

Cognitive Psychology

PSYC230

Lecture # 13

Last Time

Two different theories concerning the type of information stored in semantic knowledge

Imagery Theory

Images contain *analogue* information & spatial relations: colour, size, sound

Really just a part of:

Dual-code Theory

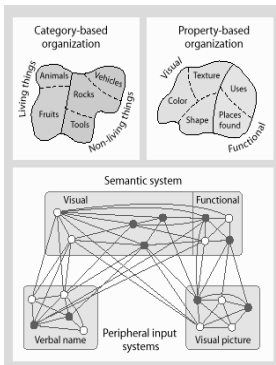
Both *Imaginal* and *Verbal* codes are used

Propositional Theory

Propositions are abstract, non-linguistic, “mentalese” that express a relationship between concepts

e.g., teaches (Sam, psychology)

Two different hypotheses concerning the organization of semantic knowledge & why category deficits occur



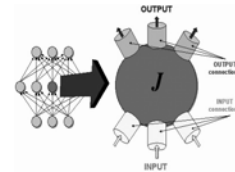
Things may be represented in several ways, depending on our experience with them

Our representations of facts encompass multiple dimensions and are distributed (and linked) accordingly

Connectionist/PDP Models

neural networks -- information is distributed across multiple layers & processed in parallel

content addressable memory
graceful degradation
default assignment
generalisation



Production System Models

knowledge represented a set of procedures and if-then rules about the world

Newell & Simon (1972): used production rules
IF-THEN relationships

IF a particular condition is met
THEN a specific action will be performed

organised into hierarchical routines & subroutines comprising a production system

Expert systems

MYCIN - diagnosis of bacterial infections
using blood & glucose test results

Based on IF-THEN statements (productions)
500 rules can handle 100 different infections
In some cases can suggest treatment

How do we know what someone's mental representation is?

Knowledge extraction

Protocol analysis - overtly describe the steps while performing a task

Protocol analysis allows researchers to identify the procedures and rules used by experts

Ericsson & Simon (1984)

Usually identifies a series of steps (script) – procedures or goals and rules – production system

Some of their expertise
(particularly procedural scripts)
is *Implicit Knowledge*: surgery example

Weak AI -- building intelligent systems that produce intelligent outputs (like humans), even though the processes may be quite different

Pathfinder

How similar are:

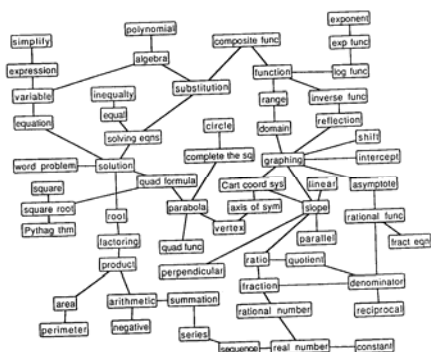
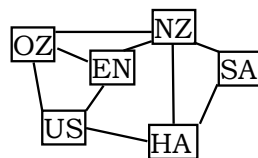
	1	6
	very similar	very different

New Zealand & Australia
New Zealand & USA
New Zealand & Hawaii
New Zealand & England
New Zealand & Samoa
Australia & USA
Australia & Hawaii
Australia & England

		NZ	OZ	US	HA	EN	SA
proximity matrix (hard to visualise)	NZ	0	3	5	4	2	2
	OZ	3	0	3	4	3	6
	US	5	3	0	3	5	6
	HA	4	4	3	0	5	3
	EN	2	3	3	5	0	5
	SA	2	6	6	3	5	0

proximity
matrix
(hard to visualise)

pathfinder
network



Expert's representation of 60 concepts from algebra
(Expert's & novices' representations are quite different)

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graph TD
    MULTIPLIER --- OVEREXERTION
    MULTIPLIER --- INFECTION
    MULTIPLIER --- PAIN
    MULTIPLIER --- DEPRESSION
    MULTIPLIER --- ATTENTION
    MULTIPLIER --- WEAKNESS
    MULTIPLIER --- MUSCLE
    MULTIPLIER --- MEMORY
    MULTIPLIER --- HEADACHES
    MULTIPLIER --- ALLERGY
    MULTIPLIER --- BREATHING
    MULTIPLIER --- GASTROINT
    MULTIPLIER --- NAUSEA
    MULTIPLIER --- SLEEP
    MULTIPLIER --- ANXIETY
    MULTIPLIER --- PALPITATIONS
    MULTIPLIER --- DISCOMFORT
    MULTIPLIER --- NEUROLOGIC
    MULTIPLIER --- FATIGUE
    MULTIPLIER --- SEXUAL
  
```

```

graph TD
    WEAKNESS --> MUSCLE
    MUSCLE --> PAIN
    PAIN --> OVEREXERTION
    OVEREXERTION --> FATIGUE
    FATIGUE --> ANXIETY
    FATIGUE --> SLEEP
    ANXIETY --> DISCOMFORT
    SLEEP --> ALLERGY
    SLEEP --> DEPRESSION
    DISCOMFORT --> SEXUAL
    DEPRESSION --> ATTENTION
    DEPRESSION --> HEADACHES
    ATTENTION --> NEUROLOGIC
    HEADACHES --> INFECTION
    INFECTION --> NAUSEA
    NAUSEA --> DIARRHEA
    DIARRHEA --> GASTROINT
    ALLERGY --> EMOTIONAL
    ALLERGY --> BREATHING
    EMOTIONAL --> MULTICHER
    BREATHING --> HEART_LUNG[HEART/LUNG]
    BREATHING --> PALPITATIONS
  
```

PFNet of symptoms associated with multiple chemical sensitivity (MCS), from asthma patients

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graph TD
    MEMORY[MEMORY] --- ATTENTION[ATTENTION]
    MEMORY --- FATIGUE[FATIGUE]
    ATTENTION --- EMOTIONAL[EMOTIONAL]
    ATTENTION --- OVEREXERTION[OVEREXERTION]
    EMOTIONAL --- DEPRESSION[DEPRESSION]
    EMOTIONAL --- SLEEP[SLEEP]
    EMOTIONAL --- ANXIETY[ANXIETY]
    OVEREXERTION --- BREATHING[BREATHING]
    OVEREXERTION --- HEARTLUNG[HEARTLUNG]
    OVEREXERTION --- MUSCLE[MUSCLE]
    DEPRESSION --- SEXUAL[SEXUAL]
    DEPRESSION --- DISCOMFORT[DISCOMFORT]
    SLEEP --- DISCOMFORT
    SLEEP --- HEADACHES[HEADACHES]
    ANXIETY --- HEADACHES
    ANXIETY --- ALLERGY[ALLERGY]
    BREATHING --- ALLERGY
    BREATHING --- HEARTLUNG
    HEARTLUNG --- PALPITATIONS[PALPITATIONS]
    MUSCLE --- MULTI_CHEM[MULTI CHEM]
    MUSCLE --- WEAKNESS[WEAKNESS]
    DISCOMFORT --- INFECTION[INFECTION]
    DISCOMFORT --- MULTI_CHEM
    HEADACHES --- INFECTION
    HEADACHES --- MULTI_CHEM
    ALLERGY --- MULTI_CHEM
    ALLERGY --- WEAKNESS
    MULTI_CHEM --- INFECTION
    MULTI_CHEM --- WEAKNESS
    INFECTION --- NAUSEA[NAUSEA]
    INFECTION --- PAIN[PAIN]
    INFECTION --- GASTROINT[GASTROINT]
    GASTROINT --- DIARRHEA[DIARRHEA]
    WEAKNESS --- MULTI_CHEM
    WEAKNESS --- INFECTION
  
```

25 Authors Co-cited with Plato

2D Multi-dimensional scaling (MDS) map

The MDS map displays the following authors (approximate coordinates):

Author	X (approx.)	Y (approx.)
diogenes-laerti	0.8	1.4
vergil	0.8	0.9
ovid	0.8	0.8
plutarch	0.8	0.7
augustine	-0.8	0.8
cicero	-0.2	0.5
bible	-0.5	0.4
aristophanes	0.5	0.3
herodotus	1.0	0.2
aristotle	-0.2	0.1
plato	-0.1	0.0
hesiod	0.8	0.0
kant-i	-2.2	0.1
hegel-gwf	-2.2	-0.4
derrida-j	-1.8	-0.5
heidegger-m	-2.2	-0.7
nietzsche-f	-1.5	-0.9
homer	0.5	-0.2
euripides	1.0	-0.3
pindar	0.5	-0.6
thucydides	1.2	-0.6
aeschylus	1.0	-0.8
sophocles	0.8	-0.9

```

graph TD
    Aeschylus --- Sophocles
    Aeschylus --- Euripides
    Euripides --- Pindar
    Euripides --- Hesiod
    Hesiod --- Euripides
    Augustine --- Bibble
    Bibble --- Plato
    Plato --- Aristophanes
    Plato --- Aristotle
    Plato --- Biogenes-Laertius
    Plato --- Homer
    Aristotle --- Kenophon
    Aristotle --- Cicero
    Aristotle --- Aquinas-I
    Aristotle --- Kant-I
    Cicero --- Flutarch
    Cicero --- Dvid
    Flutarch --- Thucydides
    Flutarch --- Herodotus
    Kant-I --- Hegel-GW
    Kant-I --- Heidegger-M
    Heidegger-M --- Deirida-I
    Deirida-I --- Nietzsche-I
    Vergil --- Dvid
  
```

New Topic

Decision making

William James

“There is no more miserable human being than one in whom nothing is habitual but indecision, and for whom the lighting of every cigar, the drinking of every cup, the time of rising and going to bed every day, and the beginning of every bit of work, are subjects of express volitional deliberation” (1890)

A black and white portrait of William James, a man with a full beard and mustache, wearing a suit and tie. He is looking slightly to the left of the camera.

Characteristics of decision making

- 1) Must select one choice from a number of choices
- 2) There is some information available about the choices
- 3) Time frame for choosing is long (longer than 1 sec)
- 4) There is uncertainty as to which is the best choice

Examples of decision making

Fire fighting
Consumer behaviour
Jury deliberations
Medical diagnosis
Aircraft flight judgements (pilots & ATCs)
Electrical & mechanical fault diagnosis
Process control
Allocation of resources
Use of safety equipment

Decision making

Normative (Rational) Models

Expected Value Theory
Subjective Utility Theory

Descriptive Decision Models

Framing Effects
Recognition-Primed Decision Making (RPD)

The SRK Model

Heuristics & Biases

Reasoning & Logic

Inductive & Deductive Reasoning

Classical Decision Theory

Normative (rational) models

Expected value theory

“economic man & woman” base decisions on utility
maximise the expected value (payoff)

$$E(v) = \sum_{i=1}^n p(i) v(i)$$

the sum of the value of each outcome multiplied by its probability

Your choice:

A 20% chance of winning \$50 $E(v) = .2 * \$50 = \10

A 60% chance of winning \$20 $E(v) = .6 * \$20 = \12

Basic Steps In Rational Decision Making

1. Identify all possible options (including doing nothing).
2. Quantify the value (or cost) of consequences of each decision.
3. Assess the likelihood of each consequence actually happening.
4. Integrate across all possibilities.

A real-life example

An anesthesiology team in a large hospital consisted of four physicians, three of whom were residents in training. The group was asked to assist with four procedures in one building (in vitro fertilisation, perforated viscus, reconstruction of a leg artery, & appendectomy) and an exploratory laparotomy in another building. All the procedures were urgent and could not be delayed for regular operating-room scheduling. There were several delays in preoperative preparation and several surgeons and nurses were pressuring the team to get the procedures finished. The situation was complicated by the fact that the staff was only able to run two operating rooms simultaneously and the best use of resources was to overlap procedures so that one case was started as another was finishing. The anesthesiologist in charge had to decide how to allocate the four team members to the five needed procedures. Also there was always the possibility that a major emergency case would come into the trauma centre in which case the anesthesiologist in charge was expected to be immediately available. The decision was relatively simple: should she allocate only the other three anesthesiologists to the five procedures or should she help out also, leaving no one available in case of an unexpected major emergency?

Apply the classical approach to the anaesthesiologist problem

Choices/possible outcomes	Probability	Utility	Expected value
-10 to +10			
Use three anaesthesiologists			
No emergency:	.80	-4	-3.2
Emergency arrives:	.20	10	2.0
		$E(v) = -1.2$	
Use four anaesthesiologists			
No emergency:	.80	6	4.8
Emergency arrives:	.20	-10	-2.0
		$E(v) = 2.8$	

Do you agree with this choice?

Different outcomes have different values for different people

*Is that how people really
make decisions?*

Quantifying cost and value, and computing costs and benefits for all options is cognitively demanding.

Expected value doesn't take into account less tangible personal things like stylish, popular, or respected "subjective utility".

Expected Value Theory was replaced by
Subjective Utility Theory

Subjective utility = individual judgements of value

Job A = .5 chance of a 20% raise in salary in 1st year,
travel required, paid holidays

Job B = .8 chance of a 10% raise in salary in 1st year,
dental care, health insurance, vacation time

Subjective probability = individual estimates of the
likelihood of outcomes

*Still a Normative (rational) approach
that assumes people consider all the alternatives*

Descriptive Decision Models

People frequently make irrational decisions
(violate the normative assumptions)

The Framing effect

(Tversky & Kahneman, 1986)

Physicians & patients make different decisions
depending on whether the choice was worded in
terms of *lives saved* or *lives lost*

Slight changes in wording the question
(the problem frame) result in different decisions

The Framing effect

A disease is expected to kill 600 people
you must choose between two
possible treatment programmes

Treatment 1: Will save 200 lives

Treatment 2: 33% chance that 600 lives will
be saved, 67% chance that no
lives will be saved

Treatment 1: 400 people will die

Treatment 2: 33% chance that no one will die,
67% chance that 600 will die

Slight changes in wording the question result
in much different decisions

The Sunk Cost Effect

Throwing good money after bad

Money and effort you've already
spent (futilely) shouldn't affect your decision
about what to do next – but it does.

Pay \$12 to see a movie
WORST movie you've ever seen
Do you get up and walk out?
Or do you stay and *get your money's worth*?

The Sunk Cost Effect

**You're driving from the ski fields back
home to Hamilton. It is late at night, and
you are having real difficulties staying
awake. But you're nearly home now.
Do you keep driving?**

Sunk costs are irrelevant to current decisions-
instead, only incremental costs should influence
future decisions.

Sunk costs have already been paid- you can't get
that cost back.

Descriptive Decision Models

People frequently make irrational decisions
(violate the normative assumptions)

Satisficing

(bounded rationality)

Herb Simon

People don't make the absolutely best decisions
they make decisions that are *good enough*

You want to buy a used car,
you decide on the features you want,
you decide what you are willing to pay

I want a sporty car, fun to drive....
and its got to look good – a red one would be great
I want it to have a good sound system,
and I've got that \$3,000 coming in next month

and so you start visiting car lots & reading ads

When you find a car that meets your criteria,
you buy it

Without visiting every car lot or considering
every car available

People take shortcuts in making decisions
based on their past experiences

Heuristics & Biases

Heuristics used in obtaining information

Heuristics used in considering alternatives

Heuristics used in selecting actions

Questions ?