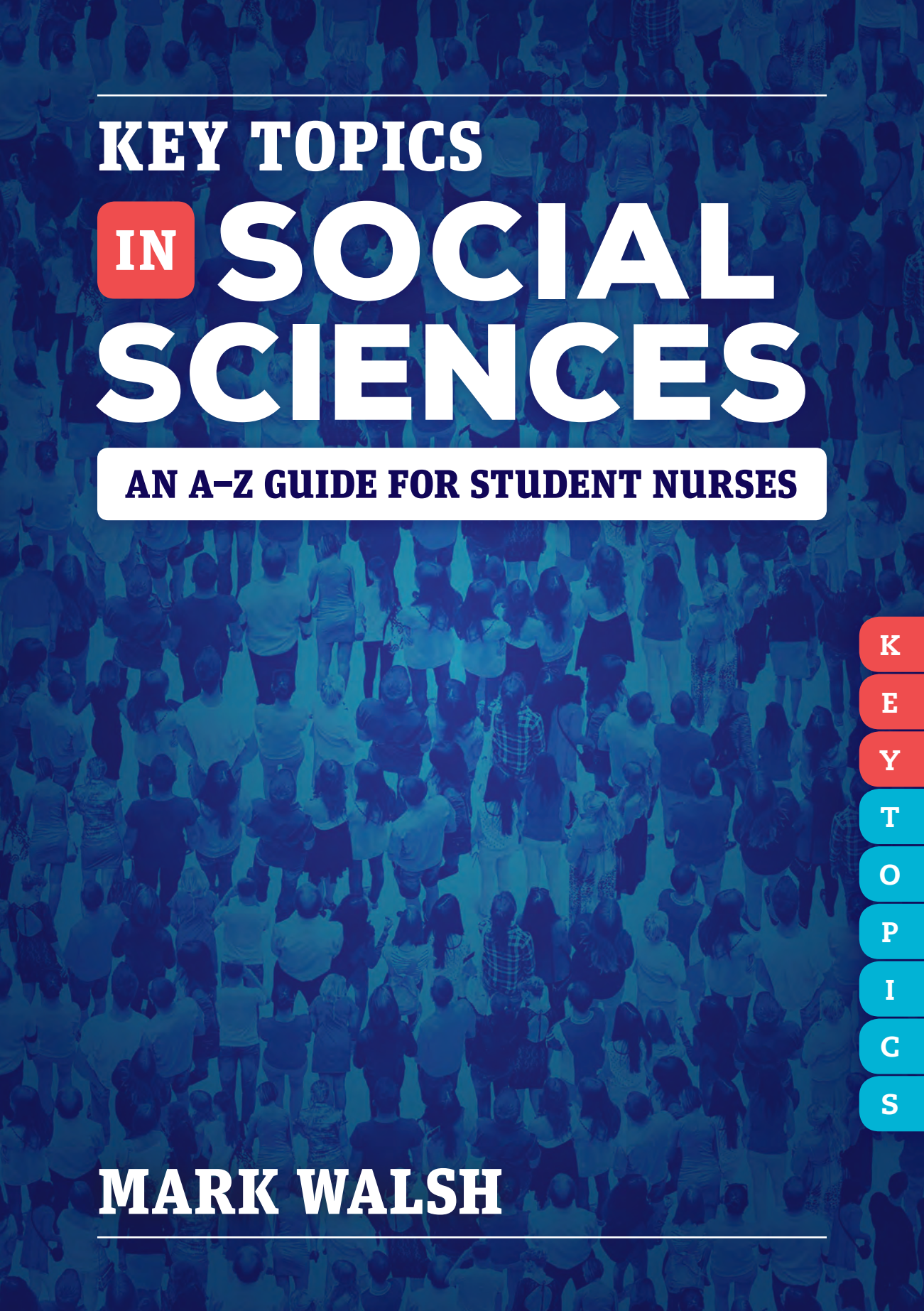
KEY TOPICS IN SOCIAL SCIENCES

AN A–Z GUIDE FOR STUDENT NURSES



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MARK WALSH

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Preface

Welcome to *Key Topics in Social Sciences*!

Developing a greater understanding of social science probably isn't the reason you chose a nurse training course and you might be wondering why you have to spend precious time trying to get to grips with social science concepts, terminology and theories. If you haven't studied social science yet, it can at first seem unfamiliar, vague and disconnected from your everyday life as a student nurse. Enthusiastic social science tutors can also forget that the words that trip off their tongues may sound obscure and meaningless to student nurses who have to cover a broad range of subjects during their degree courses. If you are new to social science, you may approach it feeling like an outsider being forced to jump through pointless hoops and fill your head with 'jargon'. In reality, studying social science is helpful and isn't as pointless or difficult as you might think at the start.

Social science concepts and theories play an important part in helping us to make sense of the complexities of everyday life, the experiences of the people you will be caring for and the world(s) and cultures they come from. As in the natural sciences, the terminology and concepts of social science do have a useful function because they enable us to think and talk about the man-made aspects of everyday life and our experiences of it. They will give you a way in to make sense of your own and other people's psychological and emotional experiences and also help you to gain a better perspective on how society more broadly can influence a person's opportunities, health choices and experiences. It might seem difficult at first, but it's important to get to grips with the 'jargon' and to learn the language of social science so that you can incorporate this into the way you think and practise as a nurse.

There are a lot of specialist social science books, dictionaries, encyclopaedias, journals and web resources out there. I suspect that your university library has a fairly good selection available. You should make use of them when you need to and have the time. The reason for this book and its A–Z format is that many student nurses don't have the time or energy to read whole social science books, carry out extensive literature reviews or hunt down obscure articles (however helpful they might be). This is a bit of a short-cut, designed to quickly get you started on new topics, to point you in the right direction in your essays and to streamline the task of building up your social science knowledge. The entries in the book don't tell you everything there is to know about a topic. They provide a way in and get you started. Treat them like a launchpad or a quick briefing that you can follow up. To make this easier, there are some 'See also' suggestions at the end of each entry. These are concepts or theories that are linked to the issue or term you have just read about. You will soon start to see the connections and have ideas about how to incorporate them into your essays. The 'Further reading' suggestions that follow provide you with a more detailed source of information on the topic if you want, and have the time, to follow this up. So, as well as saving you time, the A–Z style of the book is also trying to help you see the pathways and connections that exist between concepts, theories and terminology in the social sciences. You don't have to always follow these pathways and, hopefully, your curiosity and interest will lead you to

spot and follow new pathways as you incorporate social science into your thinking and nursing practice.

Good luck with your efforts to make sense of and learn from the social sciences. It is worth it when you realise that you are able to see and understand the challenges you face and the experiences you have, in new and different ways. I am hopeful that this book will spark your enthusiasm and get you started on your exploration of the social sciences.

Mark Walsh
March 2018

About the author

Mark Walsh is a social science tutor and specialist mental health mentor who works with students taking university and further education courses. He is an experienced mental health nurse, tutor and textbook writer.

Acknowledgements

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Harriet Davies (formerly Bradfield) – University of Cumbria

Stefan Franks – Open University

Conformity

Conformity is a concept that plays an important part in the psychology of social influence. It refers to the factors and processes that influence people to follow (or conform to) the behaviour of others.

Conformity is quite a big topic within the psychology of social influence. Majority and minority influence are two key aspects of it. Majority influence refers to situations where people follow the group, whilst minority influence refers to situations where people are influenced by and follow the minority. A number of theories have been developed to explain both majority and minority influence. Deutsch and Gerard (1955) identified two types of majority influence:

- Normative influence – where, at least publicly, the person is motivated to fit in so they are liked and accepted by others. In private the person may disagree with the majority but doesn't reveal this publicly.
- Informational influence – where a person who is self-conscious, unsure or worried about getting something wrong follows others whom they believe do know what to do. A person in this situation will conform publicly and privately.

The psychology of social influence has been important in showing how and why people tend to conform to group influences, particularly in situations of uncertainty. Asch's (1951) 'line experiment' showed how people are frequently influenced by others in their judgement even when the evidence in front of them indicates that the group is wrong. Majority influence is typically too powerful for an individual to resist.

The existence of minority influence shows that it is possible to influence the group from a minority position. Moscovici *et al*. (1969) argued that the minority needed to be forceful, persistent and unwavering whilst also appearing flexible and open-minded. If the minority maintain a consistent position or approach and also have a strong person investment in what they are doing or saying, they are more likely to influence others. Where minority influence is effective it tends to follow a 'snowball' pattern. That is, support for the minority position will be small at first but will gradually grow as more people start to agree, until a level of momentum is reached that leads to the minority position becoming the majority one.

See also – Authority; Obedience

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Emotional labour

The sociological concept of emotional labour refers to the work or effort that people put into regulating the way they appear, behave and respond to others.

In the first edition of her influential book published in 1983, Arlie Hochschild first suggested that emotional labour underpins the publicly visible facial and bodily displays that occur in certain workplaces. This type of emotional and presentation management is a feature of nursing and healthcare work, for example. Nurses and other healthcare professionals are often conscious of their non-verbal communication and the way they present themselves to patients, families and other professionals in order to manage emotionally charged or sensitive situations, for example. In doing so, they are engaged in 'emotional labour'.

Hochschild described three emotion regulation strategies that people use as part of 'emotional labour':

- *Cognitive* – these involve efforts to change images, ideas and thoughts with the aim of changing feelings associated with them; for example, using positive images of staff and patients and a 'living well' narrative in information about a dementia service to overcome negative stereotypes of this area of healthcare provision.
- *Bodily* – these involve efforts to change physical symptoms to achieve a desired or preferred emotion; for example, consciously relaxing muscles and taking deep breaths to reduce anxiety or agitation.
- *Expressive* – these involve changing or deliberately using expressive gestures (smiles, frowns, use of their hands) to achieve and convey a particular emotion. Smiling, a brief reassuring touch and making positive eye contact to try to relax somebody is an example of this strategy.

Hochschild (2012) argues that emotional labour is an expected part of work roles (such as nursing) that involve:

- face-to-face or voice-to-voice contact with the public
- situations where the worker (e.g. a nurse) is required to produce an emotional state in another person (e.g. relaxing a patient)
- the employer using strategies such as supervision and appraisal to monitor and control the emotional activities of employees.

Hochschild (2012) argues that these expectations and the level of emotional regulation imposed on employees results in individuals becoming estranged, or alienated, from their real feelings in the workplace.

See also – Alienation; Emotion; Empathy

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Freud

Sigmund Freud (1856–1939) was an Austrian doctor who developed the theory and clinical practice of psychoanalysis.

Freud first qualified as a medical practitioner, a physician, but gradually developed an interest in neurology. This led to him setting up a private medical practice for the treatment of nervous diseases in Vienna in 1886. Freud learnt a lot about human psychological development, particularly psychopathology, from the patients he treated. Freud was particularly interested in the connections between abnormal behaviour and unconscious, underlying psychological processes. He would sit and listen as his, mainly female, patients talked about their anxieties and fears. He also developed and used techniques such as free association, dream analysis and hypnosis to bring unconscious, unresolved conflicts into conscious awareness. Freud believed he could use these techniques to release a person's unconscious conflicts and thereby enable them to deal with their repressed thoughts and feelings. Overall, Freud's psychoanalytical therapy aimed to give the individual in therapy a deep insight into their psyche and personality and greater control and understanding over their emotional life.

Freud learnt a lot about human psychological development, particularly psychopathology, this way. His therapy sessions would often focus on the childhood memories and traumas experienced by his patients. Freud's ideas about the importance of early experiences and the human psychosexual development emerged out of this psychoanalytic practice.

Early psychosexual development

Freud believed that human beings go through several stages of psychosexual development and that early experiences play an important part in this. During this process a child's libido (energy) is focused on the part of their body relevant to that stage.

If the needs of a developing child are met at a particular stage, they can move on to the next stage. If the child struggles or experiences conflict at a particular stage of their development, they may become 'fixated'. Freud argued that this could result in their personality being shaped in a particular way.

Table 7 – Freud's stages of psychosexual development

Stage of development	Focus	Reasons for, and effects of 'fixation'
Oral (0–18 months)	Mouth (sucking, licking, biting)	• Child weaned too early – may develop pessimistic, sarcastic personality • Child weaned too late – may develop gullible, naively trusting personality
Anal (1–3 years)	Toilet training	• Child pressurised to begin toilet training or caught in battle of wills about it may retain faeces to deny parents control and satisfaction – may lead to obstinate, miserly or obsessive personality • Lack of toilet training boundaries – may lead to messy, creative and disorganised personality

Table 7 – Continued

Stage of development	Focus	Reasons for, and effects of 'fixation'
Phallic (3–6 years)	Sex and gender	• Child may be filled with anxiety and guilt about unconscious rivalry with same-sex parent for affection of opposite-sex parent • Boys experience 'castration anxiety', girls experience 'penis envy' • If not resolved may become homosexual/lesbian which Freud believed 'abnormal'
Latency stage (6 years to puberty)	Social pursuits e.g. friendships, sport, academic achievement	• Not strictly a psychosexual development stage • Focus is on social development
Genital stage (puberty to maturity)	Sexual relationships	• More easily negotiated if no previous fixations • If earlier conflicts resolved, will have ability to form warm, loving heterosexual relationship

The Id, the Ego and the Super-ego

Freud's interest in unconscious mental processes also led him to outline a theory about the structure and dynamics of the mind. Freud claimed that the development and expression of a person's emotions and behaviour are driven by three interrelated mental structures – the Id, Ego and Super-ego. According to Freud, the Id and Super-ego are always in conflict. The Id, or unconscious part of the personality, is focused on getting what it wants. It consists of sexual, aggressive and loving instincts and wants immediate gratification. The Super-ego is the last part of the personality to develop as a result of socialisation. Morals and a sense of right and wrong drive it – it is the person's 'conscience'. The Ego tries to balance the demands of the Id and Super-ego. It is the conscious, rational part of the personality.

Freud believed that these three structures or territories of the human mind all affect the way we function psychologically. However, we are not always aware of the actions of, or the interactions between them. A person's conscious mind (Ego) is aware of the here and now. It functions when a person is awake so that the individual behaves in a rational, thoughtful way. The conscious mind handles all the information a person receives from the outside world through their senses. The preconscious mind lies just below the surface of consciousness and contains partially forgotten ideas and feelings. It can be compared to a filing cabinet where we store everything we need to remember and which we can easily bring to conscious awareness. It also prevents disturbing unconscious memories from surfacing. The unconscious mind (Id) is the biggest part and acts as a store of all the memories, feelings and ideas that the individual experiences throughout life. The things that lurk deep in the unconscious are seen within psychodynamic theory to play a powerful, ongoing role in influencing a person's emotions, behaviour and personality.

Sigmund Freud's contribution to psychology is now extremely well known. Many of his ideas, such as the unconscious, the Ego and 'Freudian slips' have entered popular culture and everyday language. However, Freud's contribution to and influence on contemporary mental health practice is marginal. Outside of the very specialist world of psychoanalysis, few mainstream mental health practitioners currently draw on his ideas or use the clinical techniques associated with psychoanalysis.

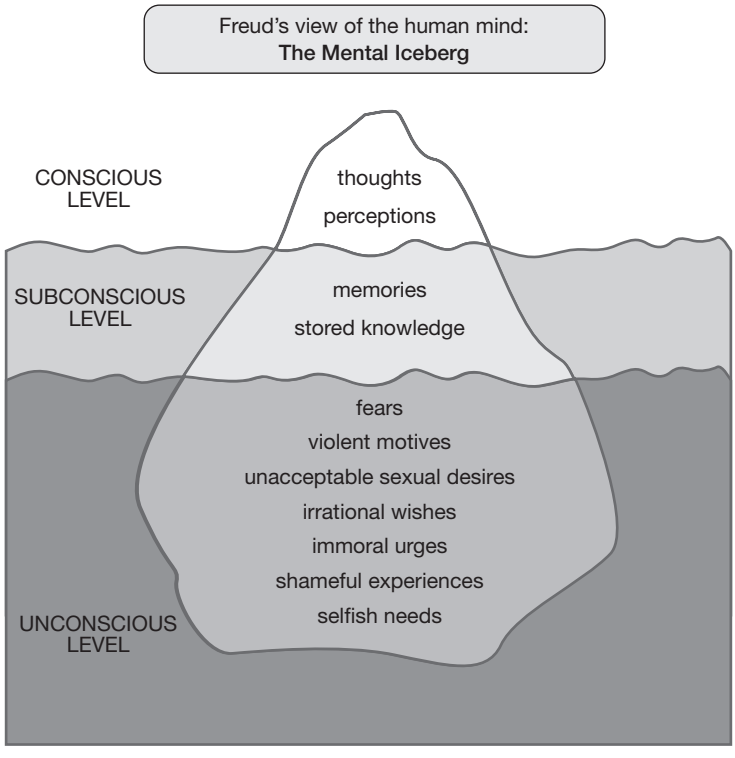

Figure 8 – Freud's view of the human mind: the mental iceberg.

See also – Defence mechanisms; Early experiences; Psychoanalysis; Psychodynamic perspective; Unconscious mind

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Functionalism

Functionalism is a sociological perspective that explains society in terms of inter-linked social structures that perform important roles for society as a whole. Functionalism, like Marxism, is a sociological perspective that sees society as being made up of interconnected parts.

The functionalist perspective is based on the idea that societies are complete systems and that the parts within them cannot be understood in isolation from each other. The functionalist perspective uses a biological metaphor to describe this. Just as the heart, lungs and brain work together to maintain human life, so the family, education system and the law (for example) work together to maintain society. Where the human body consists of interdependent organs, society consists of interdependent social institutions. Each social institution has a particular function or contribution to make to society as a whole. Each social institution must also function effectively and link with others appropriately in order for society to work as it should. Functionalists typically refer to society as a 'social system' to express this idea of an interlinked, interdependent network of social institutions.

Functionalists believe that the structure of society is designed to achieve harmony and agreement between people. Marxists, on the other hand, opt for a conflict view. This highlights social differences and the conflicting interests and values of different groups in society.

Functionalism and the family

Talcott Parsons (1902–1979) was an American sociologist who developed important aspects of the functionalist perspective in the mid-twentieth century. He believed that social institutions, such as the family, had the role of socialising people to behave in acceptable ways so that order was maintained in society. Functionalists see the family as a key social institution in society. G.P. Murdock (1949) produced a classic functionalist study of the family in which he claimed that every known society, from large, developed societies to small hunter-gatherer tribal societies, contained some form of 'family' institution. Murdock identified four key functions of the family in each of these societies:

1. A sexual function, where the family is seen as the approved context or site for the expression of sexual behaviour
2. A reproductive function, where the family is seen as the best, most stable site or context for producing and rearing children
3. A socialisation function, where the family is given the main responsibility for teaching children how to behave in society
4. An economic function, where the family is given the responsibility for providing its members with food, shelter and financial security.

Parsons (1951) also saw the family as pivotal in society, arguing that its basic functions were:

- the primary socialisation of children
- stabilisation of adult personalities (looking after and nurturing adults, especially the male breadwinner).

Critics of functionalism argue that it has a number of weaknesses. In particular, they argue that functionalism:

- ignores conflict and competition in society and paints an overly positive picture of the shared goals and values underpinning society
- focuses on the positive social functions of social institutions and roles and ignores any negative or harmful consequences; for example, adoption of the sick role by people with chronic problems and disability discourages full participation in society and may lead to dependency

- is based on notions of value consensus and assumes this underpins socialisation; however, in a diverse society many different, competing and at times antagonistic value systems coexist.

See also – Interactionism; Marxism; Social action and social structure; Sociological perspective

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Murdock, G.P. (1949) *Social Structure*. New York: Macmillan.
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Group therapy

Group therapy is a type of psychotherapy that involves a therapist (or a team of therapists) working with several people (a group) who have similar problems or shared interests. In addition to the psychological interventions that occur within the group, the communication, social interactions and relationship dynamics between group members and the group leaders play an important part in the therapeutic process.

Group therapy generally involves six to ten people meeting regularly with one or two group therapists. There can be a variety of different reasons and purposes for meeting. Groups can be used to deliver different forms of psychological therapy, including cognitive behavioural, interpersonal and psychodynamic therapies. However, the term 'group therapy' is generally associated with forms of group psychotherapy that are based on psychodynamic/psychoanalytic theories and techniques.

A general assumption of group psychotherapy is that the interactions between people in the group will replicate the problems that brought them to group therapy in the first place. As a result, the processes and dynamics of the group can be used to illustrate and understand these problems and are also a mechanism for changing the attitudes, feelings and behaviour of group members. In some cases, group therapy has a purely supportive purpose. It is used to give people who have had similar (often negative or difficult) experiences opportunities to share these experiences with others who are likely to be understanding and supportive. Alternatively, a group may be used to find out about and try out different, more positive ways of relating to other people. For example, a person may share their feelings of low self-esteem and lack of confidence but go on to test out different ways of being assertive within the group.

The role of the group therapist is to analyse and monitor the dynamics of the group, facilitate communication and enable members to participate in a safe, supported and productive way. Groups usually negotiate rules relating to confidentiality, boundaries and ways of working that the therapist and group members must always adhere to.

Group therapy is a common feature of both statutory and voluntary mental health and social care settings and is also now often available in private counselling and psychotherapy settings. In addition to 'talking therapy' groups, group therapy may be delivered through dance, drama/psychodrama, music and art therapy groups. Specialist therapeutic community settings, where people live together as a group, also make explicit use of group therapy approaches. In these settings the total environment or milieu of the setting is used as the therapy medium. All workers and members of the therapeutic community are part of the group. Their daily activities and interactions are the focus of regular analysis and discussion, often at a weekly 'community meeting'. Group members can use these meetings to raise issues, make comments about what has been happening or criticise how they have been treated or even be confronted about their attitudes and behaviour towards others.

See also – Cognitive behavioural therapy; Family therapy; Mental illness

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Health

Health is a contested concept in the broad medical and health and social care field. It is used in various ways to refer to the functional state of the human body and to the extent to which an individual is free from disease, illness and injury and able to experience a sense of physical, psychological and emotional wellbeing. Definitions of health can be categorised as holistic, negative and positive.

Holistic definitions

The holistic approach to health suggests we should take all aspects of a person's life into account when we're looking at their health. This approach is concerned with the 'whole person' and includes an individual's:

- physical (bodily) health and wellbeing
- intellectual (thinking and learning) wellbeing
- social (relationship) wellbeing
- emotional (feelings) wellbeing.

Many holistic definitions also see spiritual wellbeing as integral to an individual's 'health'.

The term 'wellbeing' is linked to, but can also be differentiated from, health. Wellbeing is used in western societies to refer to the way people feel about themselves. If people feel 'good' (positive) about themselves and are happy with life they will have a high level of wellbeing, and vice versa. As individuals, we are the best judges of our personal sense of wellbeing. From a holistic perspective, health cannot be achieved without wellbeing.

Positive definitions

Positive definitions of health focus on the qualities, characteristics and assets that enable a person to flourish and experience holistic wellbeing. Using a positive approach, the World Health Organization (WHO, 1946) has defined health as being "a state of complete physical, mental and social wellbeing, not merely the absence of disease of infirmity".

What the WHO is doing here is actually providing us with *two* definitions, and making it clear that it supports only the positive definition of health as a *state of complete physical, mental and social wellbeing*. The key term here is 'wellbeing', which seems to suggest that the person feels good both mentally and physically, despite the existence of any 'objective' mental or physical infirmities.

The positive definition of 'health' is vague and unclear in 'medical' terms. It seems to suggest that 'health' has as much to do with general quality of life issues as it does with biology. Alternative health and complementary therapy practitioners tend to use this kind of definition as part of their practice more than traditional medical practitioners do.

Negative definitions

Negative definitions of health focus on the absence of diagnosable disease or illness.

The second part of the quote from the WHO suggests that 'health' is the state of *not* having an illness, infirmity or disease. This is a more commonly used and accepted, though not necessarily a 'truer' or better, way of defining 'health' in the UK. Using this definition, we would say that when a person feels unwell they are 'unhealthy', or lack 'health'. In other words, 'health' is defined by the absence of ill health. Within this definition, a distinction is often made between illness and disease. Illness involves a person's own, or 'subjective', definition of their lack of health, of 'not feeling right' or 'feeling unwell'. However, disease is a biological state in which an individual's body is affected by some form of observable physical 'abnormality' or pathology. The simplest way to understand this is to view the body as a machine that may at times malfunction because, for some reason, one or more of the parts stops working. The damage to the machine part is 'disease'.

Currently, most healthcare practice and policy is based on this type of negative definition. Taking the machine metaphor we used earlier, it is the role of the doctor to identify physical faults and repair them. This is achieved through 'curative medicine', based on surgery and the use of pharmaceuticals (drugs) that alleviate biological disorder.

See also – Biomedical model; Social model of health

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Intersectionality

This concept refers to the idea that a number of different social inequalities or social divisions intersect and become interwoven in the production of social disadvantage, unfair discrimination and social exclusion. As a result, intersectionality is used to explain the complexity and persistence of social inequalities.

The impact of social class on social relations, life opportunities and the structure of society was the focus of many sociologists for much of the twentieth century. The work of Karl Marx in the nineteenth century on class structures and dynamics within capitalism largely motivated this focus on the power of social class to shape society. Consequently, sociologists paid less attention to other social factors and processes that also influenced social experiences, such as gender, ethnicity and culture, for example. However, by the late twentieth century it was clear that social class alone did not and could not provide a sufficient explanation for social inequalities. At the end of the 1980s social scientists began to explore how social divisions in society (around gender, race/ethnicity, sexual orientation and age, for example) 'cut across' and intersected each other. They were interested in how people's lives and identities were affected at the intersection of class, gender and 'race'/ethnicity, for example.

A lot of the early work and subsequent development of social science in this area resulted from an interest in social and cultural diversity and the growth of identity-driven politics. Intersectionality allowed social class to be connected to other forms of social division and also exposed the weakness of sociological work that was based on overgeneralised notions of 'women', the 'working class' or the 'black community', for example. It was realised that members of these groups may not primarily identify with gender, class or ethnicity, for example. Their social identities may be much more complex and nuanced. The life, opportunities and identity of a young, lesbian white working class woman may be very different from that of an older, heterosexual black working class woman, despite their shared class position. Intersectionality draws attention to the social differences and divisions that affect each of these women and points social scientists towards the way that power relations affect their respective lives. It is the particular ways in which intersecting social categories combine that determine how a person experiences the social world. Social scientists applying the concept of intersectionality are interested in the interplay between social positions rather than in the power of a single factor to determine a person's life experiences and opportunities.

Intersectionality has played an important role in helping social scientists to recognise and explore the impact of social and cultural diversity in society. It has been used to show that the impact of social disadvantage may not be evenly spread or uniformly experienced across a class, gender or ethnic group. However, some critics of this approach also argue that in acknowledging the significance of diverse social identities and experiences, intersectionality takes the focus away from the structured patterns of social inequality and disadvantage. Population-level data continues to show, for example, that a person's social class has a profound impact on life chances and mortality rates.

See also – Ethnicity; Gender; Identity; Social class

Further reading

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May, V.M. (2015) *Pursuing Intersectionality, Unsettling Dominant Imaginaries.* New York: Routledge.

Labelling theory

Labelling involves attaching generalised descriptions (labels) to people as a way of summing them up. Labelling should be avoided in health and social care settings as labels are often stigmatising and negative (e.g. diagnostic labels such as 'depressive') and can become a 'master status' that affects the way a person thinks about themselves and the way others treat them. Labelling may also affect the way care practitioners communicate with service users because some labels (such as 'schizophrenic', for example) can lead to insensitive, negative and less favourable treatment.

Labelling theory developed as part of the interactionist perspective within sociology. When applied to the health and social care field, labelling theory has been used to help care practitioners understand what happens during face-to-face interactions. In particular, interactionism has shown how the labelling of behaviour is a social process that has implications for the way people are treated and identify themselves in health and social care settings. Labelling theory has been used to explain how the medical process of diagnosing health problems is, in fact, often a social process. For example, in the nineteenth century women who exhibited a range of symptoms including crying and laughing for 'no reason' were diagnosed with the disease of 'hysteria'. Medical practitioners at the time believed 'hysteria' was caused by women trying to do activities, such as going out to work, that were beyond their natural abilities. The cure was rest and a return to domestic activity. However, there was no such disease. Labelling the symptoms as illness was in fact a way of controlling and oppressing women. Health and social care practitioners are now aware that using crude diagnostic labels such as 'hysteric', 'schizophrenic' or 'spastic' stereotypes a person in a negative way and can be discriminatory and unhelpful as a way of describing a person's care needs.

See also – Interactionism; Prejudice; Sociological perspective; Stigma

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Becker, H.S. (1997) *Outsider: studies in the sociology of deviance*. New York: Free Press.
Goffman, E. (1990) *Stigma: notes on the management of spoiled identity*. London: Penguin.

Maslow's hierarchy of needs

Maslow's hierarchy of needs is a model of human motivation based on the gradual satisfaction of different types of human need.

Abraham Maslow (1943) was interested in motivation and the way this affects human behaviour. He wanted to show that humans are not blindly reacting to situation or stimuli, as behaviourism implies. He believed that a person's behaviour and development are needs-driven.

Maslow's humanistic approach to development and behaviour is based on the belief that human beings have a number of different types of 'need' and that these needs must be met or satisfied in a particular sequence before the person can develop further. Specifically, a person's basic physiological needs must be met first before they can satisfy their safety and security needs. Their behaviour will then be motivated by a desire to satisfy their love and emotional needs. When these are satisfied, the person will be motivated to meet their self-esteem needs. At this point, the individual is in a position to focus on achieving their full potential or need for self-actualisation.

Maslow's contribution to the humanistic perspective focuses on the way in which human behaviour and development are motivated by distinctly human qualities and needs.

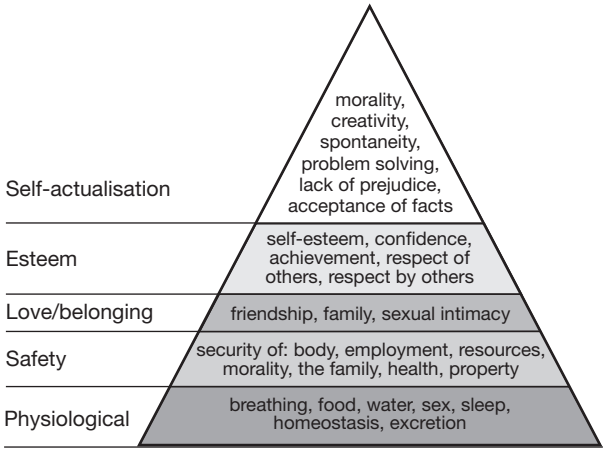

Figure 9 – Maslow's hierarchy of needs. Adapted and reproduced under a Creative Commons Attribution-Share Alike 4.0 International Licence. Author: Saul McLeod.

See also – Humanistic perspective; Self-actualisation

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Maslow, A. (1943) *Motivation and Personality.* New York: Harper and Row.

Psychiatry

Psychiatry is a branch of medicine dealing with disorders in which mental or behavioural features are most prominent. Psychiatry provides a set of beliefs and concepts about emotional and psychological difficulties based on medical ideas of 'illness' and 'disorder'. These ideas, and the mental healthcare practices that result from them, are dominant within the statutory and private sector mental health systems in the UK and in developed, westernised countries generally.

Medically qualified psychiatrists tend to believe that mental illnesses originate from biological dysfunction. These include dysfunction of the brain, malfunctioning biochemical processes and the inheritance of 'faulty' genes that predispose people to mental illnesses. Psychiatrists who base their healthcare practice on biological psychiatry identify mental illness as being located within the individual who experiences mental 'distress' and exhibits symptoms of behavioural and/or emotional 'disorder'. Consequently, biologically orientated forms of psychiatry tend to underplay, and in more extreme cases ignore, the possible contribution and impact of other non-biological factors (cultural, social, psychological and spiritual, for example) in the causation of mental health problems.

Criticism of psychiatry

Critics of psychiatry challenge the medical claim that people experiencing mental distress have a mental 'illness' and that this is likely to be caused by factors within the individual (such as a 'broken brain'). There are many different critics of psychiatry who dispute the 'illness' approach to mental distress. These include the service user movement, mental health practitioners who use non-medical ways of understanding and explaining mental distress and academics who question the validity of 'mental illness' as a concept and claim it is a 'myth'.

See also – Anti-psychiatry; Mental illness; Social model of health

Further reading

Burns, T. (2006) *Psychiatry; a very short introduction*. Oxford: Oxford University Press.

Katona, C., Cooper, C. and Robertson, M. (2016) *Psychiatry at a Glance*, 6th edition. Chichester: John Wiley & Sons.

Szasz, T. (1961) *The Myth of Mental Illness: foundations of a theory of personal conduct*. New York: Hoeber-Harper.

Violence (and aggression)

Violence is "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (World Health Organization). Violence is often preventable, particularly where it is triggered by excessive consumption of alcohol.

A number of different factors have been identified as a way of explaining why people sometimes use violent behaviour. These can be divided into innate, socialisation and situational factors.

Table 16 – Factors influencing violent behaviour

Type of factor	Explanation
Innate	• Aggression and violence are seen by biological psychologists as evolutionary instincts 'hard wired' into human beings as survival mechanisms and linked to testosterone levels • Psychoanalytical theory sees aggression and violence as an inborn tendency or drive to destroy; part of the death wish, but also linked to a survival instinct • Neuropsychologists argue that increased aggression and violent behaviour can result from a damaged and dysfunctional brain
Socialisation	• Behavioural psychologists argue that reinforcement of aggressive and violent behaviour by parents and siblings increases the likelihood of violent behaviour later in life • Social learning theory suggests that observation of aggressive and violent behaviour by role models legitimises this kind of behaviour and leads to imitation
Situational	• People living in overcrowded areas with high levels of poverty and fewer opportunities are more likely to experience and use aggression and violence in everyday life • Pain, frustration, loud noises, alcohol and hot environments are also situational factors that may combine with innate and socialised factors to trigger aggressive and violent responses • Normally non-violent people are more likely to behave aggressively and act violently when they are part of a group that behaves in a similar way

See also – Behaviour; Behaviourism

Further reading

Ray, L. (2011) *Violence and Society*. London: SAGE Publications.

Welfare

A dictionary definition of 'welfare' says that it means "well-being; help given to people in need" (*Collins English Dictionary*, 1995). This definition expresses two important, and slightly different, ways of understanding 'welfare' that are also reflected in how people approach social policy.

The first part of the definition says that 'welfare' means 'wellbeing'. In turn 'wellbeing' might be seen to mean things such as the sense of security, happiness and comfort that people seek or want and perhaps even have a 'right' to in their daily lives. A desire to improve the wellbeing of individuals who belong to certain social groups is often given as a reason for the development of healthcare and social policies and can be the focus of healthcare practice.

The second part of the dictionary definition of 'welfare' suggests that it has something to do with the 'help given to people in need'. Sealey (2015) identifies five main areas of basic human welfare needs: health, education, housing, income maintenance and personal social care. A welfare need can be seen as something that is a necessity for life (e.g. food, water, shelter) as well as something that can enhance the quality of a person's life (e.g. education). Social policies do focus on the creation and delivery of 'welfare *services*' (help) to meet the welfare needs of particular groups of people (those 'in need'). The welfare services typically provided in this way are state-funded health and social services. These may be delivered by statutory organisations or by private or independent sector organisations who have been commissioned to do this on behalf of the state. As such, statutory health and social policies tend to focus on providing services that aim to protect and support those social groups whose members *lack* wellbeing. These include, for example, people who are experiencing poverty and people who have health problems.

See also – Citizenship; Community; Social model of health; Social policy; Welfare state

Reference and further reading

Alcock, P., Haux, T., May, M. and Wright, S. (2016) *The Student's Companion to Social Policy*, 5th edition. Chichester: John Wiley & Sons.

Hills, J. (2015) *Good Times, Bad Times: the welfare myth of them and us*. Bristol: Policy Press.

Sealey, C. (2015) *Social Policy Simplified: connecting theory and concepts with people's lives*. Basingstoke: Palgrave Macmillan.