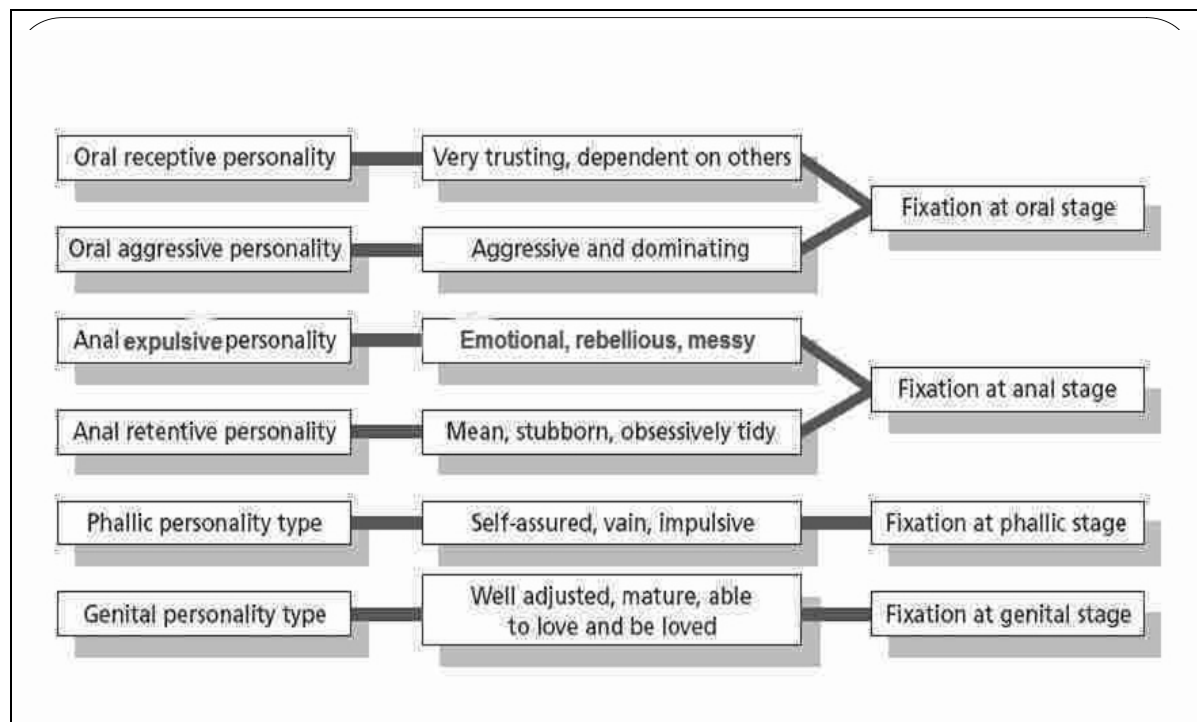
The ego and superego develop in order to exercise this control and direct the need for gratification into socially acceptable channels. Gratification centres of different areas of the body at different stages of growth, making the conflict at each stage psychosexual.

Psychoanalytic theory suggested that personality is mostly established by the age of five. Early experiences play a large role in personality development and continue to influence behaviour later in life. If these psychosexual stages are completed successfully, the result is a healthy personality. If certain issues are not resolved at the appropriate stage, fixation can occur. A fixation is a persistent focus on an earlier psychosexual stage. Until this conflict is resolved, the individual will remain "stuck" in this stage. For example, a person who is fixated at the oral stage may be over-dependent on others and may seek oral stimulation through smoking, drinking, or eating.



Freud's Psychosexual Stages

Stage	Focus
Oral (0-18 months)	Pleasure centers on the mouth--sucking, biting, chewing
Anal (18-36 months)	Pleasure focuses on bowel and bladder elimination; coping with demands for control
Phallic (3-6 years)	Pleasure zone is the genitals; coping with incestuous sexual feelings
Latency (6 to puberty)	Dormant sexual feelings
Genital (puberty on)	Maturation of sexual interests



Erik Erikson's Theory of Psychosocial Development

Erik Erikson's (1902-1994) theory of psychosocial development is one of the best-known theories of personality in psychology. Much like Sigmund Freud, Erikson believed that personality develops in a series of stages. Unlike Freud's theory of psychosexual stages, Erikson's theory describes the impact of social experience across the whole lifespan.

One of the main elements of Erikson's psychosocial stage theory is the development of ego identity. Ego identity is the conscious sense of self that we develop through social interaction. According to Erikson, our ego identity is constantly changing due to new experiences and information we acquire in our daily interactions with others.

When psychologists talk about identity, they are referring to all of the beliefs, ideals, and values that help shape and guide a person's behaviour. The formation of identity is something that begins in childhood and becomes particularly important during adolescence, but it is a process that continues throughout life. Our personal identity gives each of us an integrated and cohesive sense of self that endures and continues to grow as we age.

In addition to ego identity, Erikson also believed that a sense of competence motivates behaviours and actions. Each stage in Erikson's theory is concerned with becoming competent in an area of life. If the stage is handled well, the person will feel a sense of mastery, which is sometimes referred to as ego strength or ego quality. If the stage is managed poorly, the person will emerge with a sense of inadequacy.

In each stage, Erikson believed people experience a conflict that serves as a turning point in development. In Erikson's view these conflicts are centred on either developing a psychological quality or failing to develop that quality. During these times, the potential for personal growth is high, but so is the potential for failure.

Erikson's Stage Theory in its Final Version			
<i>Age</i>	<i>Conflict</i>	<i>Resolution or "Virtue"</i>	<i>Culmination in old age</i>
Infancy (0-1 year)	Basic trust vs. mistrust	Hope	Appreciation of interdependence and relatedness
Early childhood (1-3 years)	Autonomy vs. shame	Will	Acceptance of the cycle of life, from integration to disintegration
Play age (3-6 years)	Initiative vs. guilt	Purpose	Humor; empathy; resilience
School age (6-12 years)	Industry vs. Inferiority	Competence	Humility; acceptance of the course of one's life and unfulfilled hopes
Adolescence (12-19 years)	Identity vs. Confusion	Fidelity	Sense of complexity of life; merging of sensory, logical and aesthetic perception
Early adulthood (20-25 years)	Intimacy vs. Isolation	Love	Sense of the complexity of relationships; value of tenderness and loving freely
Adulthood (26-64 years)	Generativity vs. stagnation	Care	Caritas, caring for others, and agape, empathy and concern
Old age (65-death)	Integrity vs. Despair	Wisdom	Existential identity; a sense of integrity strong enough to withstand physical disintegration

Learning Theories

During the first half of the twentieth century, a new school of thought known as behaviourism rose to become a dominant force within psychology. Behaviourists believed that psychology needed to focus only on observable and quantifiable behaviours in order to become a more scientific discipline.

According to the behavioural perspective, all human behaviour can be described in terms of environmental influences. Some behaviourists, such as John B. Watson and B.F. Skinner, insisted that learning occurs purely through processes of association and reinforcement. Later, psychologist Albert Bandura rejected this narrow perspective and demonstrated the powerful effects of observational learning.

Classical Conditioning- is a process of behaviour modification by which a subject comes to respond in a desired manner to a previously neutral stimulus that has been repeatedly presented along with an unconditioned stimulus that elicits the desired response. **(Stimulus ->Response)**

Operant conditioning- is a method of learning that occurs through rewards and punishments for behaviour. Through these rewards and punishments, an association is made between behaviour and a consequence for that behaviour.

Social Child Development Theories

There is a great deal of research on the social development of children. John Bowlby proposed one of the earliest theories of social development. He believed that early relationships with caregivers play a major role in child development and continue to influence social relationships throughout life.

Social Learning Theory

The social learning theory proposed by **Albert Bandura** has become perhaps the most influential theory of learning and development. While rooted in many of the basic concepts of traditional learning theory, Bandura believed that direct reinforcement could not account for all types of learning.

His theory added a social element, arguing that people can learn new information and behaviours by watching other people. Known as observational learning (or modelling), this type of learning can be used to explain a wide variety of behaviours.

Basic Social Learning Concepts

There are three core concepts at the heart of social learning theory. First is the idea that people can learn through observation. Second is the idea that internal mental states are an essential part of this process. Thirdly, this theory recognizes that just because something has been learned, it does not mean that it will result in a change in behaviour.

Observational Learning

In his famous Bobo doll experiment, Bandura demonstrated that children learn and imitate behaviours they have observed in other people. Bandura *et al* (1963) carried out a classic study on observational learning or modelling- where young children were shown one of two films. One film showed a female adult behaving in an aggressive way towards a Bobo doll. The other film showed a female adult behaving non-aggressively. The children who had watched the adult behave aggressively were much more likely to attack the Bobo doll than those who had watched the non-aggressive film.

Bandura (1965) carried out another study on aggressive behaviour. One group of children were shown a film of an adult kicking and punching a Bobo doll. The 2nd group saw the same aggressive behaviour performed by the adult but this time the adult was rewarded by another adult for their behaviour. A 3rd group saw the same aggressive behaviour, but this time the adult was punished by another adult, who warned them not to be so aggressive in the future. Those children who had seen the model rewarded or seen the model neither rewarded nor punished- behaved much more aggressively to the doll than those who had seen the model punished.

Bandura identified three basic models of observational learning: A **live model**, which involves an actual individual demonstrating or acting out a behaviour: A **verbal instructional model** which involves descriptions and explanations of behaviour: A **symbolic model**, which involves real or fictional characters displaying behaviours in books, films, television programs, or online media.

Intrinsic Reinforcement

Bandura noted that external, environmental reinforcement was not the only factor to influence learning and behaviour. He described intrinsic reinforcement as a form of internal reward, such as pride, satisfaction, and a sense of accomplishment. This emphasis on internal thoughts and cognitions helps connect learning theories to cognitive developmental theories. While many textbooks place social learning theory with behavioural theories, Bandura himself describes his approach as a 'social cognitive theory.'

Learning does not necessarily lead to a change in behaviour. While behaviourists believe that learning leads to a permanent change in behaviour, observational learning demonstrates that people can learn new information without demonstrating new behaviours.

The Modelling Process

Not all observed behaviours are effectively learned. Factors involving both the model and the learner can play a role in whether social learning is successful. Certain requirements and steps must also be followed.

Attention:

In order to learn, you need to be paying attention. Anything that detracts your attention is going to have a negative effect on observational learning. If the model is interesting or there is a novel aspect to the situation, you are far more likely to dedicate your full attention to learning.

Retention:

The ability to store information is also an important part of the learning process. Retention can be affected by a number of factors, but the ability to pull up information later and act on it is vital to observational learning.

Reproduction:

Once you have paid attention to the model and retained the information, it is time to actually perform the behaviour you observed. Further practice of the learned behaviour leads to improvement and skill advancement.

Motivation:

Finally in order for observational learning to be successful, one has to be motivated to imitate the behaviour that has been modelled. Reinforcement and punishment play an important role in motivation. Experiencing these motivators can be highly effective, but so can observing others experience some type of reinforcement or punishment.

In addition to influencing other psychologists, Bandura's social learning theory has had important implication in the field of education. Today, both teachers and parents recognize the importance of modelling appropriate behaviours. Other classroom strategies such as encouraging children and building self-efficacy are also rooted in social learning theory.

Lev Vygotsky (1896-1934) proposed a seminal learning theory that has gone on to become very influential, especially in the field of education. Like Piaget, Vygotsky believed that children learn actively and through hands-on experiences. His socio-cultural theory also suggested that parents, caregivers, peers and the culture at large were responsible for the development of higher order functions.

Cognitive Theories of Development

Cognitive theories of development examine how thought processes and mental operations influence growth and change. Although there is no general theory of cognitive development, the most historically influential theory was developed by Jean Piaget, a Swiss Psychologist (1896-1980).

His theory provided many central concepts in the field of developmental psychology and concerned the growth of intelligence, which for Piaget, meant the ability to more accurately represent the world, and perform logical operations on representations of concepts grounded in the world.

The theory concerns the emergence and acquisition of schemata - schemes of how one perceives the world - in "developmental stages", times when children are acquiring new ways of mentally representing information.

The theory is considered "constructivist", meaning that, unlike nativist theories (which describe cognitive development as the unfolding of innate knowledge and abilities) or empiricist theories (which describe cognitive development as the gradual acquisition of knowledge through experience), it asserts that we construct our cognitive abilities through self-motivated action in the world.

Jean Piaget created one of the most famous theories of cognitive development, suggesting that children are not just passive recipients of information. Instead, he proposed that children are little scientists" who actively construct their knowledge and understanding of the world. Piaget's theory of cognitive development accounts for the steps and sequence of children's intellectual development.

Table 2.1

Piaget's Four Stages of Cognitive Development

Stage	Description	Age Range
Sensorimotor	An infant progresses from reflexive, instinctual action at birth to the beginning of symbolic thought. The infant constructs an understanding of the world by coordinating sensory experiences with physical actions.	Birth to 2 years
Preoperational	The child begins to represent the world with words and images; these words and images reflect increased symbolic thinking and go beyond the connection of sensory information and physical action.	2 to 7 years
Concrete operational	The child can now reason logically about concrete events and classify objects into different sets.	7 to 11 years
Formal operational	The adolescent reasons in more abstract and logical ways. Thought is more idealistic.	11 to 15 years

Piaget's Theory

Stage	Age Range	Description
Sensorimotor	0-2 years	Coordination of senses with motor response, sensory curiosity about the world. Language used for demands and cataloguing. Object permanence developed
Preoperational	2-7 years	Symbolic thinking, use of proper syntax and grammar to express full concepts. Imagination and intuition are strong, but complex abstract thought still difficult. Conservation developed.
Concrete Operational	7-11 years	Concepts attached to concrete situations. Time, space, and quantity are understood and can be applied, but not as independent concepts
Formal Operations	11+	Theoretical, hypothetical, and counterfactual thinking. Abstract logic and reasoning. Strategy and planning become possible. Concepts learned in one context can be applied to another.

Kohlberg's Theory of Moral Development

Moral development is a major topic of interest in both psychology and education. One of the best known theories was developed by psychologist Lawrence Kohlberg (1927-1987) who modified and expanded upon Jean Piaget's work to form a theory that explained the **development of moral reasoning**.

Piaget described a two-stage process of moral development, while Kohlberg's theory of moral development outlined **six stages within three different levels**. Kohlberg extended Piaget's theory, proposing that moral development is a continual process that occurs throughout the lifespan.

Kohlberg based his theory upon research and interviews with groups of young children. A series of moral dilemmas were presented to these participants and they were also interviewed to determine the reasoning behind their judgments of each scenario.

"The Heinz Dilemma"

A woman was near death from cancer. There was one drug that the doctors thought might save her. It was a form of radium that a chemist in the same town had recently discovered. The drug was expensive to make, but the chemist was charging ten times what the drug cost him to make.

He paid \$200 for the radium and charged \$2,000 for a small dose of the drug. The sick woman's husband, Heinz, went to everyone he knew to borrow the money, but he could only get together about \$ 1,000 which is half of what it cost. He told the chemist that his wife was dying and asked him to sell it cheaper or let him pay later. But the chemist said: "No, I discovered the drug and I'm going to make money from it." So Heinz got desperate and broke into the man's store to steal the drug-for his wife. Should the husband have done that?" (Kohlberg, 1963).

Kohlberg was not interested so much in the answer to the question of whether Heinz was wrong or right, but in the *reasoning* for each participant's decision. The responses were then classified into various stages of reasoning in his theory of moral development.

Level 1: Pre-conventional Morality

Stage one: Obedience and Punishment:

The earliest stage of moral development is especially common in young children, but adults are also capable of expressing this type of reasoning. At this stage, children see rules as fixed and absolute. Obeying the rules is important because it is a means to avoid punishment.

Stage 2 - Individualism and Exchange

At this stage of moral development, children account for individual points of view and judge actions based on how they serve individual needs. In the Heinz dilemma, children argued that the best course of action was the choice that best-served Heinz's needs. Reciprocity is possible at this point in moral development, but only if it serves one's own interests.

Level 2: Conventional Morality

Stage 3: Interpersonal Relationships

Often referred to as the "good boy-good girl" orientation, this stage of moral development is focused on living up to social expectations and roles. There is an emphasis on conformity, being "nice," and consideration of how choices influence relationships.

Stage 4: Maintaining Social Order

At this stage of moral development, people begin to consider society as a whole when making judgments. The focus is on maintaining law and order by following the rules, doing one's duty and respecting authority.

Level 3: Post-conventional Morality

Stage 5: Social Contract and Individual Rights

At this stage, people begin to account for the differing values, opinions and beliefs of other people. Rules of law are important for maintaining a society, but members of the society should agree upon these standards.

Stage 6: Universal Principles

Kohlberg's final level of moral reasoning is based upon universal ethical principles and abstract reasoning. At this stage, people follow these internalized principles of justice, even if they conflict with laws and rules.

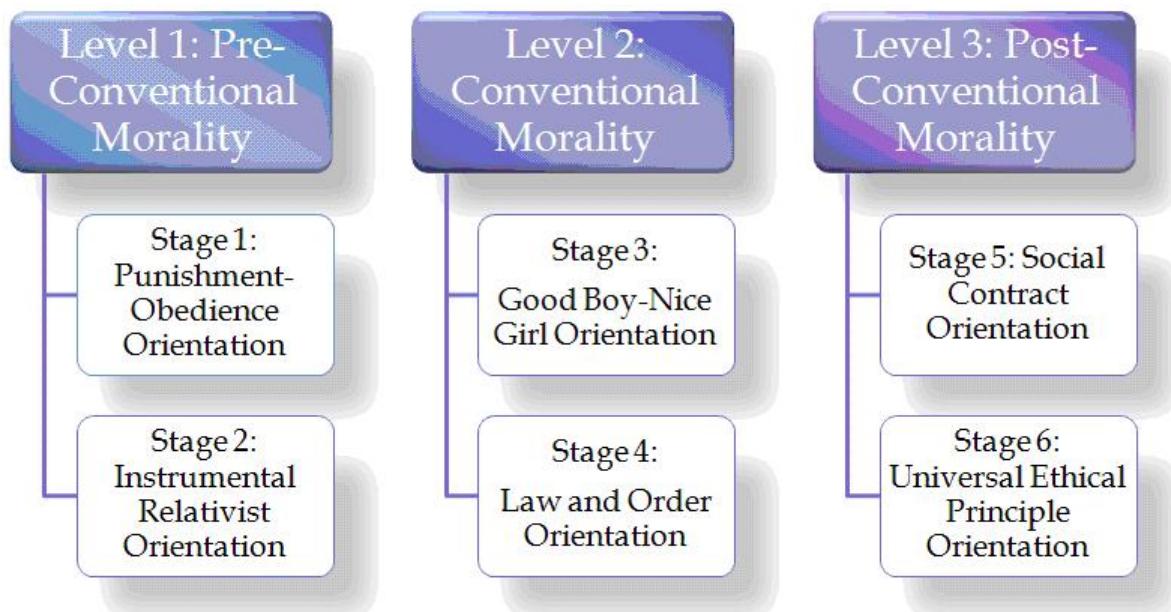
Criticisms of Kohlberg's Theory of Moral Development:

Does moral reasoning necessarily lead to moral behaviour? Kohlberg's theory is concerned with moral thinking, but there is a big difference between knowing what we *ought* to do versus our actual actions.

Is justice the only aspect of moral reasoning we should consider? Critics have pointed out that Kohlberg's theory of moral development overemphasizes the concept as justice when making moral choices. Factors such as compassion, caring and other interpersonal feelings may play an important part in moral reasoning.

Does Kohlberg's theory overemphasize Western philosophy? Individualistic cultures emphasize personal rights while collectivist cultures stress the importance of society and community. Eastern cultures may have different moral outlooks that Kohlberg's theory does not account for.

KOHLBERG'S STAGES OF MORAL DEVELOPMENT



Erickson's Stages of Development

Erik Erickson (1902-1994) a German born American developmental psychologist and psychoanalyst is famous for his theories on psycho-social and physical development.

Erickson's Stages of Development- Lifespan

Stage:	Conflict	Events	Outcome
Infancy to 18 months	Trust vs. Mistrust	Feeding	Develop trust when caregivers respond; mistrust when they don't.
Early Childhood 2-3 years	Autonomy vs. Shame & Doubt	Toilet Training	Develop a sense of personal control. Success-autonomy Failure-shame, doubt
Pre-school 3-5 years	Initiative vs. Guilt	Exploration	Asserting power and control over environment. Success-sense of purpose. Failure-disapproval, guilt.
School age 6-11 years	Industry vs. Inferiority	School	Cope with new academic and social demands. Success-competence. Failure-weak self-image.
Adolescence 12-18 years	Identity vs. Role Confusion	Social Relationships	Develop "self." Success-true to yourself. Failure-confusion and weak self.
Young Adult 19-40 years	Intimacy vs. Isolation	Relationships	Loving relationships. Success-strong relationships. Failure-loneliness.
Middle Age 41-64	Generativity vs. Stagnation	Work & Parenthood	Need to create and nurture. Success-usefulness and accomplishment. Failure-withdrawal.
Maturity 65-death	Ego Integrity vs. Despair	Reflection on Life	Success-feelings of wisdom Failure- regret, bitterness and despair

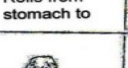
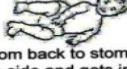
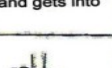
(Erikson, 1968)

Erickson's Stages of Psychosocial Development

Erikson's Stages of Psychosocial Development

Stage	Ages	What issues concern the child at this stage?			
Stage One	Infancy-1 year	Trust	versus	Mistrust	If needs are met, child develops a sense of trust
Stage Two	1-2 year	Autonomy	versus	Shame	Develops a need to do things for themselves or will doubt their abilities
Stage Three	3-5 years	Initiative	versus	Guilt	Initiate and carry out tasks or feel guilty for not being independent (potty training?)
Stage Four	6-adolescence	Industry (Competence)	versus	Inferiority	Gain pleasure from applying themselves or feel inferior (Do I have worth?)
Stage Five	Adolescence	Identity	versus	Identity Confusion	Testing roles and integrating to form a single identity or will be confused about self
Stage Six	Young adult	Intimacy	versus	Isolation	Forming close, intimate relationships or feel socially isolated
Stage Seven	Middle adult	Generativity	versus	Stagnation	Develop of sense of contribution to the world or feel lack of purpose
Stage Eight	Late adult	Ego Integrity	versus	Ego Despair	Have I lived a full life? Satisfaction or failure?

Stages of Physical Development

	stage1: Birth to 6 months	Stage 2: 6 to 12 months	Stage3: 12 to 24 months	Stage 4: 2 to 3 years
Head and Body control	 Lies on stomach and holds head up  pushes up on hands  Rolls from stomach to	 Rolls from back to stomach  Rolls to side and gets into sitting		
Sitting	 Sits only with support  Sits leaning on hands	 Sits alone Twists and reaches  Catches self if pushed	 Moves into and out of sitting  Balances self if lifted	
Moving from place to place	 stand with support	 May crawl or shuffle  Pulls to stand	 Walks alone or with one hand  Squats to	 kicks a ball  Balances on one foot Jumps

Physical Developmental Milestones

Physical developmental milestones are abilities that most children are able to perform by a certain age. During the first year of a child's life, physical milestones are centred on the infant learning to master self-movement, hold objects and hand-to-mouth coordination.

From Birth to 3 Months

- At this age, most babies begin to:
- Use rooting, sucking and grasping reflexes
- Slightly raise the head when lying on the stomach
- Hold head up for a few seconds with support
- Clench hands into fists
- Tug and pull on their own hands
- Repeat body movements

From 3 to 6 Months

At this age, babies begin to develop greater agility and strength. They:

- Roll over
- Pull their bodies forward
- Pull themselves up by grasping the edge of the crib
- Reach for and grasp object
- Bring object they are holding to their mouths
- Shake and play with objects

From 6 to 9 Months

During this time, children become increasingly mobile. They usually begin to:

- Crawl
- Grasp and pull object toward their own body
- Transfer toys and objects from one hand to the other

From 9 to 12 Months

In addition to the major milestones such as standing up and walking, children also begin to develop more advanced fine-motor skills. In this window of development, most babies are able to:

- Sit up unaided
- Stand without assistance
- Walk without help

- Pick up and throw objects
- Roll a ball
- Pick up objects between their thumb and one finger

From 1 to 2 Years

Children become increasingly independent and this age and tasks requiring balance and hand-eye coordination begin to emerge. During this stage of development, most children are able to:

- Pick things up while standing up
- Walk backwards
- Walk up and down stair without assistance
- Move and sway to music
- Colour or paint by moving the entire arm
- Scribble with markers or crayons
- Turn knobs and handles

From 2 to 3 Years

Building on earlier skills, children become increasingly adept at activities that require coordination and speed. From one to three years of age, most children:

- Run in a forward direction
- Jump in one place
- Kick a ball
- Stand on one foot
- Turn pages of a book
- Draw a circle
- Hold a crayon between the thumb and fingers

From 3 to 4 Years

Physical abilities become more advanced as children develop better movement and balance skills. From age three to four, most children begin to:

- Ride a tricycle
- Go down a slide without help
- Throw and catch a ball
- Pull and steer toys
- Walk in a straight line
- Build a tall towers with toy blocks
- Manipulate clay into shapes

From 4 to 5 Years

During this period of development, children become increasingly confident in their abilities. Most children begin to:

- Jump on one foot
- Walk backwards
- Do somersaults
- Cut paper with safety scissors
- Print some letters
- Copy shapes including squares and crosses

Cognitive Developmental Milestones

From Birth to 3 Months

Major developmental milestones at this age are centred on exploring the basic senses and learning more about the body and the environment. During this period, most infants begin to:

- See objects more clearly within a distance of 13 inches
- Focus on moving objects, including the faces of caregivers
- Tell between sweet, salty, bitter and sour tastes
- Detect differences in pitch and volume
- See all colours in the human visual spectrum
- Respond to their environment with facial expressions
- Demonstrate anticipatory behaviours like rooting and sucking at the site of a nipple or bottle

From 3 to 6 Months

In early infancy, perceptual abilities are still developing. From the age of three to six months, infants begin to develop a stronger sense of perception. At this age, most babies begin to:

- Recognize familiar faces
- Respond to the facial expressions of other people
- Recognize and react to familiar sounds
- Begin to imitate facial expressions

From 6 to 9 Months

To learn more about the mental processes of infants, researchers have come up with a number of creative tasks that reveal the inner workings of the baby brain. From the age of six to nine months, researchers have found that most infants begin to:

- Understand the differences between animate and inanimate objects
- Tell the differences between pictures depicting different numbers of objects
- Utilize the relative size of an object to determine how far away it is
- Gaze longer at "impossible" things, such as an object suspended in midair

From 9 to 12 Months

As infants become more physically adept, they are able to explore the world around them in greater depth. Sitting up, crawling, and walking are just a few of the physical milestones that allow babies to gain a greater mental understanding of the world around them. As they approach one year of age, most infants are able to:

- Understand the concept of object permanence, the idea that an object continues to exist even though it cannot be seen
- Imitate gestures and some basic actions
- Respond with gestures and sounds
- Like looking at picture books
- Manipulate objects by turning them over, trying to put one object into another

From 1 Year to 2 Years

After reaching a year of age, children's physical, social, and cognitive development seems to grow by leaps and bounds. Children at this age spend a tremendous amount of time observing the actions of adults, so it is important for parents and caregivers to set good examples for behaviour. Most one-year-olds begin to:

- Understand and respond to words
- Identify objects that are similar
- Tell the difference between "Me" and "You"
- Imitate the actions and language of adults
- Can point out familiar objects and people in a picture book
- Learn through exploration

From 2 to 3 Years

At two years of age, children are becoming increasingly independent. Since they are now able to better explore the world, a great deal of learning during this stage is the result of their own experiences.

- Sort objects by category (i.e., animals, flowers, trees, etc.)
- Stack rings on a peg from largest to smallest
- Imitate more complex adult actions (playing house, pretending to do laundry, etc.)
- Identify their own reflection in the mirror by name
- Respond to simple directions from parents and caregivers
- Name objects in a picture book
- Match objects with their uses

From 3 to 4 Years

Children become increasingly capable of analyzing the world around them in more complex ways. As they observe things, they begin to sort and categorize them into different categories, often referred to as schemas. Since children are becoming much more active in the learning process, they also begin to pose questions about the world around them. " At the age of three, most children are able to:

- Demonstrate awareness of the past and present
- Actively seek answers to questions
- Learn by observing and listening to instructions
- Organize objects by size and shape
- Understand how to group and match object according to colour
- Have a longer attention span of around 5 to 15 minutes
- Asks "why" questions to gain information

From 4 to 5 Years

As they near school age, children become better at using words, imitating adult actions, counting and other basic activities that are important for school preparedness. Most four-year-olds are able to:

- Rhyme
- Name and identify many colours
- Draw the shape of a person
- Count to five
- Tell where they live
- Draw pictures that they often name and describe

Social Emotional Developmental Milestones

While physical developmental milestones are often some of the easiest to observe, the early years of a child's life are also marked by other developmental milestones, including social and emotional ones. In many cases, these achievements can be difficult or even impossible to identify directly since they often involve such things as increased self-awareness. Such skills can be difficult to see, but they are just as important as the physical milestones, especially since social and emotional skills become so important once a child enters school.

From Birth to 3 Months

During the first three months, babies are actively learning about themselves and the people around them. Part of this skill-building involves:

- Looking at their own hands and sucking on fingers
- Looking at the part of their body that a parents or caregiver is touching
- Understanding how the legs and arms are attached
- Realizing that they are separate beings from those around them
- Learning to be comforted and soothed by adults
- Enjoying social stimulation and smiling at people
- Responding to touch

From 3 to 6 Months

Social interaction becomes increasingly important. During this period of development, most babies begin to:

- Respond when their name is called
- Smile
- Laugh
- Play peek-a-boo

From 6 to 9 Months

As babies get older, they may begin to show a preference for familiar people. Between the ages of six to nine months, most children can:

- Express a number of emotions including happiness, sadness, fear, and anger
- Distinguish between familiar family and friends and strangers
- Show frustration when a toy is taken away
- Respond to spoken words and gestures

From 9 to 12 Months

As children become more social, they often begin to mimic the actions of others. Self-regulation also becomes increasingly important as the child approaches one year of age. Most children can:

- Hold a cup and drink with help
- Imitate simple actions
- Feed themselves small bites of food
- Express anxiety when separated from parents or caregivers

From 1 to 2 Years

From the age of one to two years, kids often spend more time interacting with a wider range of people. They also start to gain a greater sense of self-awareness. At this stage, most can:

- Recognize their own image in the mirror
- Initiate play activities
- Play independently, often imitating adult actions
- Act pleased when they accomplish something
- Start trying to help, often by putting toys away
- Express negative emotions including anger and frustration
- Become more self-assertive and may try to direct the actions of others

From 2 to 3 Years

During the toddler years, children become more and more creative and confident. At two years old, most children begin to:

- Become aware that they are a boy or girl
- Begin to dress and undress themselves
- Demonstrate personal preferences about toys, food, and activities
- Start saying "No" to adults
- Enjoy watching and playing with other children
- Become defensive about their own possessions
- Use objects symbolically during play
- Often have rapid changes in mood

From 3 to 4 Years

Because three-year-olds are becoming increasingly able to perform physical actions, their sense of confidence and independence becomes more pronounced at this age.

During the third year, most children begin to:

- Follow directions
- Perform some tasks with little or no assistance
- Share toys with other children
- Make up games and ask other children to join in
- Begin engaging in pretend play

From 4 to 5 Years

During the fourth year, children gain a greater awareness of their own individuality. As their physical skills increase, they are more capable of exploring their own abilities which can help lead to great confidence and personal pride. At this age, most children begin to:

- Understand basic differences between good and bad behaviour
- Develop friendships with other kids
- Compare themselves to other children and adults
- Become more aware of other people's feelings
- Enjoy dramatic, imaginative play with other children
- Enjoy competitive games

Early Childhood

Early childhood is often referred to as "pre-school age," "exploratory age" or "toy age." When children attend preschool, they broaden their social horizons and become more engaged with those around them. Impulses are channelled into fantasies, which leaves the task of the caretaker to balance eagerness for pursuing adventure, creativity and self-expression with the development of responsibility. If caretakers are properly encouraging and consistently disciplinary, children are more likely to develop positive self-esteem while becoming more responsible, and will follow through on assigned activities.

As children grow their past experiences will shape who they are, and allow them to perceive the world in their own way. If not allowed to decide which activities to perform, children may begin to feel guilt upon contemplating taking initiative. This

negative association with independence will lead them to let others make decisions in place of them.

During a child's preschool and beginning school years, intelligence is demonstrated through logical and systematic manipulation of symbols related to concrete objects. Operational thinking develops which means actions are reversible, and egocentric thought diminishes. Children go through the transition from the world at home to that of school and peers. Children learn to make things, use tools, and acquire the skills to be a worker and a potential provider. Children can now receive feedback from outsiders about their accomplishments.

If children can discover pleasure in their activities, including their intellectual stimulation, most importantly in learning reading, writing, and basic maths, they will develop a sense of competence. If they are not successful or cannot discover pleasure in the process, they may develop a sense of inferiority and feelings of inadequacy that may haunt them throughout life. This is when children think of themselves as industrious or as inferior.

Adolescence

Adolescence is the period of life between the onset of puberty and the full commitment to an adult social role. It is the period known for the **formation of personal and social identity** (Erik Erikson) and the **discovery of moral purpose** (William Damon). Intelligence is demonstrated through the logical use of symbol is related to abstract concepts and formal reasoning.

A return to egocentric thought often occurs early in the period. Only 35% develop the capacity to reason formally during adolescence. (Huitt *et al* 1998)

Adolescence is divided into three parts: Early Adolescence: 9 to 13 years: Mid Adolescence: 13 to 15 years: Late Adolescence: 15 to 18 years. The adolescent unconsciously explores questions such as "**Who am I? Who do I want to be?**" Like toddlers, adolescents must explore, test limits, become autonomous, and commit to an identity, or sense of self. Different roles, behaviours and ideologies must be tried out to select an identity. Role confusion and inability to choose vocation can result from a failure to achieve a sense of identity.

Early Adulthood

Early adulthood, according to theorists such as Erik Erikson, is a stage where development is mainly focused on maintaining relationships. Examples include creating bond of intimacy, sustaining friendships, and ultimately making a family. Some theorists state that development of intimacy skills rely on the resolution of previous developmental stages. A sense of identity gained in the previous stages is also necessary for intimacy to develop. If this skill is not learned the alternative is alienation, isolation, a fear of commitment, and the inability to depend on others.

Emerging Adulthood

A related framework for this part of the life span is that of emerging adulthood. This concept suggests that people transition after their teenage years into a period not characterized as relationship building and an overall sense of constancy with life, but with years of living with parents, phases of self-discovery, and experimentation.

Middle Adulthood

Middle adulthood generally refers to the period between ages 25 to 69. During this period, middle-aged adults experience a conflict between generativity and stagnation. They may either feel a sense of contributing to society, the next generation or their immediate community or a sense of purposelessness. Physically, the middle-aged experience a decline in muscular strength, reaction time, sensory keenness, and cardiac output. Women experience the menopause and a sharp drop in the hormone oestrogen. Men experience an equivalent endocrine system event to menopause. Andropause in males is a hormone fluctuation with physical and psychological effects that can be similar to those seen in menopausal females. As men age, lowered testosterone levels can contribute to mood swings and a decline in sperm count and sexual function and responsiveness can be affected.

Old Age

This stage generally refers to those aged over 70. According to Erikson's Theory of Psychosocial Development, old age is the stage in which individuals assess the quality of their lives. In reflecting on their lives, people in this age group develop a feeling of integrity if deciding that their lives were successful or a feeling of despair if evaluation of one's life indicates a failure to achieve goals.

Physically, older people experience a decline in muscular strength, reaction time, stamina, hearing, distance perception, and the sense of smell. They also are more susceptible to illnesses such as cancer and pneumonia due to a weakened immune system. Programs aimed at balance, muscle strength, and mobility has been shown to reduce disability among mildly (but not more severely) disabled elderly.

Sexual expression depends in large part upon the emotional and physical health of the individual. Many older adults continue to be sexually active and satisfied with their sexual activity,

Mental disintegration may also occur, leading to dementia or ailments such as Alzheimer's disease. It is generally believed that **crystallized intelligence** (knowledge and skills that are accumulated over a lifetime) increases up to old age, while **fluid intelligence** (Fluid intelligence to the ability to reason quickly and to think abstractly) decreases with age. Whether or not normal intelligence increases or decreases with age depends on the measure and study. Longitudinal studies show that speed declines. Some cross-sectional studies suggest that intellect is stable.

Parenting Variables and Parenting Styles

Parenting variables alone have typically accounted for 20 to 50 percent of the variance in child outcomes.

Parenting styles

Authoritative Parenting is characterized as those parents who have high parental warmth, responsiveness, and demand, and who rate low in negativity and

conflict. These parents are assertive but not intrusive or overly restrictive. This method of parenting is associated with more positive social and academic outcomes.

Authoritarian parenting is characterized by low levels of warmth and responsiveness with high levels of demanding and firm control. These parents focus on obedience and they monitor their children regularly. In general, this style of parenting is associated with maladaptive outcomes. The outcomes are more harmful for middle class boys than girls, preschool white girls than preschool black girls, and for white boys than Hispanic boys. Furthermore, the negative effects of authoritarian parenting among Asian Americans can be offset by positive peer support. Finally, among African Americans, some elements of authoritarian parenting such as firm control and physical discipline do not serve as predictive factors for negative outcomes.

Permissive parenting is characterized by high levels of responsiveness combined with low levels of demand. These parents are lenient and do not necessarily require mature behaviour. They allow for a high degree of self-regulation and typically avoid confrontation. Compared to children raised using the authoritative style, preschool girls raised in permissive families are less assertive. Additionally, preschool children of both sexes are less cognitively competent than those children raised under authoritative parenting styles

Rejecting or neglectful parenting is the final category. This is characterized by low levels of demanding and responsiveness. These parents are typically disengaged in their child's lives, lacking structure in their parenting styles and are unsupportive. Children in this category are typically the least competent of all the categories.

Parenting Roles: Mother and Father Factors

Parenting roles in child development have typically focused on the role of the mother. Recent literature, however, has looked toward the father as having an important role in child development. Affirming a role for fathers, studies have shown that children as young as 15 months benefit significantly from substantial engagement with their father. In particular, studies in the U.S. and New Zealand

found the presence of the natural father was the most significant factor in reducing rates of early sexual activity and rates of teenage pregnancy in girls.

Another argument is that neither a mother nor a father is actually essential in successful parenting, and that single parents as well as homosexual couples can support positive child outcomes. According to this set of research, children need at least one consistently responsible adult with whom the child can have a positive emotional connection. Having more than one of these figures contributes to a higher likelihood of positive child outcomes.

Another parental factor often debated in terms of its effects on child development is divorce. Divorce in itself is not a determining factor of negative child outcomes. In fact, the majority of children from divorced families fall into the normal range on measures of psychological and cognitive functioning. A number of mediating factors play a role in determining the effects divorce has on a child; for example, divorcing families with young children often face harsher consequences in terms of demographic, social, and economic changes than do families with older children.

Positive co-parenting after divorce is part of a pattern associated with positive child coping, while hostile parenting behaviours lead to a destructive pattern leaving children at risk. Additionally, direct parental relationship with the child also affects the development of a child after a divorce. Overall, protective factors facilitating positive child development after a divorce are maternal warmth, positive father-child relationship, and cooperation between parents.

Attachment Theory

Attachment theory, originally developed by John Bowlby (1907-1990), focuses on the importance of open, intimate, emotionally meaningful relationships. Attachment is described as a biological system or powerful survival impulse that evolved to ensure the survival of the infant. A child who is threatened or stressed will move toward caregivers who create a sense of physical, emotional and psychological safety for the individual. Attachment feeds on body contact and familiarity. Later Mary Ainsworth developed the Strange Situation protocol and the concept of the secure

base. There are four types of attachment styles: Secure: Anxious-avoidant: Anxious-resistant: Disorganized.

Secure attachment is a healthy attachment between the infant and the caregiver. It is characterized by trust.

Anxious-avoidant is an insecure attachment between an infant and a caregiver. This is characterized by the infant's indifference toward the caregiver.

Anxious-resistant is an insecure attachment between the infant and the caregiver characterized by distress from the infant when separated and anger when reunited.

Disorganized is an attachment style without a consistent pattern of responses upon return of the parent.

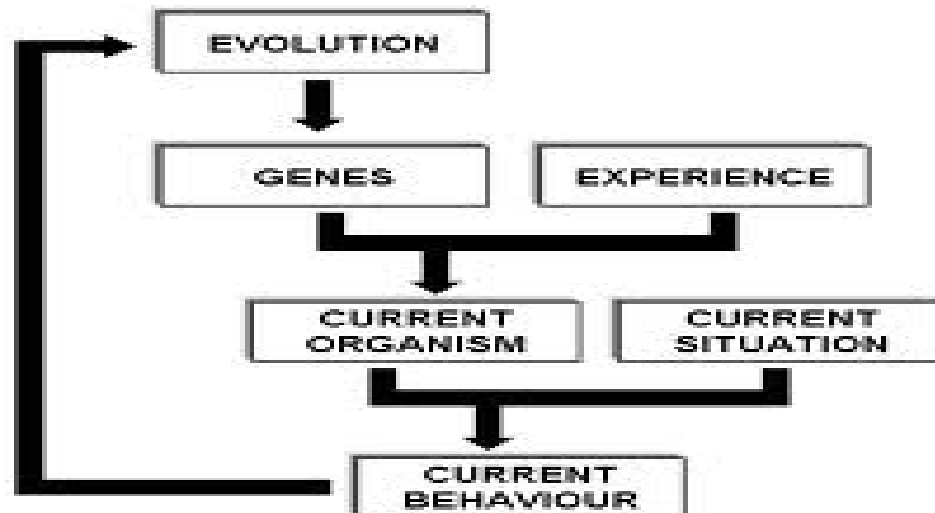
A child can be hindered in its natural tendency to form attachments. Some babies are raised without the stimulation and attention of a regular caregiver, or under conditions of abuse or extreme neglect. The possible short-term effects of this deprivation are anger, despair, detachment, and temporary delay in intellectual development. Long-term effects include increased aggression, clinging behaviour, detachment, psychosomatic disorders, and an increased risk of depression as an adult.

Nature V's Nurture

The **Nature V's Nurture** debate is one of the oldest issues in psychology. This debate is concerned with the extent to which particular aspects of behaviour are a product of either inherited (i.e. genetic) or acquired (i.e. learned) characteristics. Nature is that which is inherited or genetic. Nurture refers to all environmental influences after conception, i.e. experience.

Nature V Nurture

Nature/Nurture and Human Development



Source: Fink, P.J. (2000). *Genetics/Anatomy* (1st Edition). Boston: Allyn and Bacon.

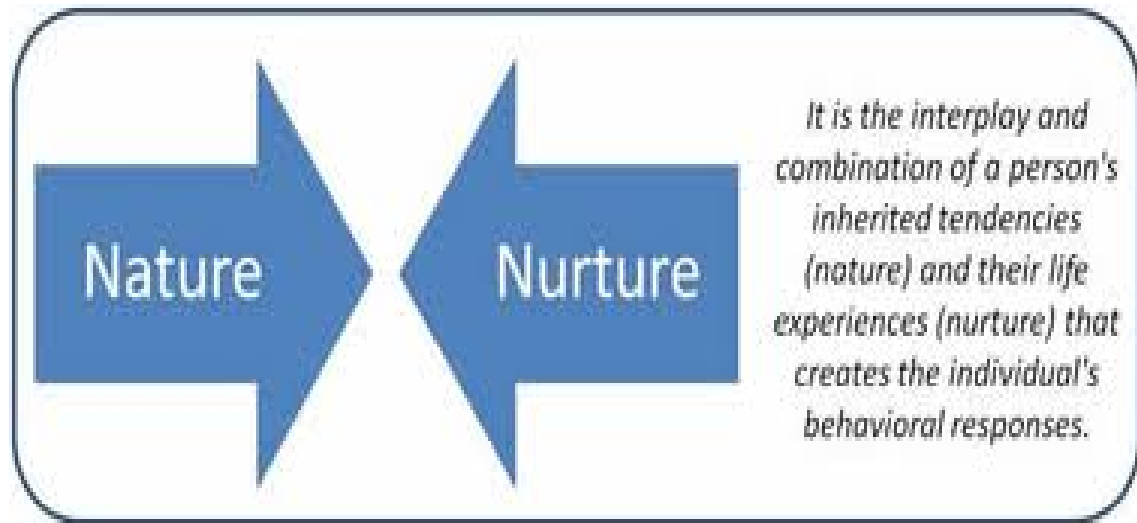
Nature V Nurture

Approaches to Psychology



Biological Approach	Psychoanalysis	Cognitive Psychology	Humanism	Behaviorism
Focus on genetic, hormonal, and neuro-chemical explanations of behavior.	Innate drives of sex and aggression (nature). Social upbringing during childhood (nurture).	Innate mental structures such as schemas, perception and memory and constantly changed by the environment.	Maslow emphasized basic physical needs. Society influences a person's self concept.	All behavior is learned from the environment through conditioning.

Nature V Nurture



It has long been known that certain physical characteristics are biologically determined by genetic inheritance. Colour of eyes, straight or curly hair, pigmentation of the skin and certain diseases (such as Huntington's chorea) are all a function of the genes we inherit. Other physical characteristics, if not determined, appear to be at least strongly influenced by the genetic make-up of our biological parents.

Height, weight, hair loss (in men), life expectancy and vulnerability to specific illnesses (e.g. breast cancer in women) are positively correlated between genetically related individuals. These facts have led many to speculate as to whether psychological characteristics such as behavioural tendencies, personality attributes and mental abilities are also “wired in” before we are even born.

Those who adopt an extreme heredity position are known as **nativists**. Their basic assumption is that the characteristics of the human species as a whole are a product of evolution and those individual differences are due to each person's unique genetic code. Characteristics and differences that are not observable at birth, but which emerge later in life, are regarded as the product of maturation. The classic example of the way this affects our physical development are the bodily changes that occur in early adolescence at puberty. Nativists also argue that maturation governs the

emergence of attachment in infancy, language acquisition and even cognitive development as a whole.

At the other end of the spectrum are the environmentalists – also known as **empiricists** (not to be confused with the other empirical / scientific approach). Their basic assumption is that at birth the human mind is a **tabula rasa (a blank slate)** and that this is gradually “filled” as a result of experience (e.g. behaviourism). From this point of view psychological characteristics and behavioural differences that emerge through infancy and childhood are the result of learning.

It is how you are brought up (nurture) that governs the psychologically significant aspects of child development and the concept of maturation applies only to the biological. So, when an infant forms an attachment it is responding to the love and attention it has received, language comes from imitating the speech of others and cognitive development depends on the degree of stimulation in the environment and, more broadly, on the civilization within which the child is reared.

Examples of an **extreme nature positions** in psychology include Bowlby's (1969) theory of attachment, which views the bond between mother and child as being an innate process that ensures survival. Likewise, Chomsky (1965) proposed language is gained through the use of an innate language acquisition device. Another example of nature is Freud's theory of aggression as being an innate drive (called thanatos).

In contrast Bandura's (1977) social learning theory states that aggression is learnt from the environment through observation and imitation. This is seen in his famous Bobo doll experiment (Bandura, 1961). Also Skinner (1957) believed that language is learnt from other people via behaviour shaping techniques.

In practice hardly anyone today accepts either of the extreme positions. There are simply too many “facts” on both sides of the argument which are inconsistent with an “all or nothing” view. So instead of asking whether child development is down to nature or nurture the question has been reformulated as “**How much?**”

This question was first framed by Francis Galton (1822-1911) in the late 19th century. Galton (himself a relative of Charles Darwin) was convinced that intellectual ability was largely inherited and that the tendency for “genius” to run in families was the outcome of a natural superiority. This view has cropped up time and again in the

history of psychology and has stimulated much of the research into intelligence testing (particularly on separated twins and adopted children). A modern proponent is the American psychologist Arthur Jensen. Finding that the average I.Q. scores of black Americans were significantly lower than whites he went on to argue that genetic factors were mainly responsible – even going so far as to suggest that intelligence is 80% inherited.

The storm of controversy that developed around Jensen's claims was not mainly due to logical and empirical weaknesses in his argument. It was more to do with the **social and political implications that are often drawn from research** that claims to demonstrate natural inequalities between social groups.

Contemporary Views of Nature V's Nurture

Today, the majority of experts believe that behaviour and development are influenced by both nature and nurture. However, the issue still rages on in many areas such as in the debate on the origins of homosexuality and influences on intelligence. While few people take the extreme nativist or empiricist approaches, researchers and experts still debate the degree to which biology and environment influence behaviour.

Bibliography

Baltes, P. B., Reese, H., & Lipsett, L. (1980) Lifespan developmental psychology, Annual Review of Psychology 31: 65 – 110.

Bennett, P (2007) Abnormal Clinical Psychology; An Introductory Textbook (Second edition). Maidenhead: Open University Press

Bronfenbrenner, U. (1979). The Ecology of Human Development: Experiments by Nature and Design. Cambridge, MA: Harvard University Press. ([ISBN 0-674-224574](#))

Buskist, W, C. Heth, C. Schmalz, R. (2010) Psychology: The Science of Behaviour, Fourth Edition. Oxford University Press

Darwin, C. (1877). A Biographical Sketch of an Infant. Mind, 2, 285-294.

Eysenck, M.W. (2000) Psychology: A Students Handbook. New York; Psychology Press

Feldman, D, E. Papalia, R, D,(2010). A child's world : infancy through adolescence (12th ed. ed.). New York: McGraw-Hill. p. 57. [ISBN 9780073532042](#).

Flaherty, S, C. Sadler,L,S. (2001) "A Review of Attachment Theory in the Context of "Adolescent Parenting". Journal of Pediatric Health Care 25 (2): 114 121.[10.1016/j.pedhc.2010.02.005](#)

Freud, S. (1962). Three Essays on the Theory of Sexuality, trans. James Strachey. New York: Basic Books.

Kohlberg, L, (1958). "The Development of Modes of Thinking and Choices in Years 10 to 16". Ph. D. Dissertation, University of Chicago.

Kohlberg, L (1973). "The Claim to Moral Adequacy of a Highest Stage of Moral Judgment". Journal of Philosophy (The Journal of Philosophy, Vol. 70, No. 18) **70** (18): 630–646. [10.2307/2025030](#).

Lerner, R.M. (2002) Concepts and theories of human development. Mahwah, NJ: Erlbaum

McLeod, S. "[Developmental Psychology](#)". Simply Psychology
<http://www.simplypsychology.org>

McLeod, S. "Psychosexual Stages" Simply Psychology
<http://www.simplypsychology.org>

McLeod, S, "Erik Erikson". Simply Psychology. <http://www.simplypsychology.org>
[Psychology.http://www.simplypsychology.org](http://www.simplypsychology.org)

Myers, D. (2002) Exploring Psychology, fifth edition, New York; Worth publishers

Myers, D. (2008). Exploring Psychology. Worth Publishers. ISBN 1-57259-096-3.

Neil R, C. Blanchard-Fields, J.C. Cavanaugh, F (2009). Adult development and aging (6th ed). Australia: Wadsworth Cengage

Newman, B, M. Newman, P. R. (2011). Development Through Life : A Psychosocial Approach. Belmont, CA: Wadsworth Cengage Learning. pp. 215-217.ISBN 111134468X.

Reid, V.; Striano, T. & Koops, W. (2007) Social Cognition During infancy. Psychology Press.

Schaie, K. W. (1990). Intellectual development in adulthood. In J. E. Birren & K. W. Schaie (Eds.), Handbook of the psychology of aging, 3rd ed., (pp. 291-309). New York: Academic Press

Siegler, R. (2006). **How** Children Develop, Exploring Child Development Student Media Tool Kit & Scientific American Reader to Accompany How Children Develop. New York: Worth Publishers. ISBN 0-7167-6113-0.

Slater, A.; Lewis, M. (2006). Introduction to Infant Development. Oxford: Oxford University Press. ISBN 0-19-928305-2.

Smith, P. Cowie, H. & Blades, M. Understanding Children's Development. Basic psychology (4 ed.). Oxford, England: Blackwell.

Steinberg, L. (2008). Adolescence (8th ed. ed.). Boston: McGraw-Hill Higher Education. pp. 60–365. ISBN 9780073405483.

Upton, P, (2011). Developmental Psychology: Critical Thinking in Psychology.
Exeter: Learning Matters. p. 62. ISBN 0857252763.

Vygotsky, L.S. (1978). Mind in Society. Cambridge, MA: Harvard University Press.

Whiteside, M. Becker, F. (2000). "Parental factors and the young child's post divorce adjustment: A meta-analysis with implications for parenting arrangements." Journal of Family Psychology 14 (1): 5–26. :10.1037/0893-3200.14.1.5.

Bibliography

Adler, A. (1927). *Understanding Human Nature*. New York: Greenburg.

Allport, F. H. (1924). Response to social stimulation in the group. *Social psychology*, 260-291.

American Psychiatric Association (2013), *Diagnostic and statistical manual of mental disorders, (Fifth Edition)*, Washington, DC: American Psychiatric Publishing

Anderson, N.; Ones, D.S.; Sinangil, H.K. & Viswesvaran, C. (Eds.). (2002). *Handbook of industrial, work and organizational psychology*, Volume 1: Personnel psychology. Thousand Oaks, CA: Sage Publications Ltd.

Anderson, N.; Ones, D.S.; Sinangil, H.K. & Viswesvaran, C. (Eds.). (2002). *Handbook of industrial, work and organizational psychology*, Volume 2: Organizational psychology. Thousand Oaks, CA: Sage Publications Ltd.

Association for Humanistic Psychology. (2001). Overview of humanistic psychology. Retrieved from <http://www.ahpweb.org/aboutahp/whatis.html>

Atkinson, R. C., & Shiffrin, R. M. (1968). Chapter: Human memory: A proposed system and its control processes. In Spence, K. W., & Spence, J. T. *The psychology of learning and motivation* (Volume 2). New York: Academic Press. pp. 89–195.

Aube, C. & Rousseau, V. (2005). Team goal commitment and team effectiveness: The role of task interdependence and supportive behaviors. *Group Dynamics: Theory, Research, and Practice*, 9, 189–204.

Bandura, A., & Walters, R. H. (1963). *Social learning and personality development*. New York: Holt, Rinehart, & Winston.

Baltes, P. B., Reese, H., & Lipsett, L. (1980) Lifespan developmental psychology, *Annual Review of Psychology* 31: 65 – 110.

Banyard, P. (2002). Psychology in practice: Health. London, England: Hodder & Stoughton Educational.

Barrick, M.R.; Stewart, S.L.; Neubert, M.J. & Mount, M.K. (1998). Relating member ability and personality to Work-team processes and team effectiveness. *Journal of Applied Psychology*, 83, 377–91.

Bartol, C. R., & Bartol, A. M. (1999). History of Forensic Psychology. In A. K. Hess & Irving B. Weiner (Eds.), *Handbook of Forensic Psychology* (2nd edn). London: John Wiley and Sons.

Beck, A. T. Rush, A. J, Shaw, B. F, Emery, G. (1979). *Cognitive Therapy of Depression*. New York: The Guilford Press. pp. 11. ISBN 0-89862-919-5.

Beck, A.T. (1976). *Cognitive therapy of the emotional disorders*. New York: New American Library.

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford press.

Beck,A.,Davis, D. & Freeman, A. (2007). *Cognitive Therapy of Personality Disorders*, 2nd Ed. New York: Guilford Press. ISBN 978-1-59385-476-8

Belar, C. D., Mendonca McIntyre, T. & Matarazzo, J. D. (2003). Health psychology. In D. K. Freedheim & I. Weiner (Eds.), *Handbook of Psychology*. Vol.1: History of Psychology. New York: Wiley

Benjamin, L. (2005). "A history of clinical psychology as a profession in America and a glimpse at its future". *Annual Review of Clinical Psychology* 1 (1): 1–30.

Benjamin, L. (2007). *A brief history of modern psychology*. Malden, MA: Blackwell Publishing. ISBN 978-1-4051-3206-0.

Bennett, P (2007) *Abnormal Clinical Psychology; An Introductory Textbook* (Second edition). Maidenhead: Open University Press.

Bitter, J. & Corey, G.. (2001). "Family Systems Therapy" in Gerald Corey (ed.). *Theory and Practice of Counseling and Psychotherapy*. Belmont, CA: Brooks/Cole.

Blackburn, R. (1996). What is forensic psychology? *Legal and Criminological Psychology*. 1996 Feb; Vol 1(Part 1) 3-16.

Blanchard-Fields, N. Cavanaugh, F (2009). *Adult development and aging* (6th ed). Australia: Wadsworth Cengage

Borman, W.C.; Ilgen, D.R. & Klimoski, R.J. (Eds.). (2003). *Handbook of psychology: Vol 12 Industrial and organizational psychology*. Hoboken, NJ: John Wiley & Sons.

Bronfenbrenner, U. (1979). *The Ecology of Human Development: Experiments by Nature and Design*. Cambridge, MA: Harvard University Press. ([ISBN 0-674-224574](#))

Brown, J. S., Collins, A., Duguid, P. (1989). Situated cognition and the culture of learning: Proximal development: *Educational Researcher*, 18 (1), 32-34.

Buskist, W, C. Heth, C. Schmalz, R. (2010) *Psychology: The Science of Behaviour*, Fourth Edition. Oxford University Press

Carlson, N. R. (2008). *Foundations of Physiological Psychology*. 7th ed. Boston: Pearson Education.

Carlson, N. R. (2013). *Emotion: Physiology of Behaviour*. Boston: Allyn and Bacon.

Case, R. (1985). *Intellectual development: Birth to adulthood*. New York: Academic Press.

Cheshire, K. & Pilgrim, D. (2004). *A short introduction to clinical psychology*. London; Thousand Oaks, CA: Sage Publications. ISBN 0-7619-4768-X

Cohen, L.M.; McChargue, D.E.; & Collins, Jr. F.L. (Eds.). (2003). *The Health Psychology Handbook: Practical issues for the Behavioral Medicine Specialist*. Thousand Oaks, CA: Sage Publications.

Cole, M. (1985). The zone of where culture and cognition create each other: Vygotskyian perspective. Cambridge: Cambridge University Press.

Cole, M. (2005). Culture in Development. In: Bornstein, M. Lamb, M. (ED's). Developmental Science. An Advanced Textbook. (pg. 45-102). Mahwah, NJ: Lawrence Erlbaum Associates.

Compas, B. Gotlib, I. (2002). Introduction to clinical psychology. New York, NY: McGraw-Hill Higher Education. ISBN 0-07-012491-4.

Coolican, H. (2007). Applied Psychology. (2nd Edition). London: Hodder Arnold.

Dalby, J. T. (1997) Applications of Psychology in the Law Practice: A guide to relevant issues, practices and theories. Chicago: American Bar Association. ISBN 0-8493-0811-9

Darwin, C. (1877). A Biographical Sketch of an Infant. Mind, 2, 285-294.

Davis, J. A. (2001). Stalking crimes and victim protection. CRC Press. 538 pages. ISBN 0-8493-0811-9.

Dematteo, J.S.; Eby, L.T. & Sundstrom, E. (1998). Team-based rewards: Current empirical evidence and directions for future research. *Research in Organizational Behavior*, 20, 141–83.

De Waal, F.B.M. (2002). Evolutionary Psychology: The wheat and the chaff. Current Directions in Psychological Science, 11, 187–191.

Dunnette, M.D. (Ed.). (1976). *Handbook of industrial and organizational psychology*. Chicago: Rand McNally.

Duntley, J. D., & Shackelford, T. K. (2006). Toward an evolutionary forensic psychology. *Social Biology*, 51, 161-165.

Duttweiler, P.C. (1984). The Internal Control Index: A Newly Developed Measure of Locus of Control. *Educational and Psychological Measurement*, 44, 209-221

Elliot, A.J. (1999). Approach and avoidance motivation and achievement goals. *Educational Psychologist*, 34, 169–89.

- Ellis, A. (1962). Reason and emotion in Psychotherapy. Secaucus, NJ: Prentice-Hall
- Emmer, E.T. & Stough, L.M. (2001). Classroom management: A critical part of educational psychology with implications for teacher education. *Educational Psychologist*, 36, 103–12.
- Eysenck, M.W. (2000) *Psychology: A Students Handbook*. New York; Psychology Press.
- Farrell, P. (2010). School psychology: Learning lessons from history and moving forward. *School Psychology International*, 31(6), 581-598.
- Feldman, D, E. Papalia, R, D,(2010). *A child's world : infancy through adolescence* (12th ed. ed.). New York: McGraw-Hill. p. 57. ISBN 9780073532042.
- Flaherty, S, C. Sadler,L,S. (2001) "A Review of Attachment Theory in the Context of "Adolescent Parenting". *Journal of Pediatric Health Care* 25 (2): 114 121.[10.1016/j.pedhc.2010.02.005](https://doi.org/10.1016/j.pedhc.2010.02.005)
- Freud, S. (1962). *Three Essays on the Theory of Sexuality*, trans. James Strachey. New York: Basic Books.
- Freud, A. (1936). *Ego & the mechanisms of defense*. New York: Basic Books.
- Freud, S., & Breuer. J. (1895). *Studies on hysteria*. In *Standard edition* (Vol. 2, pp. 1–335).
- Freud, S. (1896). *Heredity and the etiology of the neuroses*. In *Standard edition* (Vol. 3, pp. 142–156).
- Freud, S. (1900). *The interpretation of dreams*. In *Standard edition* (Vols. 4 & 5, pp. 1–627).
- Freud, S. (1909). *Notes upon a case of obsessional neurosis*. In *Standard edition* (Vol. 10, pp. 153–249).
- Freud, S. (1909). *Analysis of a phobia of a five year old boy*. In *The Pelican Freud Library* (1977), Vol 8, Case Histories 1, pages 169-306
- Furnham, A. & Steele, H. (1993). "Measures of Locus of Control: A critique of children's, health and work-related locus of control questionnaires", *British Journal of Psychology* **84**, 443-79.

Gabbard, G. (2005). *Psychodynamic Psychiatry in Clinical Practice*, 4th Ed. Washington, DC: American Psychiatric Press. ISBN 1-58562-185-4

Gardner, Howard. (1983) *Frames of Mind: The Theory of Multiple Intelligences*. New York: Basic Books.

Gudjonsson, G. (1991). Forensic psychology - the first century. *Journal of forensic psychiatry*, 2(2), 129.

Gudjonsson, G. Haward, L. *Forensic Psychology. A guide to practice*. (1998) ISBN 0-415-13291-6 (pbk.), ISBN 0-415-13290-8

Guzzo, R.A. & Shea, G.P. (1992). Group Performance and intergroup relations in organizations. *Handbook of industrial and organizational psychology* (Vol. 3, pp. 269–313).

Hackman, J.R.; Brousseau, K.R. & Weiss, J.A. (1976). The interaction of task design and group performance strategies in determining group effectiveness. *Organizational Behavior and Human Performance*, 16, 350–65.

Hackman, J.R. & Oldham, G.R. (1980). *Work redesign*. Reading, MA: Addison-Wesley.

Haines, V.Y. & Taggar, S. (2006). Antecedents of team reward attitude. *Group Dynamics: Theory, Research, and Practice*, 10, 194–205.

Hall, J., Llewelyn, S. (2006). *What is clinical psychology* (4th Edition). United Kingdom: Oxford University Press. ISBN 0-19-856689-1.

Hayes, N. (2010) *Understanding Applied Psychology*. London: Hodder Education.

Jarvis, M. (2000). *Theoretical approaches in psychology*. London: Routledge

Kline, P. (1989). Objective tests of Freud's theories. *Psychology Survey*, 7, 127-45.

Hamilton, W.D. (1964). The genetical evolution of social behaviour: I and II. *Journal of Theoretical Biology*, 7, 1–52.

Hayes, N. (2010) *Understanding Applied Psychology*. London: Hodder Education.

Hull, C. L. (1943). Principles of Behaviour: An Introduction to Behaviour Theory. New York: Appleton-Century-Crofts.

<http://www.harleytherapy.co.uk/counselling/freuds-main-theories-psychoanalysis.htm#ixzz3aJNKONax>

Jarvis, M. (2000). Theoretical approaches in psychology. London: Routledge.

Johnston, M. (1994). Health psychology: Current trends. *The Psychologist*, 7, 114–118.

Johnston, M., Weinman, J. & Chater, A. (2011). A healthy contribution. *The Psychologist*, 24(12), 890-892.

Kohlberg, L. (1958). "The Development of Modes of Thinking and Choices in Years 10 to 16". Ph. D. Dissertation, University of Chicago.

Kohlberg, L. (1973). "The Claim to Moral Adequacy of a Highest Stage of Moral Judgment". *Journal of Philosophy* (The Journal of Philosophy, Vol. 70, No. 18) **70** (18): 630–646. [10.2307/2025030](https://doi.org/10.2307/2025030).

Koppes, L.L. (Ed.). (2007). *Historical perspectives in industrial and organizational psychology*. Mahwah, NJ: Lawrence Erlbaum.

Klusman, L. (2001). "Prescribing Psychologists and Patients' Medical Needs; Lessons From Clinical Psychiatry". *Professional Psychology: Research and Practice* 32(5): 496–500. doi:10.1037/0735-7028.32.5.496

Lant, T.K. "Organizational Cognition and Interpretation," in Baum, (Ed)., *The Blackwell Companion to Organizations*. Oxford: Blackwell Publishers.

Le Doux, J. Emotional Circuits in the Brain. *Annual Review of Neuroscience*, 23, 155-183.

Leichsenring, F. Leibing, E. (2003). "The effectiveness of psychodynamic therapy and cognitive behaviour therapy in the treatment of personality disorders: A meta-analysis". *The American Journal of Psychiatry* 160 (7): 1223–33.

Lerner, R. M. (2002). *Concepts and theories of human development*. Mahwah, NJ: Erlbaum

Lezak, M., Howieson, D. Loring, D. (2004). *Neuropsychological assessment* (4th ed.). New York, NY: Oxford University Press. ISBN 0-19-511121-4.

Lock, E.A. & Latham, G.P. (1990). *A theory of goal setting and task performance*. Englewood Cliffs, NJ: Prentice-Hall.

Luthans, F., & Kreitner, R. (1985). *Organizational behavior modification and beyond: An operant and social learning approach* (2nd ed.). Glenview, IL: Scott, Foresman.

Marks, D. Murray, M. Evans, B. & Estacio, V. (2011) *Health Psychology. Theory-Research-Practice* (3rd Ed.) Sage Publications. ISBN 1-84860-622-2(hbk) 978-1848606227.

Maslow, A. H. (1968). *Toward a psychology of being* (2nd ed.). Princeton, NJ

McDougall, W. (1908). *An introduction to social psychology*. Londres: Methuen.

McGoey, K.E. & DuPaul, G.J. (2000) Token reinforcement and response cost procedures: Reducing the disruptive behavior of preschool children with attention-deficit/hyperactivity disorder. *School Psychology Quarterly*, 15, 330–43.

McLeod, S. A. (2007), *Cognitive Psychology*: Retrieved from <http://www.simplypsychology.org/cognitive.html>

McLeod, S. *"Developmental Psychology"*. Simply Psychology. <http://www.simplypsychology.org/psychodynamic.html>

McLeod, S. A. (2014). *Biological Theories of Gender*. <http://www.simplypsychology.org/gender-biology.html>

McLeod, S. A. (2007). Psychodynamic Approach.
<http://www.simplypsychology.org/psychodynamic.html>

McLeod, S. A. (2007). Psychology Perspectives.
<http://www.simplypsychology.org/perspective.html>

McLeod, S. "Psychosexual Stages". Simply Psychology.
<http://www.simplypsychology.org/psychodynamic.html>

McLeod, S. A. (2007). Social Psychology. <http://www.simplypsychology.org/social-psychology.html>

McMillan, M. (2004). The Person-Centred Approach to Therapeutic Change. London, Thousand Oaks: SAGE Publications. ISBN 0-7619-4868-6

Michie, S.; & Abraham, C. (Eds.). (2004). Health psychology in practice. London. BPS Blackwells.

Minsky, R. (1998). Psychoanalysis and culture. Cambridge, UK: Polity Press.

Mitchell, T.R. & Silver, W.R. (1990). Individual and group goals when workers are interdependent. Effects on task strategy and performance. *Journal of Applied Psychology*, 75, 185–193.

Murchison, C. (1935). A handbook of social psychology.

Murphy, G., & Murphy, L. B. (1931). Experimental social psychology

Myers, D. (2008). Exploring Psychology. Worth Publishers. ISBN 1-57259-096-3

Neisser, U (1967). Cognitive psychology. Appleton-Century-Crofts: New York

Newell, A., & Simon, H. (1972). Human problem solving. Prentice-Hall.

Neumann, I. Brain Oxytocin: A Key Regulator of Emotional and Social Behaviours in Both Females and Males. *Journal of Neuroendocrinology*, 20, 858*865.

Newman, B. M. Newman, P. R. (2011). *Development Through Life : A Psychosocial Approach*. Belmont, CA: Wadsworth Cengage Learning. pp.215-217. ISBN 111134468X

Nicholas, D. R. & Stern, M. (2011). Counseling psychology in clinical health psychology: The impact of specialty perspective. *Professional Psychology: Research and Practice*, 42(4), 331-337. doi:10.1037/a0024197

O'Donohue, W.; Ferguson, K.E. (2006). "Evidence-based practice in psychology and behaviour analysis" *Behav Analyst Today* 7 (3): 335–50. doi:10.1037/h0100155

O'Mahony, B. (2013). *So, You Want to Be a Forensic Psychologist? Create Space*. ISBN 9781482011814

Ogden, J. (2007). *Health Psychology: A Textbook (4th ed.)*. Berkshire, England: Open University Press.

Ogden, J. (2012). *Health Psychology: A Textbook (5th ed.)*. Maidenhead, UK: Open University Press.

Ogloff, J. R. P., & Finkelman, D. (1999). Psychology and Law: An Overview. In R. Roesch, S. D. Hart, & J. R. P. Ogloff (Eds.), *Psychology and Law the State of the Discipline*. New York: Springer. ISBN 0-306-45950-7

Pavlov, I. P. (1897). *The Work Of The Digestive Glands*. London: Griffin

Plante, T.(2005). *Contemporary clinical psychology*. New York, NY: Wiley & Sons. ISBN 0-471-47276-X.

Prochaska, J.O. & DiClemente, C. C. (1982) "Transtheoretical therapy: Toward a more integrative model of change" from 'Psychotherapy: Theory, Research, and Practice', 19, 276-288.

Quick, J.C.; & Tetrick, L.E. (Eds.). (2003). *Handbook of Occupational Health Psychology*. Washington, DC: American Psychological Association.

Reid, V.; Striano, T. & Koops, W. (2007) Social Cognition During infancy. Psychology Press.

Reisman, J. (1991). A history of clinical psychology. United Kingdom: Taylor Francis. ISBN 1-56032-188-1.

Ribner, N.G. (2002). California School of Professional Psychology Handbook of Juvenile Forensic Psychology. Jossey-Bass. ISBN 0-7879-5948-0

Roesch, R., & Zapf, P. A. (Eds.). (2012). Forensic assessments in criminal and civil law: A handbook for lawyers. NY: Oxford University Press. ISBN 9780199766857

Rogelberg, S.G. (Ed.). (2002). *Handbook of research methods in industrial and organizational psychology*. Malden, MA: Blackwell.

Rogers, C. R. (1951). Client-centred therapy. Boston: Houghton Mifflin.

Rotter, J.B. (1966). Generalized expectancies of internal versus external control of reinforcements. *Psychological Monographs*, 80

Salas, E.; Stagl, K. & Burke, C. (2004). 25 years of team effectiveness in organizations: Research themes and emerging needs, in C. Cooper & I. Robertson (eds), *International Review of Industrial and Organizational Psychology*, Vol. 19 (pp. 47–91). Chichester, UK: John Wiley & Sons.

Schaie, K. W. (1990). Intellectual development in adulthood. In J. E. Birren & K. W. Schaie (Eds.), *Handbook of the psychology of aging*, 3rd ed., (pp. 291-309). New York: Academic Press

Seifert, K. & Sutton, R. (2009) *Educational Psychology: Second Edition*. Global Text Project, pp. 33–37.

Seligman M., Csikszentmihalyi M. (2000). "Positive psychology: An introduction". *American Psychologist* 55 (1): 5–14. doi:10.1037/0003-066x.55.1.5

Seligman M., Rashid T., Parks A. (2006). "Positive Psychotherapy". *American Psychologist* 61 (8): 774–88. doi:10.1037/0003-066x.61.8.774

Shaffer, J. B. P. (1978). Humanistic psychology. Englewood Cliffs, NJ: Prentice-Hall.

Sherif, M. (1935). A study of some social factors in perception. Archives of Psychology (Columbia University).

Shweder & Herdt, G. (2000) Cultural Psychology (pp259-286). Cambridge: Cambridge University Press.

Siegler, R. (2006). **How** Children Develop, Exploring Child Development Student Media Tool Kit & Scientific American Reader to Accompany How Children Develop. New York: Worth Publishers. ISBN 0-7167-6113-0.

Skinner, B. F. (1971). Beyond Freedom and Dignity. New York: Knopf.

Skinner, B. F. (1938). The behaviour of Organisms: An Experimental Analysis. New York: Appleton-Century

Skinner, B. F. (1948). 'Superstition' in the pigeon. Journal of Experimental Psychology, 38, 168-172.

Slater, A.; Lewis, M. (2006). Introduction to Infant Development. Oxford: Oxford University Press. ISBN 0-19-928305-2.

Slater, L. (2004). Opening Skinner's box: Great psychological experiments of the twentieth century. New York: Norton

Slife, B. Barlow, S. & Williams, R. (2001). Critical issues in psychotherapy: translating new ideas into practice. London: SAGE. ISBN 0-7619-2080-3

Smeyers, P. Depaepe, M. (2012). The Lure of Psychology for Education and Educational Research. "The Journal of Educational Philosophy", 46, 315-331.

Smith, P. Cowie, H. & Blades, M. Understanding Children's Development. Basic psychology (4 ed.). Oxford, England: Blackwell.

Snowman, J. (1997). Educational Psychology: What Do We Teach, What Should We Teach? "Educational Psychology", 9, 151-169

Spearman, C. (1904). "General intelligence" objectively determined and measured. *American Journal of Psychology*, 15, 201–93.

Steinberg, L. (2008). *Adolescence* (8th ed. ed.). Boston: McGraw-Hill Higher Education. pp. 60–365. ISBN 9780073405483.

Sulloway, F. J. (1991). Reassessing Freud's case histories: The social construction of psychoanalysis. *Isis*, 82(2), 245-275.

Sundstrom, E.; De Meuse, K.P. & Futrell, D. (1990). Work teams: applications and effectiveness. *American Psychologist*, 45(2), 120–33.

Sundstrom, E.; McIntyre, M.; Halfhill, T. & Richards, H. (2000). Work Groups: From the Hawthorne Studies to Work Teams of the 1990s and Beyond. *Group Dynamics: Theory, Research, and Practice* (Vol 4, No 1. 44–47).

Taylor, S.E. (1990). Health psychology. *American Psychologist*, 45, 40–50.

The British Psychological Society. (2011). *Health Psychology in applied settings: A guide for employers*.

Thorndike, E. L. (1905). *The elements of psychology*. New York: A. G. Seiler.

Thorndike, E.L. (1912). *Education: A first book*. New York: MacMillan.

Thurschwell, P. (2000). *Sigmund Freud*. London: Routledge.

Tolman E. C. (1948). Cognitive maps in rats and men. *Psychological Review*. 55, 189–208

Truax, C.B. (1966). Therapist's empathy, genuineness, and warmth and patient therapeutic outcome. *Journal of Consulting Psychology*, 30, 395-401

Upton, P, (2011). Developmental Psychology: Critical Thinking in Psychology.
Exeter: Learning Matters. p. 62. [ISBN 0857252763](#).

Van Vianen, A.E.M. & De Dreu, C.K.W. (2001). Personality in teams: Its relationship to social cohesion, task cohesion, and team performance. *European Journal of Work and Organizational Psychology*, 10(2), 97–120.

Vygotsky, L.S. (1978). Mind in society. The development of higher psychological processes. Cambridge: Cambridge University Press.

Wageman, R. & Baker, G. (1997). Incentives and cooperation: The joint effects of task and reward interdependence on group performance. *Journal of Organizational Behavior*, 18, 139–58.

Watson, J. B. (1913). Psychology as the behaviourist views it, *Psychological Review*, 20, 158-178.

Watson, J. B. (1930). Behaviourism (revised edition). University of Chicago Press.

Watson, J. B., & Rayner, R. (1920). Conditioned emotional reactions. *Journal of Experimental Psychology*, 3, 1, pp. 1–14

Wertsch, J. V. (1985). Vygotsky and the social formation of mind. Cambridge: Harvard University Press.

Whiteside, M. Becker, F. (2000). "Parental factors and the young child's post divorce adjustment: A meta-analysis with implications for parenting arrangements." *Journal of Family Psychology* 14 (1): 5–26. :[10.1037/0893-3200.14.1.5](#).

Whitney, K. (1994). Improving group task performance: The role of group goals and group efficacy. *Human Performance*, 7, 55–78.

Woolfolk, A. Winne, P. Perry, N. (2006). Educational Psychology (3rd Canadian ed). Toronto, Canada: Pearson.

Zimmerman, B., Schunk, D. (2003). Educational psychology: A century of contributions. Mahwah, NJ, US: Erlbaum.

