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8 Psychological perspectives for health and social care

logy is a science devoted to the study of the mind and behaviour. are different 'schools' of psychology, which have grown up different ways of understanding the mind and behaviour, called ctives. A perspective is a point of view or a way of considering rtain ideas can be linked together and their relative importance.

iit you will be introduced to several of these psychological perspectives and ged not only to understand them but also to apply them to a work setting. its merits but no one perspective can explain all behaviour. For example, the l perspective explains behaviour in terms of brain and bodily functions, such luence of brain chemicals and hormones. By contrast, the psychodynamic ve sees behaviour as originating in early childhood experiences and otivated by unconscious forces. You will therefore be encouraged to think about the strengths and weaknesses of each one, and to use more than one ve to explain different types of behaviour in individuals.

Learning outcomes

After completing this unit you should be able to:

1 understand psychological approaches
2 understand psychological approaches to health and social care.

1 Understand psychological approaches to study

Get started

What kind of psychologist are you?

Consider the following scenario and discuss reasons for Aisha's behaviour.

Five-year-old Aisha's parents divorced a year ago. Today her dad is taking her out for the day. He arrives at the house to find his ex-wife flustered and upset because her new baby has been up all night and Aisha has refused to wear the clothes she laid out for her. The trip starts with a visit to McDonald's, with a breakfast of chicken nuggets, chips and Coke. Aisha throws a tantrum when they leave because she wanted ice-cream and her dad refused so he promised she could have a packet of Smarties in the car if she behaved well. Her mum has specifically asked him not to give her Smarties because they are so sweet and sugary. Towards the end of the day, Aisha's dad needs to get some food from the supermarket and once again Aisha throws a tantrum. He tells her if she behaves he will give her some sweets in the car on the way home.

1 Could Aisha's tantrums be in any way linked to her parents' divorce? Make some suggestions about how and why their divorce may influence her behaviour.

2 What would you say to Aisha's dad about giving her Smarties when her mum has asked him not to?

1.1 The behaviourist perspective

In the introduction to this unit it was explained that perspectives in psychology explain behaviour based on a particular set of beliefs and ideas. The key idea of the behaviourist perspective is that we can understand any type of behaviour by looking at what the person has learned. This will include personality traits such as shyness, confidence, optimism or pessimism, as well as more fleeting behaviours such as offering to help with the washing up.

Behaviourist psychologists explain all human behaviour as resulting from experience. Two key thinkers associated with this perspective are Pavlov (classical conditioning) and Skinner (operant conditioning). Although these two theorists believed that different processes were involved, they both explained all types of behaviour as being the result of learning – everything from shyness to aggression, from happiness to depression. This is quite different from, say, the psychodynamic or biological approaches, which are explored later in this unit.

Classical conditioning

The first theory of learning we shall investigate is called classical conditioning. This theory was developed by a Russian physiologist called Ivan Pavlov (1849–1936). He was working with dogs to investigate their digestive systems. The dogs were attached to a harness, as shown opposite, and Pavlov attached monitors to their stomachs and mouths so he could measure the rate of salivation (production of saliva).

He noticed one day that a dog began to salivate when the laboratory assistant entered the room with a bowl of food, but before it had actually tasted the food. Since salivation is a reflex response (which until then was thought to be produced only as a result of food touching the tongue), this seemed unusual. Pavlov speculated that the dog was salivating because it had learned to associate the laboratory assistant with food. He then developed his theory in the following way.

Food automatically led to the response of salivation. Since salivation is an automatic (not learned)

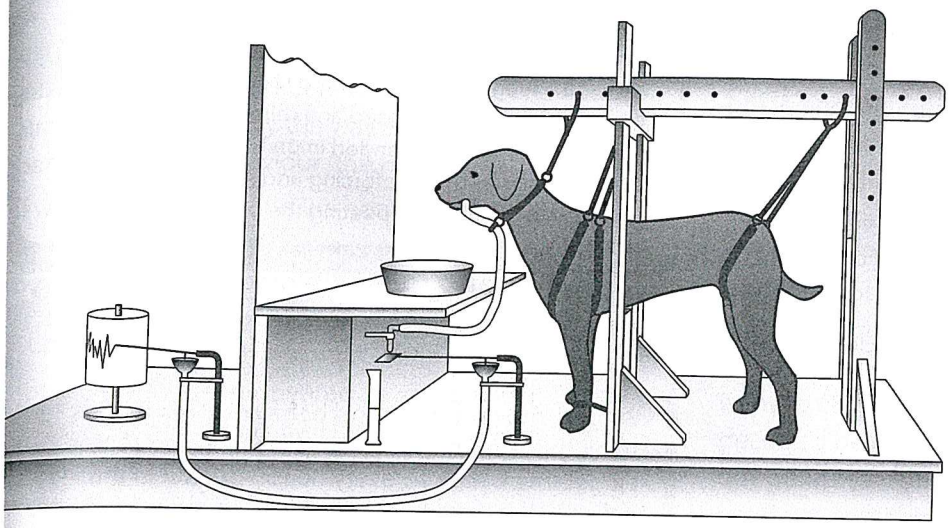


Fig 8.1: The harness used by Pavlov while conducting his conditioning experiments with dogs

esponse, he called this an **unconditioned response** UR). 'Unconditioned' means ' not learned'. As food utomatically leads to this response, he called this an **nconditioned stimulus** (US). Pavlov then presented ood at the same time as ringing a bell (a neutral timulus), to see if the dog would learn to associate ne bell with food. Over several trials the dog learned nat the bell was associated with food and eventually began to salivate when only the bell was rung nd no food was presented. It had thus learned ne **conditioned response** (CR) of salivation to the **onditioned stimulus** (CS) of the bell.

Operant conditioning

his type of learning is associated with the theories Burrhus Frederic Skinner (1904–1990). (For a ller description of the work of Skinner and other behaviourists, consult the book *Learning and Behaviour* by L. Barker – see page 365 for details.) Skinner was an American psychologist who worked mostly with rats and pigeons, to discover some of the key principles of learning new behaviours. He used a very famous device, called a Skinner box, illustrated below. The box contains a lever which, when pressed, releases a food pellet into the box, thus reinforcing lever-pressing behaviour.

When the rat is first placed in the box it will run around, sniff the various items and at some point it will press the lever, releasing a food pellet. After a while, when the rat has repeatedly performed this action, it will learn that this behaviour (pressing the lever) is

Case study: Sandra

Sandra is 25 years old and is due to have an anti tetanus booster. She is absolutely terrified of this and asks her GP to prescribe her a tranquilliser. The doctor is, naturally, reluctant to do so and questions her a bit about why she is so afraid. Sandra reveals that she remembers having an injection when she was seven (she doesn't consciously remember her earlier immunisations), which resulted in her fainting. She has never been able to bear injections since that time.

1 Identify the unconditioned stimulus, unconditioned response, conditioned stimulus and conditioned response in Sandra's case.

2 Do you think this theory explains Sandra's fear well?

Key terms

nconditioned response – A response that regularly occurs hen an unconditioned stimulus is presented, e.g. the startle esponse resulting from a thunderclap.

nconditioned stimulus – A stimulus that regularly and onsistently leads to an automatic (not learned) response om, e,g, a clap of thunder.

onditioned response – A new, learned response to a eviously neutral stimulus that mimics the response to the nconditioned stimulus.

nditioned stimulus – A neutral stimulus that, when paired th the unconditioned stimulus, produces a conditioned arned) response, just as the unconditioned response used

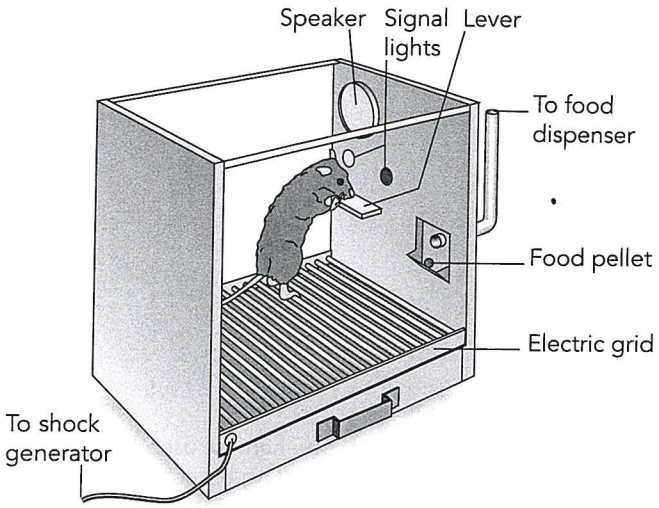


Fig 8.2: A rat in a typical Skinner box

automatically followed by the release of a food pellet (the consequence). Because the pellet is experienced as *reinforcing* (something the rat would like to have more of), this consequence increases the probability of the behaviour being repeated. There are two types of reinforcement: **positive reinforcement** and **negative reinforcement**.

Skinner investigated negative reinforcement by running a very low electrical current on the floor of the Skinner box. The current could be de-activated if the rat pressed the lever. The behaviour of lever pressing was thus negatively reinforcing. For humans, this can be demonstrated by the example of using pain relief. For example, if you have a headache and you take a painkiller, which results in the headache going away, you are negatively reinforced for taking a painkiller.

Punishment occurs when behaviour is followed by a consequence that is experienced as unpleasant. Skinner investigated this by giving the rat a small electric shock when it pressed the lever. The consequence of lever pressing (the electric shock) was experienced as unpleasant, so the rat learned to stop pressing the lever.

Key terms

Positive reinforcement – This happens when the consequence following a particular behaviour is experienced as desirable.

Negative reinforcement – This happens when behaviour results in a consequence that removes something unpleasant.

Reflect

Have you ever worked really hard to finish an assignment and felt pleased and relieved when it was completed and handed in on time? The consequence here is reinforcing and increases the probability of you repeating the behaviour again.

Case study: Sean

Sean is known for his kind behaviour. His friends think this is a bit over the top because he seems to get involved with every needy person in the college. If he is out on the street he almost seems to search out homeless people and gives away more money than he can afford.

One day, in discussion with a group of friends who are curious about his behaviour, he explains that when he was a small child he was out in a shopping precinct with his father, who gave money to a homeless person. His father asked him to give some money out of his pocket money but he refused. The disapproving response from his father was experienced by him as punishing (he felt bad). Next time they were out together, he gave all his pocket money (50p) away and his father praised him.

Ever since that experience, he learned that not being kind made him feel guilty and uncomfortable, whereas being kind led to feelings of pleasure and pride and took away any initial feeling of guilt. He thus felt that the punishment for not being kind was removed by giving money (negative reinforcement). The act of giving in itself had therefore developed his sense of worth and was thus positively reinforcing.

1 **If Sean hadn't felt guilty about refusing to give money, would the consequence have changed his later behaviour?**

2 **Do you think Sean's kindness and generosity can be fully explained in terms of operant conditioning?**

1.2 Social learning theory

The effects of other individuals on behaviour

We do not live in a vacuum and there are many influences on our behaviour – from peers, siblings, parents, television, sports personalities and other celebrities, as any parent of a teenager can tell you!

According to social learning theory, role models are very important. While we may learn new behaviours from anyone, the likelihood of imitating such behaviours is strongly influenced by the way we perceive the person performing the behaviour (the model).

If we observe someone we admire behaving in a particular way, we are more likely to imitate such behaviour. If, for example, a sports personality such as Cristiano Ronaldo is shown on television recommending wearing a cycle helmet, we are much more likely to feel motivated to imitate such behaviour ourselves because this will bring us closer to being like this admired model. On the other hand, if cycle helmet wearing is associated with a model we look down on (e.g. someone we regard as a 'geek') then we are much less likely to imitate it. The diagram below illustrates factors associated with a model that influence whether we will imitate him or her.

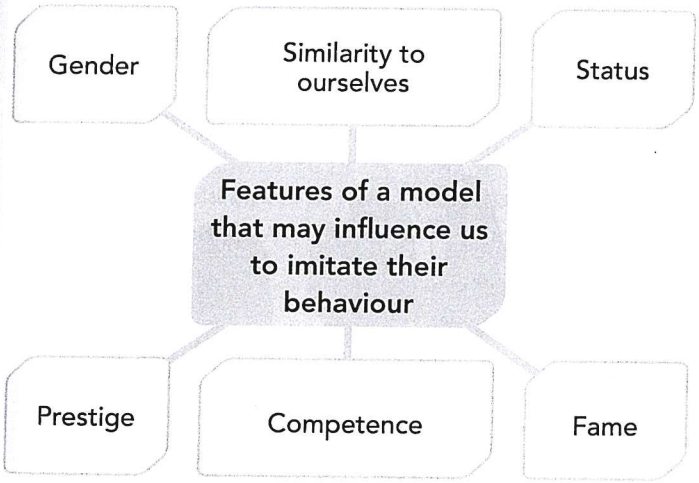


Fig 8.3: Certain attributes of a model make it more likely that their behaviour will be imitated

Activity 1: How much are you influenced by observing others?

Over the course of the next few weeks, make notes on how you personally are influenced by observing the behaviour of another individual. This may be a lecturer, teacher, peer or someone you meet on a work placement. Do you imitate the type of clothing, hairstyle and mannerisms of others in order to 'fit in'?

The effects of groups on behaviour

Our behaviour is dramatically influenced by the presence of others, however much we may believe ourselves to be truly individual in our beliefs and behaviour. Nowhere is this more clearly demonstrated than in the experiments conducted in the 1950s by social psychologist Solomon Asch. He was interested in a concept called **majority influence**. This is when the presence of other people causes us to change our public behaviour or opinions because we do not want to stand out from the crowd. We have a powerful desire to belong and will 'go along' with what others in our group say, think or do in order to fit in. This is what he did to test this idea.

A group of six stooges or confederates of the experimenter (people who were play-acting according to instructions) were joined by a naïve participant (a genuine participant who knew nothing about the nature of the experiment) in a task that supposedly tested visual perception. The experimenter explained that the task involved stating whether a target line shown matched the length of one of a set of three

Key term

Majority influence – A type of influence exerted by groups that is associated with the individual's desire to be accepted. Behaviour, beliefs and views are changed publicly in order to be in line with the norms of a group, although privately they are unchanged.

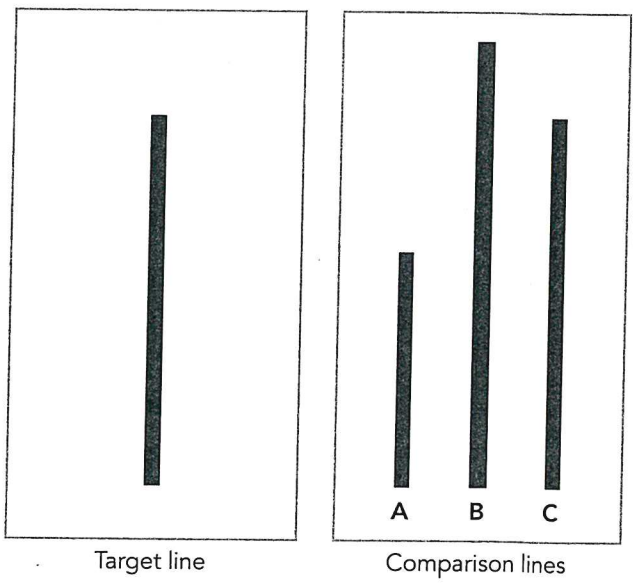


Fig 8.4: The target line and comparison lines used in Asch's experiment

lines (a, b and c) similarly shown to all participants. An example of this task is given in Fig 8.4.

As far as the genuine participant was concerned, all those taking part in the experiment were similarly naïve (i.e. didn't know what was happening and were genuine participants). The group was seated in a horseshoe arrangement, with the naïve participant always last but one to be asked to make a judgement. The procedure began with the first participant stating out loud whether the target line was equal in length to one of the specified comparison lines. The next person in the horseshoe then answered, and so on, right through to the end. This 'perceptual trial' was repeated 18 times but on 12 of the 18 trials the confederates all gave the same wrong answer when the correct answer was obvious. Astonishingly, out of 123 naïve participants, 28 per cent gave an incorrect answer eight or more times. This shows clearly how an individual can be influenced by a group.

The effects of culture and society on behaviour

Culture refers to the shared values, norms, language, customs and practices of a group. Although we tend to think of culture as being specific to different countries, it also refers to different sub-groups within society. For example, people from different socioeconomic groups within the UK will share different aspects of culture, such as the value placed on eating at a table rather than on your lap in front of the television; the way in which money is spent; how to talk to your elders, and so on. It is important to understand how culture affects our behaviour in order to gain a full understanding of the people we encounter and those we work with. Watson (1970) found that the average amount of eye contact made varied between countries, with high degrees of eye contact being seen as insolent by some Africans and East Asians, whereas among Indians and Latin-Americans this was seen as desirable.

Fig 8.5: The participant is always the last but one person to give his or her judgement out loud

e extent to which we value individualism is also avily dependent on culture. Generally speaking, European cultures and the USA, self-reliance, sertiveness and individualism are highly valued its and parents see it as part of their duty to enable ldren to grow up with these characteristics. In ıny Eastern and Asian cultures, by contrast, the ıphasis is on collectivism: the child is socialised out the needs of the group before his or her own eds. Thus, a 40-year-old American male living at me with his parents would perhaps be seen as a ummy's boy' and disparaged as such, whereas in ts of Africa, India and China this would be seen as mal, admirable behaviour and as showing respect parents.

Fig 8.6: The way we think and feel about ourselves influences the way others respond to us

Activity 2: Investigating social and cultural norms

Do you always join a queue at the back and stand n line until you get to the front? Is your language and speech more formal with teachers and people in authority than with friends and family? Think of how your upbringing has influenced your behaviour. Discuss with others whether their experience is the same or different, and think of three more examples of norms that may differ across social and cultural boundaries.

Case study: Ruby

Ruby has just begun her work placement at a residential care home for the elderly, and her supervisor, Janine, is giving her a brief description of the people she will be working with. When describing 85-year-old George, Janine says:

> 'Well, George... What can I say? He's just trouble, from start to finish. He moans and grumbles all the time, annoys the other residents, and is attention-seeking. Lots of people are much worse off than he is, but he causes the most disruption.'

1 What sort of expectations do you think Ruby will have of George?
2 Do you think Janine's negative attitude to George affects his well-being, and if so, how?
3 Do you think it is possible to break the self-fulfilling prophecy?

e self-fulfilling prophecy

is an important concept in psychology that has g impact on the way we behave towards others expect them to behave towards us. If we believe elves to be worthwhile, pleasant and likeable then vill almost certainly be polite and cheerful towards e we meet, thus creating a favourable impression. sponse, those who come into contact with us eive us favourably and behave in a positive way rds us, with the result that our positive self-beliefs onfirmed. If, on the other hand, we are angry, full sentment, believe the world is against us and so nen we are likely to behave in a more aggressive, ontational or argumentative way, in which case s how we will be responded to, which will confirm iews of ourselves and the world. An example of illustrated in Fig. 8.6.

Role theory

There is a similarity between role theory and the self-fulfilling prophecy, in that role theory suggests that, because we live within a particular culture, society and social group, we are influenced by other people. This influence helps lead us to adopt certain roles and try to live up to the expectations that go with this role. For example, a nurse is expected to be level-headed, warm and competent. However, whereas we might expect a surgeon to be similarly level-headed and

competent, we would not necessarily expect him or her to be particularly warm. Since we all take on many different roles, our behaviour will change according to the role we are currently in. A woman visiting the zoo with her children will take on the role of a mother; whereas when she goes to work she may be a colleague, a supervisor or a subordinate and she will adopt the expectations of her job role. Later, if she goes out to a party she may adopt the role of a friend.

Albert Bandura

Social learning theory explains behaviour as the result of learning from people we are exposed to in our environment. We can also learn new behaviours from people we observe, either in real life or in the media. This is known as **observational learning** and this theory was developed by the American psychologist, Albert Bandura.

The person we learn from is known as a **role model**, and the process of imitating is called **modelling**. However, we do not imitate all behaviour we observe and remember. Whether or not it is in our interests to imitate particular behaviour is influenced by characteristics of the model (see Figure 8.3 on p. 341). If we see a model being punished for a certain behaviour, we are less likely to imitate it than if we see him or her being positively reinforced.

Reflect

What features of a model would influence you to imitate that person?

1.3 The psychodynamic approach

This approach is associated with the Austrian psychologist Sigmund Freud (1856–1939), who developed the theory of psychodynamic psychology and the treatment known as psychoanalysis. A key follower of Freud was Erik Erikson (1902–1994), who adapted aspects of Freud's approach.

The importance of the unconscious mind: Sigmund Freud

Freud described the occasion when a Member of Parliament was referring to the MP for Hull, with whom he disagreed about some policy. Instead of saying 'the honourable member from Hull' he started to say, 'the honourable member from Hell'. What do you think caused him to say Hell when he should have said Hull?

Freud was one of the earliest thinkers to bring to public attention the idea that we are not always aware of all aspects of ourselves. He suggested that what we are aware of is represented in our conscious mind but that many of our memories, feelings and past experiences are locked up in a part of our mind he called the 'unconscious'. We cannot access the contents of our unconscious, but they often 'leak out' in dreams and slips of the tongue. Freud believed that the conscious mind was like the tip of an iceberg – only a small part being available to awareness. Part of the unconscious that we can easily access he called the pre-conscious. This contains information not yet in consciousness but that can easily be retrieved (e.g.

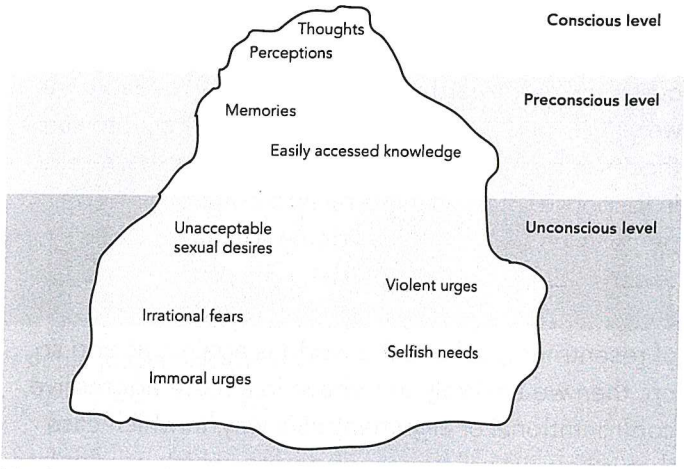


Fig 8.7: According to Freud, the conscious mind represents the 'tip of the iceberg'. Most of our experiences and memories are either pre-conscious or unconscious

Key terms

Observational learning – This occurs when we observe someone behaving in a particular way and we remember this behaviour. We can learn positive and negative behaviours from observing others. For example, we may observe someone going to the aid of a person who collapses.

Role model – An individual who has characteristics that inspire us to copy their behaviour (for example, because they are prestigious, attractive or have high status).

Modelling – The process of basing behaviour, attitude, style of speech or dress on someone we admire or want to be like.

the name of Aunt Edie's cat). The rest, well under the surface, consisted of the unconscious. This is illustrated in Fig 8.7.

The importance of early experiences

The importance of early experience in determining later behaviours is clearly illustrated by Freud's developmental theory of psychosexual stages. He believed that we all go through several stages of psychosexual development. At each stage, the individual's libido (energy) is focused on a part of the body that is particularly relevant at that stage. If the needs of the developing child are met at each stage, it moves on to the next developmental stage. If, however, there is struggle or conflict or some unsatisfactory experience, the individual becomes 'fixated' (stuck) at this stage. This results in certain ways of being, or personality traits, which are carried through into adulthood and which can explain behaviour later in life.

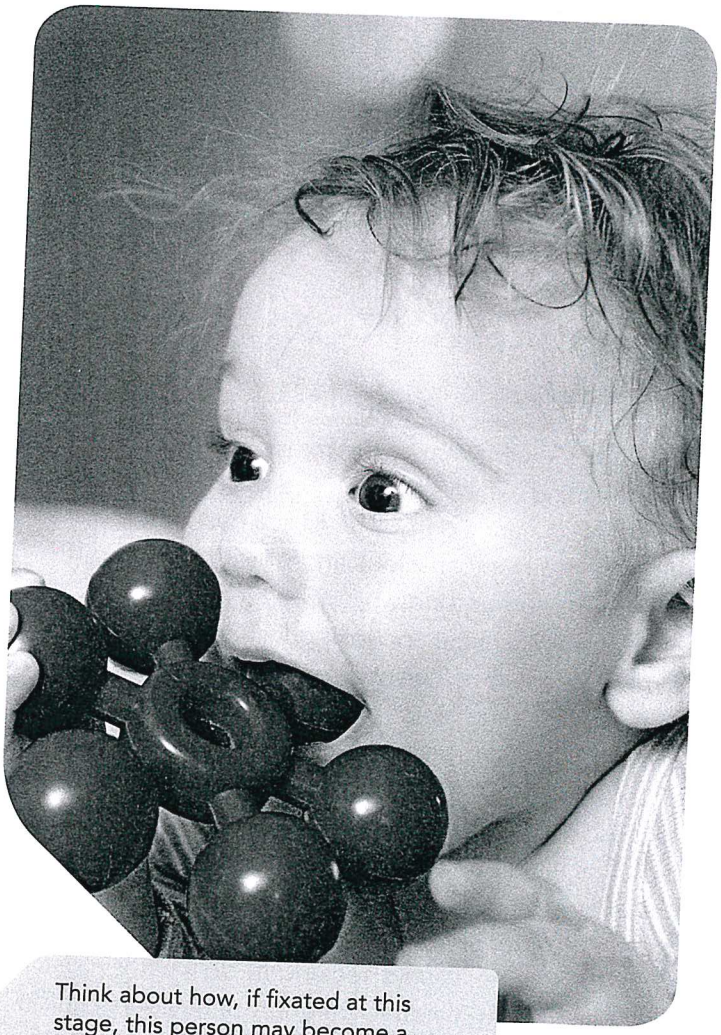
The earliest stage is the 'oral stage'. The focus here is on the mouth and activities such as sucking, biting and licking. (You will probably have noticed that young babies seem to put everything in their mouths.) Freud believed that there could be two reasons for fixation. If the infant was weaned too early, it would feel forever under-gratified and unsatisfied and would develop into a pessimistic, sarcastic person. If, on the other hand, it was over-gratified (weaned too late) the individual would develop a gullible personality, naively trusting in others and with a tendency to 'swallow anything'. This stage lasts from birth to approximately 18 months.

If the infant successfully passes through the oral stage without becoming fixated, the next stage is the 'anal stage', which lasts from approximately one to three years. Here the libido is focused on aspects to do with potty training. If there is a battle with parents about potty training, with the child feeling forced to use the potty before they are ready, or feeling over-controlled in various areas, they may rebel by retaining their faeces: the child refuses to 'go', thus holding on to control and withholding satisfaction from the parent. This type of fixation is called 'anally retentive' and is associated with later personality characteristics such as obstinacy, miserliness and obsessive traits. The alternative scenario is that the child is not given enough boundaries over potty training so they take excessive pleasure in excretion and become a messy, creative, disorganised sort of person.

During the ages of four to five the child passes through the 'phallic stage'. Fixation at this stage is associated with anxiety and guilty feelings about sex and fear of castration for males. If this stage is not resolved, the theory suggests that a boy may become homosexual and a girl may become a lesbian. Freud thought these were abnormal fixations; however most people today would not view them in this way.

Between the ages of five to seven and the onset of puberty, the child enters the 'latency stage', which is not strictly speaking a developmental phase but a time when the focus is on social pursuits such as sport, academic excellence and the development of friendships.

The final psychosexual stage is the 'genital stage', which begins at puberty. Freud believed that the less fixated the individual has become during the earlier



Think about how, if fixated at this stage, this person may become a smoker in later life.

stages, the more easily this stage will be negotiated, resulting in the ability to form strong heterosexual relationships with an ability to be warm and loving as well as to receive love in a new, mature fashion.

A second important feature of early experience is the development of **ego** defence mechanisms. The use of a defence mechanism allows us to block out events that threaten to overwhelm us. Examples of these are given below.

Table 8.1: Examples of defence mechanisms

Name of defence mechanism	Explanation	Example
Repression	The person forgets the event	Forgetting a traumatic event in childhood (e.g. a car crash)
Regression	Reverting to an earlier stage of development	Wetting the bed when a sibling is born, having been dry before
Denial	Pushing an event or emotion out of consciousness	Denying that a loved one has died
Displacement	Redirecting desires onto a safe object	Kicking the cat at home because your boss gave you a hard time at work

A final influence is that of the mind. Freud suggested that the mind (which he called the **psyche**) is divided into three dynamic parts. The **id** is a part of the mind which is totally unconscious and which exists at birth. It is focused on getting what it wants and consists of aggressive, sexual and loving instincts. It is the part of us that says 'I want it now!' The **superego** is formed as a result of socialisation and consists of all the instructions, morals and values that are repeatedly enforced as we are growing up. It takes on the form of a conscience and also represents our view of our ideal self. The main role of the superego is to try to subdue the activity of the id. The ego tries to balance the demands of the id and the superego. It is the rational part of the mind, always seeking to do what is most helpful for the individual. Different behaviours can be understood by trying to infer which part of the psyche is dominant at any time.

Key terms

Ego – The part of the mind whose function it is to moderate the demands of the id and prevent the superego being too harsh. It operates on the reality principle.

Id – Part of the psyche we are born with. It operates on the pleasure principle.

Psyche – The structure of the mind, consisting of three dynamic parts.

Superego – Roughly equivalent to a conscience, the superego consists of an internalisation of all the values of right and wrong we have been socialised to believe in. It also contains an image of our ideal self.

A person who is very submissive, guilty and always wanting to please may have a very strong superego.

A person who is impulsive, careless of other people's feelings, doesn't think through the consequences of their actions and is perhaps inclined to aggression, either verbal or physical, probably has a dominant id.

A person who can be submissive and assertive when necessary, who is able to think about other people's feelings but also consider and value their own needs, has probably got a strong enough ego to balance the demands of the id and the superego. They are likely to have quite a rational and realistic outlook on life.

Erik Erikson

Erik Erikson was a psychologist who agreed with much of Freud's theory in so far as he thought that we developed through a series of stages. However, he thought that these continued throughout our lifetime and were essentially social in nature. He also believed that Freud put too much emphasis on our desire for individual gratification and not enough on our need to be accepted by society and lead a meaningful life. Erikson suggested that we move through a series of psychosocial crises with a different social focus at each stage. For example between birth and the age of one, the life crisis concerns developing trust or mistrust in self and others. The social focus at this stage is the mother.

Reflect

Identify which stage you are in, as outlined by Erikson. As you work through the following section, make notes on whether you think he is correct in his explanation of this stage. Is there anything you disagree with?

PLTS

Creative thinker: By questioning Erikson's theory and generating your own ideas, you are developing your creative thinking skills.

Key terms

Trust – A sense of hope and faith in others.

Autonomy – Faith in one's ability to influence the environment through one's own actions.

Doubt – Lack of self-belief; a sense of shame associated with failure.

Initiative – A sense of purpose and belief in one's abilities to pursue appropriate goals.

Guilt – The result of trying to follow goals that conflict with those of family members.

Industry – An application of skills and abilities to projects in the world, including at school.

Inferiority – A sense of being a failure.

Identity – A consistent sense of sameness, associated with occupational choice and social roles.

Role confusion – The inability to find a social role; indecision about occupational choice and the lack of a continuous sense of self.

Case study: Word association

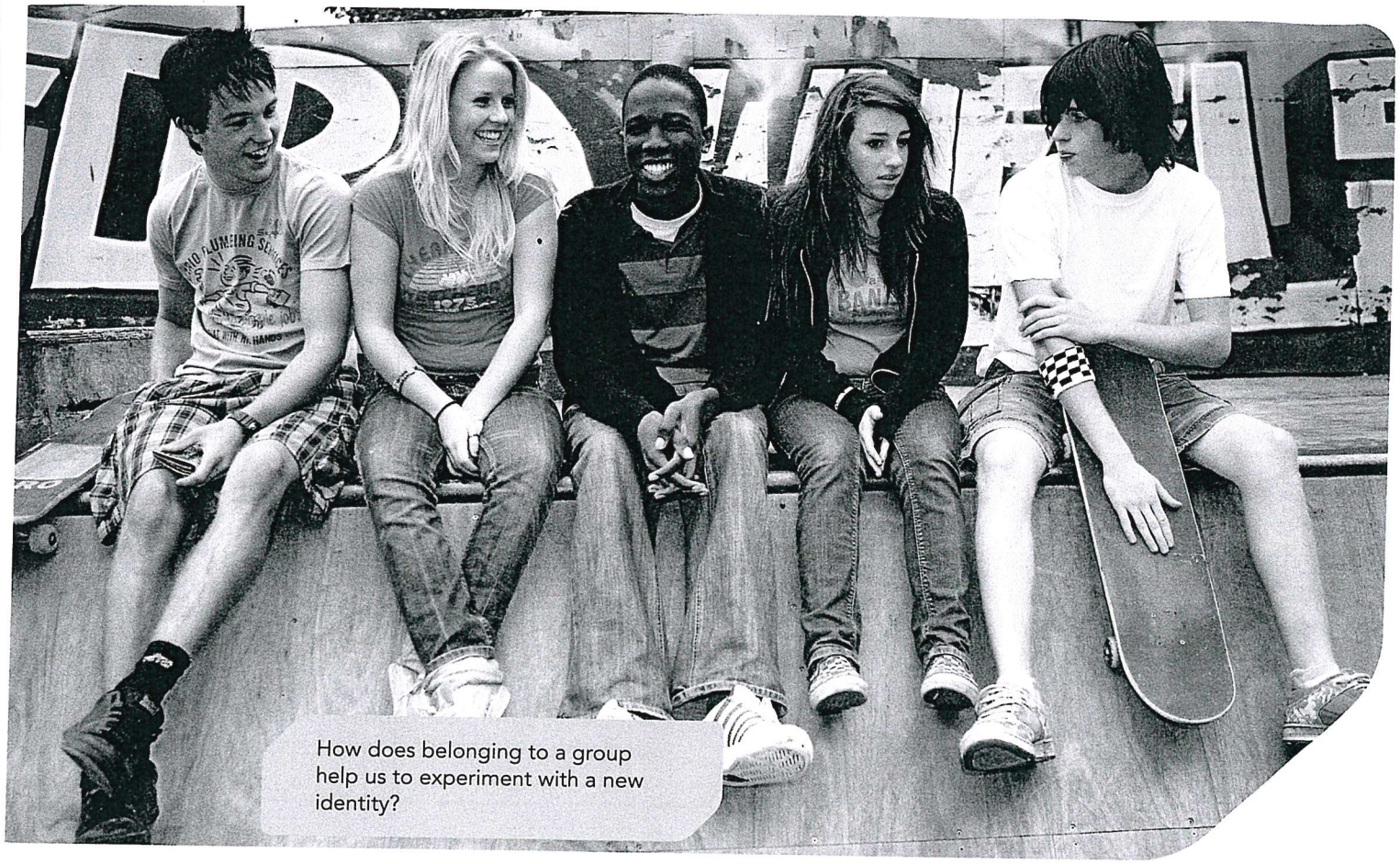
One method used by Freud to access the contents of the unconscious is known as word association. He would say a word and the patient would respond with the first word that came to mind. The speed of response and lack of conscious editing produced some curious responses. One example was a man who replied 'shroud' in response to the word 'white'. Upon further probing, Freud uncovered his client's fear that he would soon die from heart failure and be covered with a shroud. It emerged that a relative of this man had died at the age he now was, as a result of heart failure. The patient, being overweight himself, had developed a deep fear of dying at this same age but had buried the fear in his unconscious.

1 Do you agree that much of what motivates our behaviour is, indeed, unconscious? Can you think of examples?

2 Can making the contents of the unconscious accessible to the conscious mind really help us deal with our innermost fears? How and why?

Table 8.2: Psychosocial stages

Stage	Key focus of stage	Positive outcome	Negative outcome
Stage 1 (0–1 year)	How the infant is parented	Dependable, responsive, caring parenting leads to a sense of **trust**	Parenting that lacks warmth and affection or is inconsistent leads to mistrust
Stage 2 (1–3 years)	Being enabled to do things by yourself	Being supported in growing independence leads to a sense of **autonomy**	Being criticised and over-controlled leads to a feeling of **doubt** about your own competence
Stage 3 (3–6 years)	Interaction with the world	Being encouraged to try out new skills and explore the world leads to a sense of **initiative**	Being hampered in the desire to find things out (e.g. criticised, told not to be silly) leads to a sense of **guilt** and a lack of confidence
Stage 4 (6–12 years)	Understanding how things are made and how they work	The ability to succeed at realistic tasks leads to a sense of **industry**	Being pushed to take on tasks they are not ready for leads to a sense of **inferiority**
Stage 5 (12–18 years)	Developing a consistent sense of identity by experimentation	Experimentation leads to a secure sense of **identity**	The inability to experiment and develop a sense of identity leads to **role confusion** and a negative identity



How does belonging to a group help us to experiment with a new identity?

1.4 The humanistic perspective

Humanistic psychology looks at human experience from the viewpoint of the individual. It focuses on the idea of free will and the belief that we are all capable of making choices. Two psychologists associated with this approach are Abraham Maslow and Carl Rogers.

Abraham Maslow

Maslow (1908–1970) was an American psychologist who believed that we are all seeking to become the best that we can possibly be – spiritually, physically, emotionally and intellectually. He called this **self-actualisation**. He constructed a theory known as the hierarchy of needs, in which he explained that every human being requires certain basic needs to be met before they can approach the next level. This hierarchy of needs is shown in Fig 8.8.

Key term

Self-actualisation – An innate tendency we all possess as human beings to become the best that we can be in all aspects of personality and intellectual, social and emotional life.

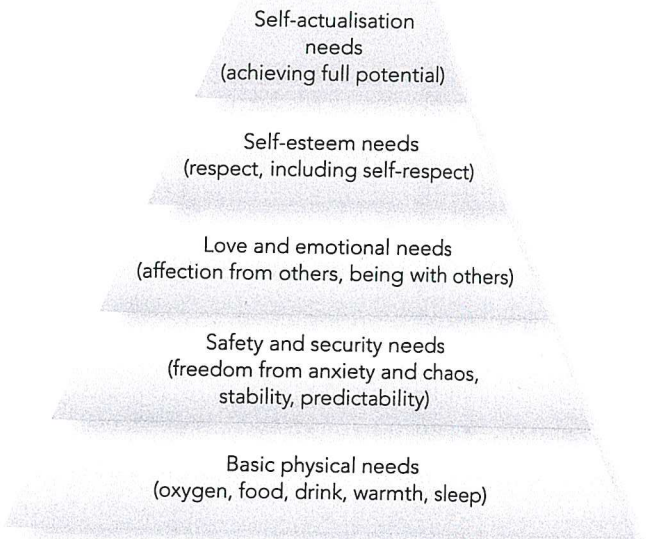


Fig 8.8: Maslow's hierarchy of needs – according to Maslow, we need to progress through each level before we can reach self-actualisation

as the diagram shows, Maslow believed that, until ur basic physiological needs are met, we will focus ll our energies on getting them met and not be able progress further. When we are well-housed, well- d and comfortable physically, we begin to focus n our emotional needs, such as the need to belong nd be loved and to feel **self-esteem**. When our lives e such that these needs are also met, we strive self-actualise. As Maslow said, 'A musician must ake music, an artist must paint, a poet must write, ne is to be ultimately at peace with himself. What a an can be, he must be. This need we may call self- tualisation.'

Case study: Amina

This case study shows how the hierarchy of needs can be applied to the case of an asylum seeker.

Amina is a refugee from Somalia. She arrived in the UK at the age of 16, having been given a place on a lorry after both her parents were killed. When she reached the UK she applied for asylum. She was housed in temporary accommodation for the first 18 months and was then granted leave to remain and given a bedsit. She is being supervised by a multi-disciplinary team, including Helen, an outreach worker from Connexions. Helen is due to visit her to assess her needs, and suggest an educational route that could enable Amina to gain qualifications, so she can eventually support herself. Helen's supervisor advises her to familiarise herself with Maslow's hierarchy of needs before she meets Amina for the first time.

At what stage of Maslow's hierarchy of needs was Amina when she first arrived in England?

What needs may she satisfy by entering education?

Suggest some questions Helen might ask in order to find out whether or not Amina is yet ready to benefit from education.

Rogers

(1902–1987) was particularly interested in the t of self. There are many aspects of the self but especially important here. **Self-concept** refers to we view ourselves. This includes physical and cal attributes such as being male or female, blonde or brunette, tall or short, as well as personality traits such as being kind, humble, assertive, hard-working. The self-concept is formed from an early age and young children **internalise** other people's judgements of them, which then become part of their self-concept. If a child is told they are silly, naughty and will come to no good, part of their self-concept will contain these aspects. If, on the other hand, a child is praised, encouraged to succeed and told they are valued, they will have a positive self-concept and see themselves as someone who is worthwhile and competent.

Key terms

Self-esteem – How valuable we feel; literally, the amount of esteem we give to ourselves. Someone with high self-esteem will believe they are loved and lovable and that they are important and valued. By contrast, an individual with low self-esteem may feel themselves to be worthless, of no value to anyone else, unloved and unlovable.

Self-concept – The way we see ourselves. In early life this comes from what we are told about ourselves (e.g. 'you're so pretty', 'you're a good footballer', 'what a kind girl you are'). As we grow older, our ability to think about ourselves develops and we begin to incorporate our own judgements (e.g. 'I did well at that test – I'm good at maths', 'I wasn't invited to that party – I must be unpopular').

Internalise – This is to do with the way we take in information from the outside world and build it into our sense of self. It then becomes part of our feelings, thoughts and beliefs about who we are and what we expect from the world around us.

Activity 3: Investigating your own self-concept

Write down 20 statements about yourself. How many of these are positive and how many negative?

Consider the influences there have been on your self-esteem. How much praise/criticism did you receive from others when you were growing up?

Are you able to feel good about your achievements, and accept praise from others or do you tend to brush it off? People with high self-esteem and a positive self-concept are able to accept praise.

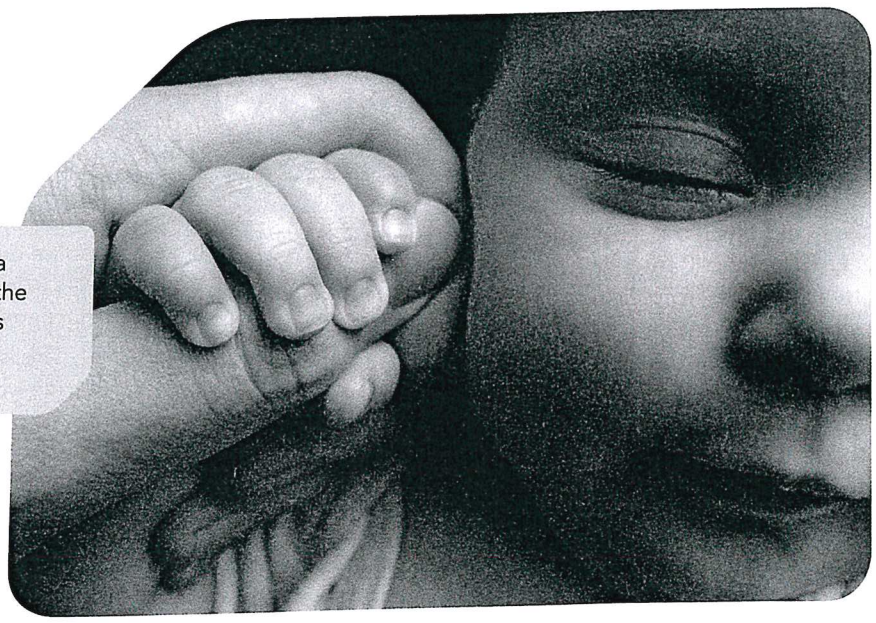
Rogers believed that we also hold a concept of self, called the ideal self. This represents a view of ourselves as we feel we should be and as we would like to be. When there is incongruence (a mismatch) between our actual self and our ideal self we become troubled and unhappy.

1.5 The cognitive/information processing perspective

This psychological perspective has gained enormous ground since the 1960s, when the influence of behaviourism began to wane. With the development of computers came the idea that brain activity was like the operation of a computer. A great deal of research has been devoted to understanding cognitive processes such as attention, memory, perception, information processing, problem solving, thought, language and other aspects of cognition. However, to understand this perspective as it relates to health and social care, we shall concentrate on just two theorists: Jean Piaget and George Kelly.

Jean Piaget

Jean Piaget (1896–1980) was a Swiss psychologist who initially worked on measuring intelligence. During his research he noticed that children of the same age made the same mistakes in logic, however bright they were. He came to the conclusion that cognition develops through a series of stages, each new stage building on the previous one. The stages and key associated features are described below. (For more information on these stages, see Unit 4.)



How does this photo show that a baby is only able to experience the world through sense perceptions and motor activity – the sensori-motor stage?

Table 8.3: Piaget's stages of development

Stage	Age	Key features
Stage 1: Sensori-motor	0–2 years	The world is experienced through motor activity and the senses
Stage 2: Pre-operational	2–7 years	Language develops along with memory. The child is egocentric and unable to conserve
Stage 3: Concrete operational	7–11 years	The child can now understand conservation but cannot yet solve problems mentally
Stage 4: Formal operational	11+	The child can now use abstract thoughts and represent problems mentally

George Kelly

George Kelly (1905–1966) developed a unique psychological theory known as the Psychology of Personal Constructs. He saw the individual as a scientist, making predictions about the future, testing them and, if necessary, revising them according to new evidence. A construct is a way of construing (interpreting and making sense of) reality and the environment. For example, if an individual develops deafness in middle age they may construe this as a disaster, withdraw from the world and become socially isolated. Alternatively, if they construe this as a challenge, they may seek out new, exciting opportunities, work around their deafness and continue to live a rich, fulfilling life.

Kelly believed that we do not have to be constrained by our past history but can seek out new, alternative, more positive meanings.

1.6 The biological perspective

Maturational theory

The theory of maturation holds that the effects of the environment are minimal. The child is born with a set of genetic instructions passed down from its parents, and its cognitive, physical and other developmental processes merely unfold over time, rather than being dependent upon the environment to mature. It is, in effect, a theory which states that development is due to nature not nurture. This is quite a contrast to learning theory or humanistic theory, where the effects of nurture are paramount.

Gesell's theory of maturation

Arnold Gesell (1880–1961) believed that development occurred according to a sequence of maturational processes. For example, development in the womb follows a fixed set of stages: the heart begins to form first, along with a rudimentary nervous system. Bones and muscles develop next and over time the organism develops into a fully functioning human being, ready to be born. As the child develops from birth onwards, its genes allow it to flower gradually into the person he or she is meant to be. The environment should provide support for this unfolding of talents, skills, personality and interests but the main thing driving this development is the maturational process.

Genetic influences on behaviour

Genes can affect behaviour in many ways. Some disorders, such as Huntington's disease, are caused by a single dominant gene, which either parent can pass on to their child. Others, such as cystic fibrosis and sickle cell anaemia, are caused when both parents pass on the gene for the disorder.

Disorders that occur regardless of environmental influences, such as those listed above, are genetically determined disorders. This means that the individual who inherits the gene or genes is certain to develop the disorder, regardless of environmental factors. An example of this is Huntington's disease. This disorder usually begins to show when the individual is aged between 30 and 50. Symptoms of dementia appear and the individual is likely to die about 15 years after the onset. Some of the changes in behaviour are listed below, though this list is not comprehensive:

- hallucinations and delusions
- severe confusion
- progressive memory loss
- inappropriate speech; use of jargon or wrong words
- personality changes including anxiety and depression, withdrawal from social interaction, decreased ability to care for oneself and inability to maintain employment.

Did you know?

Out of 23 pairs of identical twins affected by autism, both twins had the disorder in 22 cases. For a sample of 17 non-identical twins affected by autism both twins had the disorder in only 4 cases. This demonstrates that the environment is also responsible for this disorder.

Ritvo, Freeman *et al* (1985)

Disorders that are not genetically determined, but where an individual's genes may leave them with a vulnerability to developing the disorder, are far more common. A classic way of measuring the contribution of genes to any type of behaviour is through twin studies. There are two types of twins. Monozygotic (or identical) twins share 100 per cent of their genetic material since they are formed from only one fertilised egg, which has divided into two. Dizygotic (or fraternal) twins share only 50 per cent of genetic material since they occur when two eggs are fertilised by different sperm at the same time. If, the reasoning goes, one of a pair of monozygotic twins has a disorder, it would be expected that, if genes are the only influence, the second twin *must* also have the disorder.

Activity 4: The contribution of genes

Research the genetic component in susceptibility to one of the following diseases:

- breast cancer
- bowel cancer
- diabetes
- stroke.

PLTS

Team worker: If you work in a group on this activity, you will show your team working skills by collaborating with others to work towards common goals.

The influence of the nervous and endocrine systems on behaviour

For more information on the nervous system, see Unit 5.

The autonomic nervous system produces its effects through activation of nerve fibres throughout the nervous system, brain and body or by stimulating the release of hormones from endocrine glands (such as the adrenal and pineal glands). Hormones are biochemical substances that are released into the bloodstream and have a profound effect on target organs and on behaviour. They are present in very small quantities and individual molecules have a very short life, so their effects quickly disappear if they are not secreted continuously.

There are a large number of hormones including:

- melatonin, which is released by the pineal gland and acts on the brainstem sleep mechanisms to help synchronise the phases of sleep and activity
- testosterone, which is released in the testicles and may influence aggressiveness
- oxytocin, which is released by the pituitary gland and stimulates milk production and female orgasms.

Some hormones are released as a response to external stimuli. For example, the pineal gland responds to reduced daylight by increasing production of melatonin. Other hormones follow a circadian rhythm, with one peak and one trough every 24 hours. (Circadian means 'about a day' and refers to a 24-hour rhythm.) For instance, levels of cortisol rise about an hour before you wake up and contribute to your feelings of wakefulness or arousal.

Central nervous system	Autonomic nervous system	
Consists of the brain and spinal cord	Regulates organs of the body and processes such as heart rate and blood pressure; only one branch is activated at any time	
	Sympathetic branch	**Parasympathetic branch**
	Associated with arousal and the fight or flight response	Associated with rest and relaxation
	Person may appear agitated, with a fast pulse and heavy, rapid breathing	Person will appear calm and relaxed, with a slow pulse

Fig 8.9: A representation of the nervous system

2 Understand psychological approaches to health and social care

2.1 Application of the behaviourist perspective

The behaviourist perspective is extremely useful in explaining learned behaviours, as we can look at a particular behaviour and trace its origin, using the concepts of association (classical conditioning) or reinforcement or punishment (operant conditioning). The case study below gives an example of this.

Case study: Understanding challenging behaviour

Farai is 13 years old and was recently admitted to a local authority children's home after her foster placement broke down. She has fierce rages, during which she smashes windows and shouts at people. It turns out that Farai used to behave in exactly this way at her foster home and that everyone ran around trying to please her.

1 **Explain, using the terminology of learning theory, how and why Farai may have learned the undesirable behaviours.**

2 **Do you think an explanation that relies entirely on learning is sufficient to explain Farai's behaviour?**

Changing behaviour

For some people, there may be aspects of everyday life that are simply impossible to cope with. A small boy may be unable to go to school or to the park because he has an overwhelming fear of dogs, which he is likely to encounter in the vicinity of school or the park. An elderly woman may never leave her home and be isolated and depressed because her agoraphobia (fear of going out) is so severe that it dominates her life. Fortunately, as well as explaining the development of phobic behaviours, classical conditioning is also useful in helping to change such behaviours.

We can apply the principles of classical conditioning to everyday life in a very practical way. A commonly used method of changing phobic behaviour uses a method of treating acquired fears known as 'systematic desensitisation'. This involves first creating a 'hierarchy of fear'. Supposing the feared object is hospitals. The individual would create a list of aspects associated with going to hospital. It might look something like this:

Systematic desensitisation: creating a hierarchy of fear	
Most feared	The procedure itself
	Smells associated with hospital
	People in green gowns
	Hospital equipment and machinery
	Hospital wards
	Taking a lift to a ward
	Walking into the building
	Driving to the building
Least feared	Receiving an appointment card

Fig 8.10: A patient's hierarchy of fear in relation to hospitals

The principle of this procedure is to help the person achieve a state of very deep relaxation – on the assumption that relaxation and anxiety are incompatible. The aim is to replace the anxiety and fear with a state of calm and relaxation. An image of the least feared object or situation is then shown to the individual and they are encouraged to relax until they are able to view this without fear or anxiety. This may take more than one session. When this level of fear has been satisfactorily overcome, the person moves to the object or situation at the next level, again working on relaxing until they are able to contemplate the object or situation without a trace of anxiety. Over a period of time the procedure is repeated until the final, most feared, object or situation can be faced without worry.

With some treatments, the patient is encouraged to practise some of the lower level fear-inducing situations (for example, opening an envelope containing an appointment card or driving as close to the hospital as is tolerable without arousing too much anxiety).

The principles of classical conditioning are also used in a common treatment for alcoholism. Individuals are

given a drug which, when mixed with alcohol, leads to extremely unpleasant physiological effects including nausea and vomiting. The person thus learns to associate alcohol with an aversive rather than desired response.

Did you know?

Phobias are culturally specific. In Japan a syndrome known as *tai-jin-kyofu-sho* is a fear of embarrassing other people by, for example, glaring at their genitals while blushing in their presence, or making odd faces. (McNally, 1997, cited in Davison and Neale, 2001, p.129)

Shaping behaviours

Just as we can learn inappropriate or unhelpful behaviours, so we can use the principles of operant conditioning to create new, more helpful, behaviours and eliminate the unhelpful ones. Using the principles of reinforcement and punishment is a very powerful way to change someone's behaviour: this is sometimes called behaviour modification.

This technique has been used with autistic children to help them interact socially. **Target behaviours**, such as making eye contact, are identified. The child is initially reinforced (e.g. with a sweet) for looking in the general area of the adult. Once this behaviour is established, more specific behaviours (e.g. looking at the face) are reinforced, until finally the target behaviour of making eye contact is achieved. This is known as shaping behaviour.

Key term

Target behaviours – Those behaviours that have been defined as being of benefit to the individual's well-being.

2.2 Application of social learning theory

Promotion of anti-discriminatory behaviours and practices

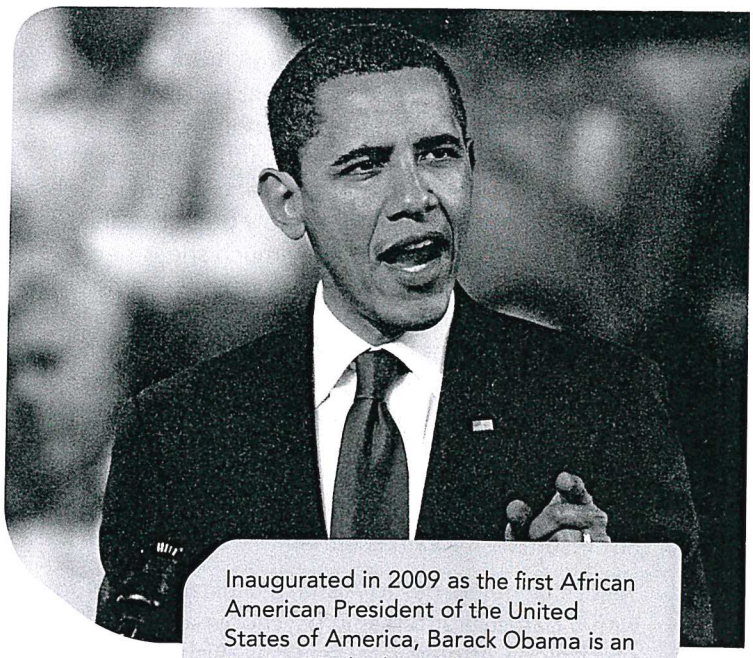
Earlier in this chapter (on p. 344) we discussed the way people can learn new behaviours by observing others. We also noted that the model's characteristics influence whether we are likely to imitate the behaviour. An example of a model who was prestigious, of high status, attractive and most definitely a 'celebrity' was the late Princess Diana. When she visited patients with HIV and AIDS at a hospital in 1987 and shook hands with a patient with AIDS, she not only broke a taboo on the subject, but also helped remove a great deal of prejudice and misunderstanding about this illness.

Activity 5: Investigating the use of role models to promote behaviour change

Take note of television adverts you see over the next few weeks and ask yourself why a particular individual was chosen to promote a product or service. What are the features they have that might appeal to viewers? What influence might they have on your behaviour or that of others?

PLTS

Independent enquirer: By carrying out this activity you may be able to gain evidence for the skill of considering the influence of circumstances, beliefs and feelings on decisions and events.



Inaugurated in 2009 as the first African American President of the United States of America, Barack Obama is an inspirational role model to all.

Another example of how a model can be influential in promoting anti-discriminatory behaviours and practices is provided by the President of the United States, Barack Obama. When lifting the ban on entering the USA, which had previously applied to individuals with HIV/AIDS, he stated that it was important for the United States to be a good role model as a country – if the overall intention was to take the lead globally in reducing the stigma associated with this disease.

The use of positive role models in health education campaigns

As explained above, role models can play a powerful part in influencing the behaviour of those who observe them. For example, celebrity chef Jamie Oliver has had a huge impact in terms of getting local authorities to re-introduce freshly cooked school meals (as opposed to pre-cooked meals, which were much less healthy). His celebrity status greatly influenced the likelihood of his message being taken on board and acted upon.

On a more practical, everyday level, modelling is an excellent way of helping patients overcome anxieties. For example, Melamed *et al* (1983) found that children in hospital suffer reduced stress and recover better from surgery if the procedures they are about to undergo are modelled, for example using films or video tapes (cited in Sarafino, 1990, p. 149).

2.3 Application of the psychodynamic perspective to health and social care practice

Understanding challenging behaviour

The basic tenet of this perspective is that much of our behaviour is driven by unconscious forces. It is therefore important to recognise that we may not be able to understand behaviours using question and answer techniques, as the individual may not be aware of what is troubling them. It is necessary to delve a little deeper and try to interpret behaviour, on the assumption that the behaviour is in some way a symptom of what is going on in the unconscious.

Understanding and managing anxiety

When we are anxious we often have fears about events that have happened or might happen, about things we have done or might do, and about whether the world is a safe or unsafe place. We often try to control anxiety using a variety of strategies. Sometimes we use denial – the ostrich approach where we bury our heads in the sand and pretend the object of our anxiety doesn't exist. Sadly, for most of us, the anxiety still seeps through, and may present itself in the form of physical symptoms.

Case study: Juliet's dilemma

Juliet is the eldest of three children. When she was 11, her mother died, and since that time her father has depended on her more and more to look after the younger children and help run the household. Juliet is a naturally conscientious and dutiful daughter and she misses her mother terribly but hides this, as she can see all too well how much she is needed by other family members. She doesn't feel able to confide in her father about her own grief but instead puts a smile on her face and busies herself with daily tasks. When she is 13, she begins to get paralysing headaches, which are so incapacitating that she has to stay in bed for up to three days at a time. Despite optical and neurological tests, there is no physiological explanation for the headaches, which do not resemble migraines either.

Juliet's GP refers her to Aisha, a clinical psychologist with a particular interest in psychodynamic psychology. After several sessions, Aisha concludes that Juliet has repressed her grief about her mother's death, that she is resentful that her father is not taking better care of her needs, and also that she is effectively having to 'mother' her younger siblings. Juliet's extreme conscientiousness also suggests that she has a dominant superego and a weak id. Although she at first denies these suggestions, Juliet gradually comes to realise that all these feelings were being buried, and the symptom of headaches served the purpose of preventing her from looking after other family members and allowed her to receive some much-needed care herself.

1 Aisha has identified that Juliet is using certain defence mechanisms. What are these?

2 Are there other explanations for Juliet's behaviour that Aisha may have missed by focusing solely on the psychodynamic perspective? Discuss these.

2.4 Application of the humanistic perspective to health and social care practice

Carl Rogers is famous for developing a particular type of counselling based on **unconditional positive regard** from the counsellor, to help the individual develop a more positive sense of self. Unconditional positive regard refers to the idea that the therapist supports and validates the person's experiences, feelings, beliefs and emotions unconditionally (i.e. without making a judgement about whether they are good or bad). In this way, over time, the person comes to accept themselves as they really are and to see themselves as worthy. The incongruence between the actual self and the ideal self dissolves as the two become closer, or the individual lets go of unrealistic expectations associated with the ideal self.

Empathy

One crucial feature of this approach to helping others is to develop empathy. Unlike sympathy, where we feel sorry for someone, empathy requires us to really listen to the other person, be in tune with their emotions and respect them for who they are. This is not always easy, as we do not always understand why someone feels so bad about an issue that we could easily dismiss. However, if we try to respect the individual we are working with and understand that the issue is of crucial importance to them, we can come closer to demonstrating empathy. True empathy requires us to put aside judgements about another person and do all we can to 'put ourselves in their shoes'.

Tips for achieving empathy

Suppose you are working with a client or patient who is terrified that eating more than three grains of rice will make them obese and ruin their lives. You are probably aware that this is factually incorrect. You may find it difficult to understand, let alone feel empathy for such an extreme view.

Now try really listening to them. Observe their body language. They may be so frozen with fear that they appear calm and indifferent. Or they may be so anxious that they are pale and sweaty with huge fearful eyes almost bulging out of their head.

Next, think of something that brings you out in a cold sweat of paralysing fear. This may be something 'real' such as having been buried under an avalanche of snow and fearing for your life, or something imaginary. Recollect this fear. Did it help for people to tell you, 'Well, you were all right, weren't you? You didn't die! Here you are – as well as anything!'? Now put aside all judgement about the individual's fear or terror. Recognise that what they are feeling makes sense to them. It is painful, agonising, terrifying. Tune in to those feelings and you will be much closer to feeling true empathy.

Understanding

Rather like empathy, understanding is of crucial importance when applying this perspective to health and social care practice. In fact, Rogers often refers to more than just understanding at an intellectual level: he talks about empathic understanding, which involves using your own emotions and sensitivity to become a more effective helper. All too often we allow our own personal experience or judgements to dominate the way we relate to others. We think 'Well, that's not a problem – they should just pull themselves together! I've dealt with worse myself!' This is a major barrier to understanding and will not help the client or patient. Instead, we need to listen carefully to what is being said and to ask probing questions that enable the individual to break down the problem and recognise its component parts. Useful questions might include:

- 'How does that make you feel?'
- 'Can you identify what it is you are afraid of?'
- 'Could you tell me a bit more about that?'
- 'That seems to have upset you?'

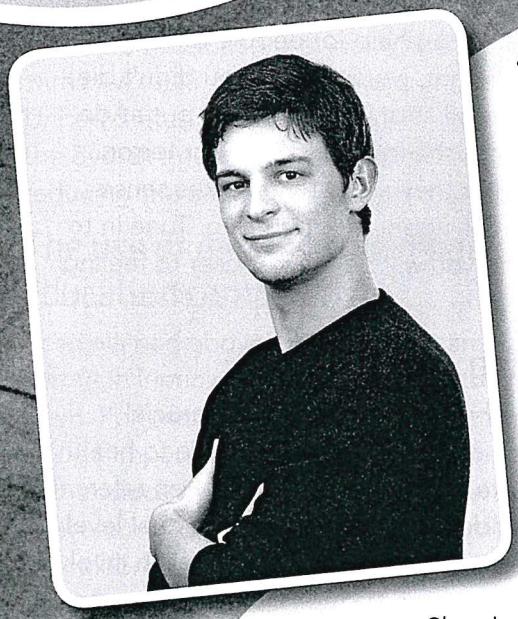
Key term

Unconditional positive regard – This refers to a totally non-judgemental way of being with and viewing a client. The therapist does not like or approve of the client at some times and disapprove of them at others: they value the client in a positive way with no conditions attached.

WorkSpace

Sanjay Bashir

Psychiatric nurse



Sanjay is a community psychiatric nurse who is visiting Irene, a 35-year-old teacher, for the first time. Irene lives in a beautiful five-bedroomed house in a leafy suburb of a university town. Her three children are all at private school and her husband is a respected university professor of biochemistry. Irene has been referred to the outreach team after a suicide attempt and is receiving medication for depression.

Sanjay himself comes from a high-rise in an inner-city suburb and has worked hard to get where he is. During the course of his visit, he finds himself feeling irritated with Irene. What has she got to be depressed about? Her life is the envy of many.

She should just pull herself together and get on with things – many people are far worse off than she is.

Sanjay is, fortunately, aware that his attitude to Irene is unhelpful so he books an appointment with his supervisor, who encourages him to identify where his judgemental feelings are coming from, and to challenge his negative perceptions of Irene. When he next visits her, he is able to use active listening and gentle probing questions to help her express her feelings, and finds that he is feeling empathy and understanding and is in a much better position to help her. He recognises that his own upbringing and experiences have left him with a tendency to be judgemental about others more fortunate than himself in material terms, and that active listening and the tips for empathy described above help him to 'see' Irene more clearly and to hear the pain in her story and thus be more understanding.

Think about it!

1. Explain how Sanjay's own upbringing was at risk of interfering with his ability to adopt a non-judgemental approach
2. Do you think the fact that Sanjay was a man and Irene was a woman might have made a difference to Sanjay's ability to show empathic understanding?
3. How might the humanistic perspective explain Irene's unhappiness?

Active listening

For more information on active listening, see Unit 1.

Another key feature of the humanistic approach is that of active listening. All too often in our interactions with others, what we think of as a conversation is merely two or more people 'queuing up to talk'. We just wait for the other person to finish what they are saying so we can have our own say. This is the opposite of active listening, which involves a very focused approach. We need to avoid daydreaming and distractions and listen sensitively to the meaning and emotions behind the other person's words. Attention is also paid to the person's body language and facial expressions. The active listener suspends all judgement about what is being said and seeks to use empathic understanding. When the listener does intervene, it is not to pass judgement but to interpret what the other person is saying, or to check understanding.

Respecting other individuals and adopting a non-judgemental approach

Giving people respect may seem an obvious feature of a helping relationship but in fact it can sometimes be quite difficult to achieve. If we find it hard to identify with the other person, for example because there are differences in gender, social class, ethnicity, religious beliefs, language, culture and so forth, then we may find ourselves taking a judgemental stance. This is a major barrier to respect. The workspace opposite illustrates this problem.

2.5 Application of the cognitive perspective to health and social care practice

Supporting individuals with learning difficulties

Individuals with learning difficulties can experience enormous frustration in their daily lives as they seek to make sense of what can be bewildering experiences. The cognitive approach can be used to help people who misread situations. By identifying irrational thoughts, an individual can be guided to change them, with consequent benefits for their emotions and behaviour. Cognitive work of this type can improve self-esteem and reduce outbursts, which may be triggered by lack of understanding of the requirements of a given situation (for example, having to wait in turn for a meal).

Consider how a cognitive approach can be used to help people with learning difficulties

Supporting individuals with emotional problems

The cognitive perspective is widely used with individuals with a wide variety of emotional problems. This perspective begins by examining how distorted and irrational negative thoughts influence feelings, which then lead to changes in behaviour.

Reflect

Do you ever find yourself having negative or irrational thoughts? For example, you might think 'I did badly on that assignment – I'm going to fail the course!'

Write down some of your negative thoughts or those of someone you know.

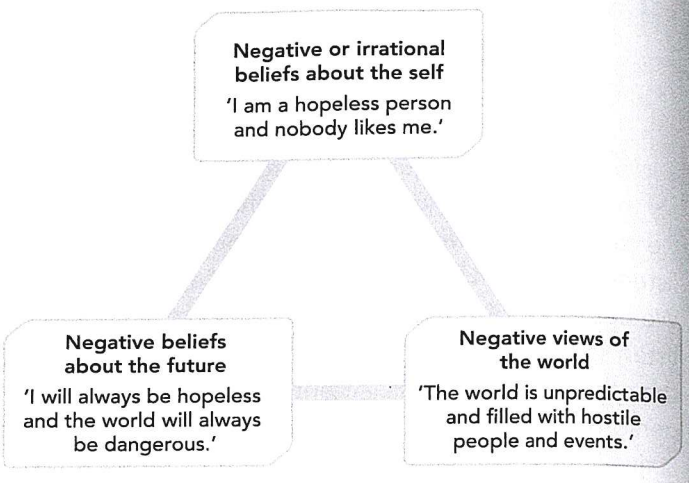


Fig 8.11: The cognitive triad described by Beck

Supporting individuals with depression

The psychologist Aaron Beck has formulated a helpful approach to understanding depression, known as cognitive behaviour therapy (CBT). The pattern of behaviour common to those suffering from depression is described by Beck as a cognitive triad. To begin with, the individual thinks he is worthless and inadequate. This self-appraisal then leads to the belief that this lack of worth means that the future will be just as bad as the present. This then generalises to a conviction that the world contains problems and difficulties that the individual is powerless to overcome. The goal of cognitive therapy is to challenge these negative thoughts and to encourage the patient to develop alternative, more positive, ways of seeing the world.

Identifying negative/irrational/distorted thinking

This can be done by keeping a diary and recording every instance of negative thinking and the feelings that follow. Initially this can be difficult, as these patterns are so automatic it can be difficult to notice them. However, it will get easier over time. For each example, try to challenge the thinking. Ask yourself:

- What is the evidence for such negative thinking?
- Are there alternative explanations? It can be helpful to think how others would respond, or ask them.
- How does it affect me to think so negatively? (This helps you develop self-awareness.)
- What type of thinking errors am I making (for example, magnifying or catastrophising)?

Supporting individuals with post-traumatic stress disorder

This disorder consists of a set of symptoms as outlined below. It is commonly experienced by soldiers but is also experienced by others who have undergone a traumatic experience (such as rape), which is too much for them to bear.

Re-experiencing the traumatic event (intrusion)

- Nightmares
- Flashbacks
- Frequent recall of the event
- Intense emotional upset produced by stimuli that symbolise the event (e.g. fireworks may symbolise a battlefield).

Avoidance of stimuli associated with the event (or numbing of responsiveness)

- The person tries to avoid thinking about the trauma or encountering stimuli that will bring it to mind
- The person may be unable to remember the event
- Decreased interest in others
- A sense of estrangement
- An inability to feel positive emotions.

Increased arousal

- Difficulties falling or staying asleep
- Difficulties concentrating
- Hyper-vigilance
- An exaggerated startle response.

Case study: Post-traumatic stress disorder

Spitzer *et al* (1981) describe the case of a 27-year-old woman referred to a psychiatrist showing symptoms of PTSD after she had witnessed her boyfriend being stabbed to death during the course of a mugging. Although she appeared to go through the grieving process and return to normal, the arrest of the murderer triggered severe symptoms. She suffered from impaired sleep and when she slept often had nightmares involving blood and shadowy figures chasing her. She became preoccupied and day-dreamed to the extent that she would forget what she was meant to be doing. This poor concentration affected her work and she began to avoid going to work and also withdrew socially, avoiding her friends.

Source: Spitzer *et al* (1981), cited in Davison & Neale (2001)

1 **Which of the symptoms shown in this case study suggest that the patient is suffering from PTSD?**

2 **Is there any evidence here of negative or irrational thinking?**

3 **According to the psychodynamic approach, does this patient appear to be using defence mechanisms to deal with this traumatic event?**

The above are some, or all, of the symptoms experienced by individuals with a diagnosis of post-traumatic stress disorder (PTSD). These are illustrated in the case study above.

The treatment of post-traumatic stress disorder usually involves a healthcare practitioner (such as a psychiatrist, psychiatric social worker or clinical psychologist) working with an individual to help them re-frame their thoughts. The aim would be to recognise that the feared events have actually happened and are not recurring so that eventually the constant mulling over of these traumas will disappear. There would also need to be some treatment involving behavioural therapy, however, and this might be accomplished by an outreach worker or home carer helping the individual to face feared situations. By confronting their feared situations and learning that they are not going to suffer as they did originally, the physiological effects of fear, panic and anxiety will diminish until the individual is eventually able to lead a normal life.

2.6 Application of the biological perspective to health and social care practice

Understanding developmental norms

You may want to read this section in conjunction with Unit 4.

Arnold Gesell developed an assessment scale to enable judgements to be made about whether a child's behaviour and understanding matches that of their chronological age (how old the child is). This scale enables the child's scores to be compared against their scores at an earlier age to determine whether development is proceeding satisfactorily. It also enables a skilled and trained assessor to identify developmental problems that may emerge for an individual, thus allowing for early and appropriate intervention. There are three overlapping stages at which development can be measured:

- between two and a half years up to age six
- between four and six years old
- between six and nine years old.

At each age there are various tests to assess different aspects of development. One test administered at around the age of four consists of comprehension questions. It measures the child's ability to use perceptual accuracy and skills involved in regulating its own behaviour and emotions by asking him to plan solutions to hypothetical social situations. This allows for a judgment to be made on the child's ability to deal with actual social situations as it reaches the age of about five years old.

The Cubes test, which is used primarily with children aged two to six, assesses the ability to follow directions and perform a structured task. Visual perception and fine motor co-ordination skills involved in colouring, cutting and handwriting are assessed against developmental norms. The child's attention span, together with the ability to perceive different shapes accurately, is also measured and together these give

information about reading comprehension, spelling and mathematical tasks.

Understanding genetic predisposition to certain illnesses or health-related behaviours

The topic of genes is also covered in Unit 4.

While it is difficult to determine the extent to which genetic inheritance influences behaviour, there is considerable evidence suggesting that genes do have a role in behaviour. One example is infantile autism, a rare (but seemingly increasing) disorder, which affects about one child in 2000. There are psychological explanations for autism (for example, see Bruno Bettleheim, 1967) but these have not been satisfactorily investigated, and current research shows that genetic influences play a more important role in this disorder.

The disorder of schizophrenia similarly shows a genetic link, though not as strong as in autism. In monozygotic (identical) twins, who share all their genetic material, 50 per cent of schizophrenia cases occur in both twins. This percentage is known as 'the concordance rate'. However, in dizygotic (non-identical twins), who share half as much of their genetic material, schizophrenia only affects both twins in 15 per cent of cases.

In 1995 Sarafino and Goldfedder investigated the concordance rate for asthma. They found 59 per cent of monozygotic twins (23 out of 39 pairs) were concordant for the disease, compared with 24 per cent of dizygotic twins (13 out of 55 pairs).

If schizophrenia and asthma are genetically determined (like cystic fibrosis), twins who share 100 per cent of their genes should both develop the particular disorder. There is clearly a genetic component in both these disorders, since monozygotic twins show a higher concordance rate than dizygotic twins, in line with the proportion of genetic material shared. However, environmental influences must explain the proportion not accounted for. In schizophrenia, for example, an individual can inherit a vulnerability to this disorder but if life goes smoothly and is relatively free of stress, this person may live a life free of illness. Similarly with asthma, environmental factors such as stress, pollutants and pollen, can be responsible for the onset of the disorder.

In terms of health-related behaviours, it is difficult to separate out the effects of nature and nurture. Suppose, for example, a child is born with a genetic vulnerability to a disease, such as breast cancer. If, as an adult, she practises regular breast examination, has a healthy lifestyle and has regular screenings, these health-related behaviours may make all the difference to the potential outcome. A healthy lifestyle and vigilant health protection measures may reduce the chances of a genetically vulnerable person contracting the disease or allow for prompt action to be taken if she is unfortunate enough to develop breast cancer. So a genetic predisposition to illness needs to be considered together with health-related behaviours in order to understand fully this aspect of the biological perspective.

Understanding the effects of shift work on individuals

When we work shifts, particularly night shifts, we tend to find that there are certain times when we feel an overwhelming urge to sleep while we should be working. Alternatively, when we go home after our shift and try to sleep and get refreshed for a new day at work we may find ourselves pacing the floor, unable to sleep. These unpleasant physical effects occur because of disruption to circadian (or biological) rhythms.

Circadian rhythms govern a cycle of physiological bodily processes which last for between 24 and 25 hours. One example is our core body temperature, which follows approximately a 24-hour cycle and influences our level of alertness. For most people, the lowest core temperature is 36.1°C (97°F) and the highest is 37.2°C (99°F). Core body temperature fluctuates (rises and falls) over the course of the day. When it is at its highest, we are at our most alert. As our temperature gets lower, we begin to feel sleepy. The graph on the next page shows typical fluctuations in body temperature.

Shift workers on an evening shift have to be awake and functioning at a high level when their body temperature is at its lowest and dropping, a time when their body is telling them to go to sleep. They therefore have to fight against an overwhelming urge to sleep. On returning home, when their temperature levels are rising, they then need to try to sleep at a time when their body clock is telling them they should be awake and encouraging alertness.

The brain is also involved in governing our desire to sleep. A part of the brain called the pineal gland is

responsible for production of the hormone melatonin. When levels of this hormone are high, we feel sleepy. As they begin to drop, we become increasingly alert. The rhythm of this hormone production is linked to the sleep–wake cycle. As it gets dark, the pineal gland recognises this and triggers an increase in melatonin production, while, when light levels increase, production of melatonin is reduced. Melatonin levels fluctuate throughout the day. Between about 8 p.m. and 10 p.m. these levels increase, with the resulting feeling of sleepiness occurring about two hours later. Melatonin levels then begin to fall, from about 2 a.m. to 7 a.m. The onset of daylight is recognised by the pineal gland, which then reduces the secretion of melatonin, leading to increased alertness. For those who are trying to sleep during the day, their levels of melatonin are working against them, as low levels encourage alertness. Similarly, those trying to work at night, when the pineal gland is secreting large amounts of this hormone, will have to fight against the sleep-inducing effects of melatonin.

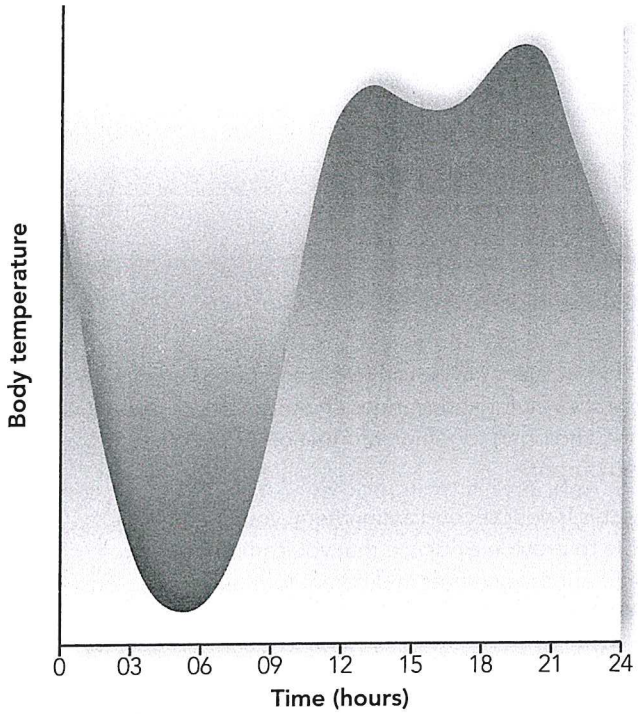


Fig 8.12: Typical fluctuations in core temperature over a 24-hour period: as our core temperature rises, we become increasingly alert

Activity 6: Are you a lark or an owl?

To find out how your own circadian rhythms operate, go to www.proprofs.com, click on 'Quiz School' and search for 'lark'. Then take the 'Are you a lark or an owl?' quiz to find out when you will be most alert.

Assessment activity 8.2

P2 P3 M2 D1 BTEC

You are a psychology student who wishes one day to have a career as an educational psychologist. At your placement, you have been asked to investigate the need for a new, larger therapy and counselling centre for local people.

You need to evaluate two psychological approaches to health and social care provision and put forward your findings. Suggest what new provision is needed for your locality.

Write a report that includes the following:

- an explanation of the different psychological approaches to health practice
- an explanation of the different psychological approaches to social care practice
- a comparison of two psychological approaches to health and social care service provision
- an evaluation of two psychological approaches to health and social care service provision.

Grading tips

P2 and P3 For P2, you need to explain the different psychological approaches to health practice, and for P3 you need to explain different psychological approaches to social care practice. Use the concepts of the different perspectives to complete this assessment. You may wish to use examples of individuals or groups of individuals who will benefit from the new centre, or to staff it with psychologists working within different perspectives.

continued on page 364

Resources and further reading

Barker, L.M. (1997) *Learning and Behaviour: Biological, Psychological and Sociocultural Perspectives*, second ed. New Jersey: Prentice Hall

Bettleheim, B. (1967) *The Empty Fortress: Infantile Autism and the Birth of the Self* New York: Macmillan Publishing

Birch, A. and Malim, T. (1988) *Developmental Psychology: From Infancy to Adulthood* Bristol: Intertext Limited

Davison, G.C. and Neale, J.M. (2001) *Abnormal Psychology,* eighth ed. New York: John Wiley and Sons

Ewen, R.B. (1993) *An Introduction to Theories of Personality,* fourth ed. Hove: Lawrence Erlbaum Associates

Eysenck, M.W. (1994) *Perspectives on Psychology* Hove: Psychology Press

Kalat, J.W. (1995) *Biological Psychology*, fifth ed. Pacific Grove: Brooks/Cole Publishing Company

Kelly, G.A. (1970), cited in Ewen, R.B. (1993) *An Introduction to Theories of Personality*, fourth ed. Hove: Lawrence Erlbaum Associates Ltd

Melamed, B.G., Dearborn, M. and Hermecz, D.A. (1983), cited in Sarafino (1990)

Nolte, D.L. & Harris, R. (1998) *Children learn what they live: parenting to inspire values* New York: Workman Publishing

Ritvo, E.R., Freeman, B.J. *et al* (1985), cited in Kalat, J.W. (1995) *Biological Psychology*, fifth ed. Pacific Grove, California: Brooks/Cole Publishing Company

Rogers, C.R. (1961) *On Becoming a Person* London: Constable & Robinson Ltd

Sarafino, E.P. (1998) *Health Psychology: Biopsychosocial Interactions*, third ed. New York: John Wiley & Sons

Sarafino, E.P. and Goldfedder, J. (1995), cited in *Asthma and Genetics* http://acc6.its.brooklyn.cuny.edu/~scintech/asthma/Genetics2.htm

Shaffer, D.R. (1993) *Developmental Psychology: Childhood and Adolescence*, third ed. Pacific Grove: Brooks/Cole Publishing Company

Watson (1970) cited in Smith, P.B. & Bond, M.H. (1993) *Social Psychology across Cultures: Analysis and Perspectives* New York: Harvester Wheatsheaf (p. 103)

Useful websites

Circadian rhythms www.guardian.co.uk/science/2003/dec/04/lastword.health

Cognitive behavioural therapy (Royal College of Psychiatrists) www.rcpsych.ac.uk

Gesell's assessment scale: www.gesellinstitute.org

Health Education & Behavior journal www.sph.umich.edu/hbhe/heb

Infantile autism (NARSAD – The Brain and Behavior Research Fund) www.narsad.org

Mind www.mind.org.uk

Stages of prenatal development www.babycenter.com