

Health promotion

A2

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What you need to know

Health promotion is the fifth topic of the Health psychology option (Papers 3 and 4). It asks how psychologists get people to live more healthily, and why people sometimes ignore good advice. You should be able to:

1. **Strategies for promoting health: fear arousal** (using fear to improve health), with a study such as **Janis and Feshbach (1953)**; and **providing information** so people know how to improve their health, with a study such as **Lewin et al. (1992)**.
2. **Health promotion in schools**, with a focus on **healthy eating**, with a study such as **Tapper et al. (2003)**.
3. **Health promotion in worksites**, with a focus on **health and safety**, with a study such as **Fox et al. (1987)**.
4. **Unrealistic optimism** as a reason people **disregard positive health advice**, with a study such as **Weinstein (1980)**.
5. **Positive psychology**: what it is, and its **three focuses**, the **pleasant life**, the **good life** and the **meaningful life**, with a study such as **Seligman (2004)**.
6. **Applying positive psychology**, through the key study **Shoshani and Steinmetz (2014)** on positive psychology in schools to improve mental health, which you must know in detail.
7. **Evaluate all of it** with the issues the syllabus names for this topic: individual and situational explanations, cultural differences, longitudinal studies, objective and subjective data, ethics, use of children in research, experiments, quantitative and qualitative data, generalisations from findings, idiographic versus nomothetic, and psychometrics.

Studies marked "e.g." in the syllabus can be swapped for another suitable one; the key study cannot. Before 2024 the topic also had the Yale model of communication, the transtheoretical model, Lau et al. (1990), Farquhar et al.'s five-city project and Cowpe (1989); they are under "Older syllabus content" because older questions ask about them.

Understand it

The topic at a glance

Part	What it covers	Study to know
Strategies	Fear arousal; providing information	Janis and Feshbach (1953); Lewin et al. (1992)
Settings	Healthy eating in schools; health and safety at work	Tapper et al. (2003); Fox et al. (1987)
Individual factors	Unrealistic optimism	Weinstein (1980)
Individual factors	Positive psychology: pleasant, good and meaningful life	Seligman (2004); Shoshani and Steinmetz (2014), key study

Strategy 1: fear arousal

Fear arousal means making people a little afraid of what an unhealthy habit could do to them, so that they change it. A message might show a damaged lung, a rotten tooth or a house fire. The idea is that fear motivates people to act.

The catch is the **amount** of fear:

- **Too much** fear can backfire: people feel so anxious that they look away, deny that it applies to them, or stop listening.
- **Too little** fear may not motivate anyone to change.
- Fear on its own does not tell people **what to do**. Fear works best when it is followed by **information** on how to avoid the danger.

Janis and Feshbach (1953): fear and tooth brushing

Aim: to find out how the level of fear in a health message affects whether people follow its advice on dental (oral) hygiene.

Participants: 200 high school students, mean age 15.

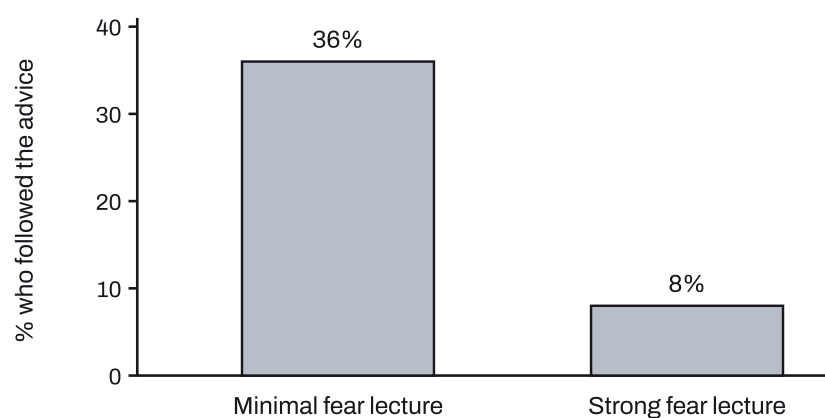
Design: an **experiment** with an **independent groups** design: four groups of 50, each hearing a different lecture.

Group	Lecture
Strong fear	dental hygiene, with slides of diseased mouths and the serious consequences of poor hygiene, including cancer

Group	Lecture
Moderate fear	a similar lecture with less disturbing pictures
Minimal fear	teeth and cavities, with no pictures and no talk of serious consequences
Control	a lecture on the structure of the human eye

Procedure: a **self-report questionnaire** was given **one week before** the lecture, **straight after** it and **one week after** it, recording emotional reactions and whether students had followed the advice (conformity).

Results: the strong fear lecture aroused the **most fear**, but the **minimal fear** lecture produced the **most change**: **36%** of the minimal fear group followed the advice, against only **8%** of the strong fear group.



Conclusion: a **low** level of fear is the most effective; strong fear may make people avoid the message.

Evaluating it:

- **Experiment:** four groups and a control give good control of variables, so the level of fear can be said to cause the difference; but a single lecture is not how people usually meet health messages.
- **Snapshot:** only about two weeks long, so it cannot show whether brushing changed for good.
- **Self-report** (subjective): students may have said they brushed better than they did (social desirability).
- **Ethics:** the strong fear group saw distressing slides, a risk of psychological harm to 15-year-olds.
- **Situational explanation:** the lecture (the situation) changed behaviour; but each student's own motivation also mattered.

Strategy 2: providing information

Providing information means giving people the knowledge and skills to improve their health: what to do, why and how. A leaflet, a manual, a website or a lesson can all provide information. It assumes that people who **know** what to do, and feel able to do it, will change.

Lewin et al. (1992): a self-help manual after a heart attack

Aim: to find out whether a self-help rehabilitation programme helps patients recover after a heart attack.

Participants: 176 patients who had recently had a **heart attack**, **randomly allocated** to two groups.

Procedure:

- **Rehabilitation group:** a **self-help rehabilitation programme**, a manual (the Heart Health Manual) with information and exercises.
- **Control group:** standard care plus a **placebo** package of information and informal counselling.
- A facilitator contacted both groups at **1, 3 and 6 weeks** after discharge; with the rehabilitation group she checked progress and encouraged them to keep to the manual's exercises.
- **Measures:** the **Hospital Anxiety and Depression Scale** and a **30-item General Health Questionnaire** at **6 weeks, 6 months and 12 months** after discharge; the patients' **GPs** reported how often they had seen them and whether they had been readmitted to hospital.

Results: at one year the rehabilitation group had **better psychological adjustment**, needed their **GP** much less often over the year, and in the first six months after discharge **hospital readmissions** were much rarer in this group. The biggest gains were for patients whose **anxiety or depression** was already at a clinical level when they went home.

Conclusion: giving heart attack patients clear information they can act on at home helps their recovery.

Evaluating it:

- **Random allocation** and a **placebo** control group: the difference can be put down to the manual, not to extra attention.
- **Longitudinal** (12 months): shows lasting change; but takes time, and patients may drop out.
- **Objective and subjective data:** GP visits and readmissions are objective; the anxiety and depression scales are self-reports, so subjective.
- **Ethics:** consent was obtained and no harm was done; but the control group did not get the programme during the study.
- **Application:** a cheap way to help patients after they leave hospital.

Health promotion in schools: Tapper et al. (2003), the Food Dudes

Many children in the UK aged **4 to 11** were not eating enough fruit and vegetables. Tapper et al. designed the **Food Dudes** programme, built on three techniques:

1. **Taste exposure:** the more often a child tastes a new food, the more they learn to like it.
2. **Modelling:** children imitate models they **like or admire**, who are their **own age or a little older**, and whose behaviour is **rewarded**; several models work better than one. The Food Dudes are peer role models shown in videos eating fruit and vegetables.

3. **Rewards:** small, desirable prizes (stickers, pens, erasers) given only when the child **eats** the target food, so the reward follows the behaviour (positive reinforcement).

Tapper et al. report several studies; any one can be described:

- **At home:** a small study of **5 to 6** year olds who watched the Food Dudes video and got rewards for eating target amounts. Fruit eaten rose from **4% to 100%**, vegetables from **1% to 83%**.
- **In a nursery:** **26** children aged **2 to 4** at a university day nursery. Fruit eaten at snack time rose from **30% to 71%**, and was **79%** at a follow-up **15 months** later, after a maintenance phase with no videos and fewer rewards. At lunchtime it rose from **17%** to **76%** at the 15-month follow-up.
- **Whole school:** the whole primary age range (**4 to 11**) in **three schools** (in Bangor, North Wales; Harwell, Oxfordshire; and Salford, Manchester). Over **16 days**, children watched **six** Food Dudes videos, with rewards, letters, a home pack and a staff manual. Fruit and vegetable eating rose a lot in all three schools, at snack time and lunchtime, for boys and girls and for infants (4–7) and juniors (7–11). Children were keen and attendance improved. After **four months** they were still eating more fruit and vegetables.

Evaluating it:

- **Field experiment:** real schools and real lunches, so good **ecological validity**; but less control of what children ate at home.
- **Longitudinal:** follow-ups of four and fifteen months show lasting change.
- **Use of children:** children may be less affected by **demand characteristics** if they don't know they are in a study, and good habits learned early may last; but children cannot consent for themselves (parents and teachers do), and repeatedly offering disliked foods could upset them.
- **Quantitative data:** percentages of food eaten can be compared before and after.
- **Generalisations:** UK children only; diets differ between cultures.

Health promotion in worksites: Fox et al. (1987), token economy at the mines

Aim: to improve **health and safety** at work by reducing accidents and injuries.

Setting and participants: workers at **two open-pit mines** in the USA, both dangerous places to work.

Procedure: a **token economy** using **trading stamps** as tokens:

- **Safe behaviour was rewarded.** The main way to earn stamps was to stay free of a **lost-time injury** (an injury that keeps a worker off work). Whole work groups also earned stamps when none of their members was hurt, so workers watched out for each other. Extra stamps came from avoiding accidents that damaged equipment, from safety ideas the mine took up, and from stepping in to stop an accident.
- **Unsafe behaviour simply went unrewarded.** An injury in the group, damage to equipment or an accident kept quiet meant that period's stamps were not earned.
- **Stamps were spent like money**, in on-site stores with a very wide range of goods to choose from.

Results: the mines became much safer. Fewer workers had **lost-time injuries**, fewer **working days** were lost to injury, and accidents and injuries **cost** the companies much less. The scheme paid for itself many times over, since its running costs were small next to these savings, and the gains did not fade after the first year but held for **several years**. The scheme ran over about **15 years** (1970 to 1985).

Evaluating it:

- **Longitudinal:** shows the scheme worked long term, not just when it was new; but costly to run, and **attrition:** workers left or joined, and one mine closed during the study.
- **Quasi-experiment:** the mines were not randomly assigned, so other changes (new managers, new equipment) could explain some of the fall.
- **Objective data:** injury records and costs are not open to the workers' bias.
- **Generalisations:** mine workers in the USA only.
- **Situational:** rewards (the situation) changed behaviour.

Unrealistic optimism: why people ignore good advice

Unrealistic optimism (also called optimistic bias or the **illusion of invulnerability**) is believing that bad things are **less likely to happen to you** than to other people, and good things **more likely**. A smoker who thinks "lung cancer happens to other people" is unrealistically optimistic. Because the person feels safe, they **disregard** health advice that is meant for them.

Weinstein (1980): "it won't happen to me"

Study 1: 258 college students rated their own chances of experiencing 42 future life events, compared with the average person like them. 18 events were positive and the rest negative, mixed together in one list. Answers were on a **15-point scale** from **100% less than average**, through **average**, to **100% more than average**.

- **Result:** students rated their own chances as **above average** for positive events and **below average** for negative events. Since not everyone can be better than average, this shows unrealistic optimism.

Study 2: 120 female students listed the factors they thought would affect their own chances of 8 future events. Another group then read these lists. Seeing that other people had just as many factors in their favour **reduced** their unrealistic optimism, though it did not remove it.

- **Conclusion:** when we judge our own risk we think of all the things in our favour, but we forget that other people have just as many, so we wrongly come out ahead.

What makes unrealistic optimism stronger (useful for "suggest why" questions):

Factor	Example
No personal experience of the problem	has never been seriously ill or injured, so thinks it won't happen
Perceived control	thinks "I can stop smoking whenever I like"

Factor	Example
Stereotype of who is at risk	thinks heart attacks happen to middle-aged men, not to a young woman
Perceived probability	thinks the chance of harm is lower for them than for others
Intensity of the outcome	a very serious outcome feels too far off to happen to them

Evaluating it:

- **Psychometrics** and **quantitative** data: a standardised scale lets ratings be compared; but students may not know their real risk, and answers may be affected by social desirability.
- **Generalisations**: college students from **Rutgers University** in New Jersey, USA (Study 2 only women), so may not apply to older people or other cultures.
- **Nomothetic**: suggests most people share this bias; but each person's optimism about each risk is individual (**idiographic**).
- **Individual explanation**: a bias in the person's thinking; but **culture** may matter too: where good medical care is easy to get, people may feel safer.
- **Application**: health messages can show people that others have the same protective factors, as in Study 2.

Positive psychology

Positive psychology studies what makes life go **well**: happiness, strengths and meaning, rather than only illness and problems. Instead of only treating disorders, it aims to build well-being so that people stay mentally healthy. **Seligman (2004)** described **three focuses**, three routes to a happy life:

Focus	What it means	Example
The pleasant life	enjoying daily pleasures and positive emotions	a favourite meal, a game, a walk, a film
The good life	feeling life is going well: knowing and using your strengths , gratitude, more positive than negative experiences, good relationships, satisfying work and activities	doing a job well that uses your talents
The meaningful life	a purpose greater than yourself , through serving others and belonging to positive institutions such as a strong family	volunteering for a charity

Don't mix them up: a daily pleasure is the pleasant life; serving others is the meaningful life.

Evaluating positive psychology:

- **Application**: it can be taught in schools and families to prevent mental illness.
- **Nomothetic**: it proposes a general route to happiness; but what is pleasant or meaningful differs between people (**idiographic**).

- **Cultural differences:** it comes from Western, affluent countries, where people have more time for leisure and charity work.
- **Determinism versus free will:** people **choose** their goals and activities (free will); but school interventions can be said to **determine** students' happiness.
- **Limits:** someone with a mental disorder may need medical help, and finding time for pleasant or meaningful activities can itself add stress.

Key study: Shoshani and Steinmetz (2014), positive psychology in schools

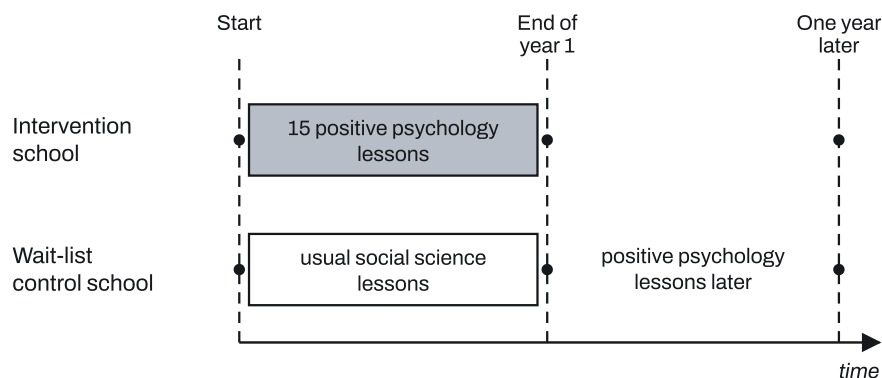
Background: positive psychology (Seligman's pleasant, good and meaningful life) suggests that well-being can be taught.

Aim: to find out whether taking part in a positive psychology programme leads to better mental health through the middle-school years.

Participants: 1167 students at the start, and 1038 with complete data at the end, in **grades 7, 8 and 9**, aged **11.8 to 14.7 years**, from **two large middle schools in the centre of Israel**. **537** were in the intervention school and **501** in a similar control school. Most (**98%**) were Jewish; **57%** reported middle socioeconomic status; **64%** lived with two parents and **36%** with one.

Withdrawals: some students left the study because of **absence**, and some because they **refused to complete the questionnaires**.

Design: a **2-year longitudinal** study with **repeated measures** over time, and an **independent measures** comparison between the intervention school and a **wait-list control** school.



Dots: the same questionnaires (BSI, RSE, self-efficacy, SWLS, LOT-R)

Procedure:

- **Intervention school:** teachers were **trained**, then taught **15 lessons** on positive psychology over the year, with activities, discussions, film clips, and stories and poems.
- **Control school:** its usual **social science** lessons about adolescence, with nothing on positive psychology. As a **wait-list** control it was given the programme **later**.
- Students were tested at the **start**, at the **end of the intervention year** and **one year later**.

Measures (self-report questionnaires):

Questionnaire	What it measures
Brief Symptoms Inventory (BSI)	psychological symptoms and distress, such as anxiety and depression
Rosenberg Self-Esteem Scale (RSE)	how worthy a person feels as a human being; 10 items , some positively and some negatively worded, rated on a 4-point scale from strongly disagree to strongly agree, with no neutral point
General Self-Efficacy Scale	belief in being able to cope with daily hassles and stressful events; 10 items on a 4-point scale from "not at all true" to "exactly true"
Satisfaction with Life Scale (SWLS)	how satisfied a person is with their life
Life Orientation Test-Revised (LOT-R)	optimism

Demographic information was also collected.

Results: over the study, students who had the lessons reported less **distress, anxiety** and **depression** (these **fell significantly**), while the same symptoms went up in the control school. The lessons also left students feeling better about themselves (**self-esteem**), more able to cope (**self-efficacy**) and more hopeful (**optimism**), and less touchy and self-conscious with other people (**interpersonal sensitivity**).

Conclusion: positive psychology lessons can improve school students' mental health, so education for well-being should be part of the school curriculum.

Evaluating it:

- **Questionnaires and psychometrics:** standardised scales give **quantitative** data that can be compared between schools and over time, and are **reliable**; answering privately may be more honest than an interview. But students may give **socially desirable** answers or show **demand characteristics**, may not understand some items, or may not know their own feelings and guess.
- **Four-point scales:** no neutral option forces a choice, so nobody can sit on the fence; but a student who genuinely feels neutral must give a false answer.
- **Longitudinal:** shows whether what was taught stayed with students over time; but young people change for many other reasons as they grow, and students dropped out.
- **Wait-list control:** a **baseline** from a similar school; and ethical, as the control school got the lessons later. Consent was obtained, so ethics is a strength.
- **Situational explanation:** the lessons (the situation) changed mental health; individual factors (home life, personality) may also have mattered.
- **Generalisations and culture:** Israeli, mostly Jewish students only, so it may not generalise to other countries.
- **Nomothetic:** proposes that positive psychology lessons improve mental health for students in general.

Issues and debates for this topic

Issue	How it applies here
Individual and situational explanations	Fear messages, leaflets, Food Dudes rewards and Fox's tokens are situational : external, the same for everyone; unrealistic optimism is individual (a bias in the person's thinking).
Cultural differences	Positive psychology and Weinstein's students are Western; Shoshani and Steinmetz is Israeli; responses to fear may differ between cultures.
Longitudinal studies	Lewin (12 months), Tapper (follow-ups to 15 months), Fox (about 15 years), Shoshani and Steinmetz (2 years); Janis and Feshbach is a short snapshot.
Objective and subjective data	Injury records, GP visits and food eaten are objective; questionnaires on mood or brushing are subjective.
Ethics	Strong fear can harm; children can't consent for themselves; control groups may miss a benefit (a wait-list solves this).
Use of children in research	Less affected by demand characteristics and habits can be set early; but consent comes from parents and children may try to please the teacher.
Experiments	Janis and Feshbach (lab-style, controlled); Tapper (field); Fox (quasi).
Quantitative and qualitative data	Most studies here give numbers that can be compared; open questions would show why people change.
Generalisations from findings	US students (Weinstein), US miners (Fox), UK children (Tapper), Israeli students (Shoshani and Steinmetz).
Idiographic versus nomothetic	Unrealistic optimism and positive psychology both offer general laws; what each person feels or enjoys is individual.
Psychometrics	Weinstein's scale; the RSE, General Self-Efficacy Scale and others in Shoshani and Steinmetz.
Determinism versus free will	People choose positive activities (free will); a school programme may determine happiness.

Older syllabus content (2021–2023 questions only)

- **Cowpe (1989)**: television adverts in ten UK regions (1976–1984) showed how chip pan fires start and how to put one out; chip pan fires fell by about **12%**. It combined **fear arousal** with **providing information**.
- **Yale model of communication**: whether a message changes behaviour depends on the **source** (a credible, trustworthy person such as a doctor), the **message** (clear, vivid), the **medium** (TV, print, social media), the **audience** and the **situation**; the message must win **attention**, be **understood** (comprehension) and be **accepted**.

- **Lau et al. (1990)**: a longitudinal questionnaire study of over 1000 university students and their parents; parents were the strongest influence on health beliefs, with peers becoming more important during college.
- **Transtheoretical model** (Prochaska et al., 1997): six stages of change, from pre-contemplation to termination.
- **Farquhar et al. (1985)**, the five-city project: a community health education campaign in two Californian towns against heart disease, compared with control towns; measures included blood pressure, weight, resting heart rate and smoking.

Key facts and formulas

There is no formula list in the 9990 exam. "Learn it" means you must remember it.

Fact	Status
Fear arousal: using fear of the consequences to change health behaviour; too much fear can backfire, too little may not motivate, and fear alone doesn't say what to do	Learn it
Janis and Feshbach (1953): 200 students, mean age 15, four groups of 50 (strong, moderate, minimal fear, control); questionnaire a week before, straight after and a week after; minimal fear most effective, 36% against 8% for strong fear	Learn it
Lewin et al. (1992): 176 heart attack patients randomly allocated to a self-help rehabilitation manual or a placebo package; better adjustment at one year, fewer GP contacts, fewer readmissions in the first six months	Learn it
Tapper et al. (2003), Food Dudes: taste exposure, modelling and rewards; whole school study of 4–11 year olds in three schools over 16 days, gains still there after four months	Learn it
Fox et al. (1987): token economy of trading stamps at two open-pit mines; fewer lost-time injuries, days lost and costs; savings far above the scheme's cost, lasting for years	Learn it
Unrealistic optimism: believing bad events are less likely, and good events more likely, for you than for others	Learn it
Weinstein (1980): 258 students rated their chances of 42 events against the average; above average for positive, below average for negative; Study 2, 120 female students, seeing others' factors reduced the bias	Learn it
Positive psychology (Seligman): the pleasant life (daily pleasures), the good life (strengths, positive experiences and relationships), the meaningful life (a purpose greater than yourself, serving others)	Learn it
Shoshani and Steinmetz (2014): 1167 students at the start, 1038 at the end, grades 7–9, aged 11.8–14.7, two middle schools in Israel; 15 lessons; tested at the start, end of year and a year later; BSI, RSE, General Self-Efficacy Scale, SWLS, LOT-R	Learn it
Shoshani and Steinmetz (2014) results: distress, anxiety and depression fell in the intervention school and rose in the control school; self-esteem, self-efficacy and optimism rose	Learn it

How to do it

We have tagged 46 questions on this topic, from 2021 to 2026 (Papers 3 and 4; 32 different questions, as variants repeat them). 12 of them have parts of more than one type, so the counts add up to 60.

Question type	Questions
Explain a strength or weakness in context	14
Describe and evaluate essay	10
Outline a study or recall a detail	10
Apply a strategy or concept to a scenario	8
To what extent essay	8
Plan a study and justify it	6
Define an issue or debate and apply it	4

1. Explain a strength or weakness in context (14 questions)

Usually 2 marks a point: the point (1), then **applied** to the study, strategy or scenario with a detail (1). A generic point with no context gets only the first mark.

1. Name the point: "too much fear can make people ignore the message", "longitudinal studies suffer attrition".
2. Tie it to **this** case: "for example, a smoker shown a very frightening picture of a diseased lung may look away and keep smoking".

Variations you will meet:

- **Weaknesses of fear arousal:** too much fear (people react badly or avoid it); too little (no change); fear without information (people don't know what to do). Any health example counts: smoking, diet, teeth.
- **A wait-list control** in Shoshani and Steinmetz: a similar school acting as a **baseline** to compare with, which was **ready** to take the lessons later.
- **Longitudinal studies of positive psychology in schools:** strength, shows whether lessons **stayed** with students over time; weakness, young people are changed by many later experiences, or move to schools that don't teach the same values. "Rich, in-depth data" is credited only if justified.
- **Four-point scales:** forces a choice (no fence-sitting), so a score can always be given; but no neutral option forces a false answer from someone genuinely undecided.
- **Why use children in healthy eating research:** less affected by demand characteristics; can be followed up as adults to see if habits last; a whole school can be given the same programme by teachers.
- **A practical problem with a teacher's plan:** students may not take it seriously; hand washing or eating habits are hard to change; past mild illnesses make them feel safe.

- **Why positive psychology might not help:** a real mental health problem needs medical help; bad periods where nothing helps; activities eat into schoolwork time and add stress; mental health is hard to measure. "They wouldn't do it" scores 0.
- **Older:** strength and weakness of longitudinal research with Fox et al. (6, levels): change over time, cost-benefit of the scheme over years; versus attrition (workers left, a mine closed) and cost. Generalisability of Fox et al. is **not** an answer about longitudinal research. "Discuss ... with a conclusion" [5]: 1 mark per point tied to the question (at least two each side), 1 for a real conclusion.

2. Describe and evaluate essay (10 questions)

Paper 3 Section C, Q12 since 2024: (a) **describe** [6], (b) **evaluate** [10] with a **named issue** (before 2024, Q6 with 8 + 10).

1. **(a):** cover **every** part the question names. The pairs asked: Shoshani and Steinmetz alone; schools **and** worksites (Tapper, Fox); fear arousal **and** providing information (Janis and Feshbach, Lewin; Tapper, Fox or Cowpe accepted for information); unrealistic optimism **and** positive psychology. Describing only one of a pair caps (a) at 4.
2. For a study give **sample, method or procedure, a measure and results**, plus two more details. For Tapper, give the procedure (how the Food Dudes and rewards were used, ages) and at least one result.
3. **(b):** start with the **named issue** (questionnaires, experiments, longitudinal studies, idiographic versus nomothetic, quantitative and qualitative data), applied to each study from (a) with a detail; then other issues from the syllabus list, each with a reason, an example from the study and some analysis (a contrast, a counter-point); then a judgement. Without the named issue the answer is capped at Level 2; points with no context stay low.
4. Get the facts right: **minimal** fear worked best; Fox's workers **missed out on** stamps, the scheme lasted **years** (not a snapshot); Shoshani and Steinmetz's control school **got** the lessons later and consent was obtained.

3. Outline a study or recall a detail (10 questions)

Short recall, 1 or 2 marks a point. Exact details score; vague ones don't.

- **How a study used fear arousal** [2]: Janis and Feshbach's four groups (strong, moderate, minimal, control), questionnaires before, after and a week later; **minimal fear** worked best, **36%** against **8%**.
- **Two features of Shoshani and Steinmetz's sample** [2]: 1167 at the start or 1038 at the end; grades 7–9; aged 11.8–14.7; two middle schools in Israel; 98% Jewish; 57% middle socioeconomic status; 64% two-parent families. "A mix of males and females" scores 0.
- **Why students withdrew** [2]: **absence**, and **refusing to complete the questionnaires**.
- **Outline the RSE or the General Self-Efficacy Scale** [2 each]: what it measures plus a feature (10 items; 4-point scale; positive and negative items). "It measures self-esteem" alone scores 0.
- **A sample of children in a healthy eating study** [2]: needs exact **ages**: "the whole primary range, 4–11, in three UK schools". "Young children" scores 0.

- **Older:** describe Fox et al. [4]; two of Tapper's techniques [4] (taste exposure, modelling, rewards; the four procedures are not techniques); two five-city measures [2] (blood pressure, weight, resting heart rate, smoking).

4. Apply a strategy or concept to a scenario (8 questions)

A named person or class. Each mark needs an idea from the topic **and** a detail tied to the scenario.

1. Pick the right knowledge: Weinstein's factors for unrealistic optimism; minimal fear plus information for a safety habit; Food Dudes-style rewards for children's eating; the three focuses for positive psychology.
2. Say **how** it would be done, step by step, for **this** person or class.
3. Check it fits: the right **age**, the **exact aim** (reducing unhealthy food, not just more vegetables), and it must be **ethical** (unethical ideas score 0).

Variations you will meet:

- **Reasons for someone's unrealistic optimism** [4] (2 + 2): a factor (no personal experience, perceived control, stereotype of who is at risk, perceived probability) plus how it shows in their health belief.
- **Fear arousal plus information** for a safety or hygiene habit: a **mild** fear message (a short clip, a poster), followed straight away by what to do; keep it **minimal** and ethical.
- **Reducing a class's unhealthy food** [4]: something for **this class** and their **age** (a sticker chart for swapping crisps for fruit, healthy-swap competitions, letters home); copying Tapper's fruit and vegetable techniques without reducing unhealthy food is capped at 3.
- **Pleasant life** for a young child or **meaningful life** for a teenager [2 each]: a daily enjoyable activity; volunteering for a charity. Don't give a good-life idea instead.
- **Another strategy for mental health in schools** [2]: one other than the key study's, such as fear arousal (used mildly) or rewards as in Tapper et al.

5. To what extent essay (8 questions)

Paper 4 Q11 [12] (2021–2023), levels-marked: argue **both sides** with named research, then a reasoned judgement. Not on 2024+ papers, but the arguments carry over to type 2 evaluations.

- **"Fear arousal is the best strategy"**: for: a little fear is worth it if health improves, people can stop watching; against: strong fear was **least** effective (Janis and Feshbach), it upsets people, and providing information (Lewin) works without fear; judgement: fear needs information alongside it (Cowpe used both).
- **"A questionnaire is the only way to assess unrealistic optimism"**: for: private, quantitative, can be anonymous (Weinstein); against: dishonest answers, interviews go deeper, observation of visits to a doctor.
- **"Schools are irrelevant; target parents at home"**: for schools: Tapper's gains at school; for home: parents' influence (Lau et al.).
- **"Young people's unrealistic optimism means they won't prevent stress"**: Weinstein's students for; individual differences against.

6. Plan a study and justify it (6 questions)

Paper 4 Section B, with the research methods topic (see that note). The health promotion part is the **psychological knowledge** behind the plan.

- **Since 2024** [24]: (a) a plan [10] with the named method and features (an **interview**: telephone or face to face; structured, semi-structured or unstructured; open and/or closed questions, with example questions and how they are scored); (b)(i) **describe** the knowledge [4]: Weinstein's two studies for unrealistic optimism, or Tapper et al. for school healthy eating; (b)(ii) **two features** of that knowledge and how each shaped your plan [2 + 2]: "Weinstein compared people's own chances with the average, so my closed question asks adults to rate their chance of heart disease from much less than average to much more than average"; (c) a reason for, and a weakness of, your question format and a reason for your interview format, each tied to your plan [2 each].
- **Closed questions**: same format for everyone, easy to score, many people quickly; but no chance to explain. **Open questions**: rich detail and reasons; but harder to analyse. **Structured**: same questions in the same order; **semi-structured**: fixed questions plus follow-ups.
- **Before 2024** [18]: a design [10] and its psychological **and** methodological evidence [8]; only one kind caps it at 5. Use the method named (a **case study** is one person or one unit, such as a school) and the strategy named (providing information means Lewin or Tapper, not fear arousal).

7. Define an issue or debate and apply it (4 questions)

(a) define **both** sides (1 + 1); (b) apply it to health promotion (2). A bare definition, or just naming a strategy, scores 0.

- **Individual versus situational**: an **individual** explanation puts behaviour down to **internal** factors (personality, beliefs); a **situational** one to **external** factors in the environment (rewards, other people); the debate is how far behaviour is caused by each.
- **Why a strategy is situational**: fear arousal or a leaflet is an **external** message, the **same for everyone**, and outside the person's control; it assumes everyone will react to it in a similar way.
- **Free will**, with a positive psychology example: people choose their own behaviour, for example choosing to take up a meaningful activity.
- **Why positive psychology is deterministic**: the school lessons can be said to have caused the students' improved mental health in Shoshani and Steinmetz; taking on the goals determines later happiness.

Worked examples

Example 1

Rafael, aged 35, works long hours and gets very little exercise. When his doctor warns him about heart disease, he says: "That happens to other people. I'm fit enough, and I can start exercising whenever I want."

(a) Identify **two** factors that may explain Rafael's unrealistic optimism, using his own words. [4]

(b) Suggest how the findings of Weinstein's second study could be used to design a health leaflet for people like Rafael. [2]

(a) *Perceived control (B1)*: Rafael believes he "can start exercising whenever" he wants, so he feels the risk is under his control and that there is no need to act now (B1). *No personal experience (B1)*: he describes heart disease as something that "happens to other people", suggesting he has never had heart problems himself, so the danger feels unreal to him (B1).

(b) Weinstein found that seeing other people's reasons for thinking they were safe reduced unrealistic optimism (B1), so the leaflet could show several office workers of Rafael's age each saying "I'm fit enough", followed by the fact that many such people still develop heart disease, so he sees he is no safer than them (B1).

Example 2

A primary school introduced a programme for its 9-year-olds in which a popular older pupil ate vegetables in a short daily video and children earned a sticker each time they ate their lunchtime vegetables. Before the programme, 20% of the children ate their vegetables at lunch. After eight weeks the figure was 65%. Six months after the programme ended it was 58%.

(a) Identify **two** techniques from Tapper et al.'s Food Dudes programme that this school used. [2]

(b) Calculate the rise in percentage points during the programme, and the percentage of that rise still present six months later, to 1 decimal place. [3]

(c) Explain **one** reason why measuring vegetable eating six months later makes this research more useful. [2]

(a) **Modelling**: the pupil in the video is liked and a little older (B1). **Rewards**: stickers given only when the vegetables are eaten (B1).

(b) Rise: $65 - 20 = 45$ percentage points (B1). Still present: $\frac{58-20}{65-20} \times 100 = \frac{38}{45} \times 100 = 84.4\%$ of the rise (M1 A1).

(c) It is longitudinal, so it shows whether the change lasted after the stickers and videos stopped (B1): most of the gain (84.4%) was kept, so the children seem to have learned to like vegetables, not just to eat them for stickers (B1).

Example 3

(a) Describe:

- a study about providing information so people know how to improve their health, and
- a study on unrealistic optimism. [6]

(b) Evaluate both studies, including a discussion about objective and subjective data. [10]

(a) Providing information: *Lewin et al. (1992)*. 176 patients who had recently had a heart attack were randomly allocated to a self-help rehabilitation manual or to standard care with a placebo information package. A facilitator contacted both groups at 1, 3 and 6 weeks. Anxiety and depression were measured with the Hospital Anxiety and Depression Scale and a 30-item General Health Questionnaire at 6 weeks, 6 months and 12 months, and GPs reported visits and readmissions. At one year the manual group were better adjusted, had seen their GPs less, and fewer had been readmitted in the first six months.

Unrealistic optimism: Weinstein (1980). In Study 1, 258 college students rated their own chances of 42 future events against the average student, on a scale from 100% less than average to 100% more. They rated themselves above average for positive events and below average for negative ones. In Study 2, 120 female students listed factors affecting their own chances of 8 events; when others read these lists, their unrealistic optimism fell but did not disappear.

Why it reaches the top level: both studies, each with sample, procedure, measures and results.

(b) Objective and subjective data (the named issue). Lewin's GP visits and hospital readmissions are objective: they are records, not the patients' opinions, so they cannot be distorted by wanting to look well. But the anxiety and depression scales are self-reports, so subjective; patients given a manual may have reported feeling better because they expected to. Weinstein's data were entirely subjective: students' guesses about their own chances. That is the point of the study, since it measures beliefs, but the study can't show their real risk, so we cannot be sure every student was unrealistic; some may genuinely be healthier than average.

Generalisations. Lewin studied heart attack patients, so the findings may not apply to other illnesses; Weinstein used students from one US university, and in Study 2 only women, so older people, who have seen illness among friends, may be less optimistic.

Individual and situational explanations. Lewin's manual is situational: the information changed recovery; yet patients' own motivation to use it is individual. Weinstein's bias is individual, a way of thinking; but culture may play a part, since easy access to good medical care can make people feel safe.

Application. Lewin's manual is a cheap way to support patients at home. Weinstein suggests health messages should show people that others have the same protective factors, which reduced optimism in Study 2.

Ethics. Lewin obtained consent and caused no harm, though the control group did not get the manual during the study; Weinstein's questionnaire carried little risk.

Overall, providing information has stronger objective evidence of changing health, while unrealistic optimism research explains why information is sometimes ignored, so the two are best used together.

Why it reaches the top level: the named issue first, applied to both studies with detail; several further issues explained with examples and contrasts; a reasoned judgement.

Common mistakes

- **Saying strong fear worked best** in Janis and Feshbach; it was **minimal** fear (March 2025 report).

- **Describing a positive psychology study** when fear arousal and providing information were asked (March 2025 report).
- **Fox et al.:** saying the employer **took away** tokens after an injury (workers simply did not gain them), describing it as promoting exercise or healthy eating, or calling it a **snapshot** (it ran for years) (June 2023 and November 2022 reports).
- **Answering a different question:** giving a strength of Fox et al. such as generalisability when a strength of **longitudinal research** was asked (November 2022 report).
- **Longitudinal evaluation that only states how long** each study lasted, with nothing evaluative (June 2023 report).
- **Ethics points that don't fit:** criticising consent or harm to the control group in Shoshani and Steinmetz, when consent was obtained and the control school got the lessons later (March 2026 report).
- **Weinstein described too briefly**, or with made-up examples instead of the study's findings; not knowing the 42 events or the scale (June 2022 and March 2021 reports).
- **Suggestions not linked to the topic:** "I would use an interview" earns 1; a question about unrealistic optimism earns the second mark (March 2021 report).
- **Conclusions that are summaries** in "discuss" questions (March 2021 report).
- **Plans ignoring the brief:** no case study when a case study was asked, or fear arousal when providing information was named (November 2022 report).
- **Anecdotal answers** about how schools or workplaces might encourage health, with no psychology (June 2023 report).
- **Vague recall:** "self-esteem" for the RSE, "young children" for a sample, "a mix of males and females" for Shoshani and Steinmetz all score 0 (2024 and 2025 mark schemes).

How to get the marks

- **"Identify":** one exact term or figure each: "aged 11.8 to 14.7", "absence".
- **"Outline", "describe":** the idea plus a detail or example; for a study, sample, procedure, measures and results, with numbers.
- **"Suggest"** in a scenario: a technique from the topic, **how** it would be done, and the person's own details; fit the age and the exact aim, and keep it ethical.
- **"Explain" a strength or weakness:** the point (1), then why it matters for this study or scenario (1).
- **Essays:** (a) every part named; (b) the named issue first, applied to each study, then other issues, each with context and analysis, then a judgement.
- **"Discuss ... include a conclusion"** and **"to what extent":** both sides tied to the question, then a decision reached by reasoning.
- **Plans:** the named method and features; knowledge from this topic that you actually **use**; reasons tied to your own plan.
- **Debates:** define **both** sides; then apply with a health promotion example, not just a definition.

Quick check

1. In Janis and Feshbach (1953), how many students were in each of the four groups, and by how many percentage points did the minimal fear group beat the strong fear group?
2. Which focus of positive psychology does each show? (a) Mei spends Saturdays helping at an animal shelter. (b) Jon looks forward to his favourite breakfast every morning.
3. In Shoshani and Steinmetz (2014), 537 of the 1038 students with complete data were in the intervention school. What percentage is that, to 1 decimal place?
4. In Tapper et al.'s nursery study, fruit eaten at snack time rose from 30% to 71%, and was 79% at the 15-month follow-up. What was the rise during the programme, and the total rise by the follow-up, in percentage points?
5. Give one reason why a wait-list control group is more ethical than an ordinary control group.

Answers

1. $200 \div 4 = 50$ in each group; $36 - 8 = 28$ percentage points.
2. (a) The **meaningful life** (serving others). (b) The **pleasant life** (a daily pleasure).
3. $\frac{537}{1038} \times 100 = 51.7\%$.
4. $71 - 30 = 41$ percentage points during the programme; $79 - 30 = 49$ by the follow-up.
5. The control group are not denied the benefit: they get the programme **later**, once the study has its comparison data.

Past questions to try

- **9990/42/O/N/24 Q5**: outlining the RSE and the General Self-Efficacy Scale, another strategy for school mental health, four-point scales.
- **9990/33/O/N/24 Q9**: cutting a class's unhealthy food.
- **9990/32/F/M/24 Q11**: ethical fear arousal for hand washing, and a practical problem.
- **9990/32/M/J/24 Q11**: the pleasant and meaningful life for two daughters, and why positive psychology might not help.