Essay

Influence of Psychology in Public Health
Return of Risk and Responsibility

Vijay Kumar Yadavendu
Magadh University, Bodh-Gaya, Bihar

Abstract: *This paper argues that the rise of health psychology, has made for a a new consciousness about health that comprises a more general heightened awareness and interest in personal health. While this may be beneficial, in the absence of a social and sociological perspective also creates the illusion that individuals control their own existence, and that taking personal action may improve health and satisfy the longing for a varied set of needs. This individuates risk and responsibility and obfuscates the larger political, economic, social and cultural structural determinants of disease and ill health.*

I

Psychology is a fragmented field --- cognitive psychology, mathematical psychology, and social psychology for instance; have little in common although they share a common heritage. Mainstream psychology is governed by the 'variable model'. Under this model, the subject matter of psychology is conceived of as a universe of actually or potentially measurable variables, the relations among which form the basis for all of the discipline's scientific propositions and laws. Health psychology is not an exception. Several definitions of health psychology have been proposed. Perhaps the most frequently quoted one is that by Joseph Matarazzo who defined health psychology as "the aggregate of the specific educational, scientific and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, and the identification of etiologic and diagnostic correlates of health, illness and related dysfunction" (Matarazzo 1980). He modified this definition to include psychology's contribution to the health care system and also to health policy formulation (Matarazzo 1982).

The prevailing dominant social-scientific theories and their underlying philosophy reflect bourgeois values. Psychology in general and health psychology in particular, is not an exception. Contemporary health psychology has two main voices: the dominant voice of traditional 'mainstream' health psychology, and the lesser known but gradually emerging voice of 'critical' health psychology (Crossley 2000). It is claimed that mainstream psychology and medicine have a long history of collaboration, and that at least psychology's involvement in health and illness goes back well over a century. The emergence of health psychology took place at a time when it became apparent that the leading causes of death

were no longer acute infectious diseases; these had been replaced by chronic illnesses, said to be closely related to particular types of individual behaviour and lifestyle that developed with the growth of a consumerist culture (Stone et al 1979). This was the first set of events that deepened the involvement of psychologists in health care. The second set of events that helped to shape the new sub-discipline of health psychology and behavioural medicine came from within psychology, and involved the development of behaviour modification, that is, changing behaviour by manipulating reinforcement in order to obtain a desired behaviour. The third event was the interest in biofeedback, which is a process whereby information about such physiological conditions as heart rate or brain wave activity is made available so that a person can learn to gain control over those responses. Studies have indicated that increased physical control could be learned for involuntary as well as voluntary responses (Miller cited in ibid).

The above three are considered important causes for the development of health psychology and with this a new consciousness pervaded comprising a more general heightened awareness and interest in health and health care. This often includes environmental and occupational health hazards, in addition to a concern for personal health enhancement. A focus on personal health and individual lifestyle modifications may coexist with, and even act to stimulate attempts to change social conditions detrimental to everyone's health. In simple terminology, health psychology is an attempt to understand relationships between what people think, feel and do about their health problems. Nevertheless, health psychology investigates person-oriented health problems such as smoking, obesity, dental hygiene, etc., with a reductionist paradigm where risk and responsibility is viewed as 'psychological dispositions'.

II

The inheritance of the Enlightenment had scientized the notion of risk. Risk was no longer located exclusively in nature but 'also in human beings, in their conduct, in their liberty, in their relations between them, in the fact of their association, in society' (Ewald 1993). The concepts of Ulrich Beck (1992, 1994, 1995, 2006) and Anthony Giddens (1990, 1991, 1994) 'risk society' and 'reflexive modernization' are influential. For Beck, modern 'late industrial' societies are moving towards 'risk society' as part of the processes of reflexive modernization which involves a questioning of the outcomes of modernity in terms of their production of 'bads', or risks. Broadly there are two perspectives: the first view is epidemiological where danger to populations is posed by environmental hazards such as pollution, nuclear waste and toxic chemical residues. In this conceptualization of risk, individual has little control. The second approach of risk focuses upon risk as a consequence of the lifestyle choices made by individual. Individual behaviour, or the individual herself/himself, is perceived to contain the problem. This approach therefore atomizes both causations and solutions, because the basic causal reasoning implies that interventionist strategies will be directed towards individuals. Both Beck and Giddens viewed risk as the product of human action and decision-making rather than of fate, and is therefore treated as a

political rather than a metaphysical phenomenon. Risk is considered to be linked to reflexivity, choice, accountability, blame as well as responsibility.

Beck credited with establishing issues of risk as central to social theory. He postulates that risk has become the defining feature of late modernity and it has replaced the distribution of wealth as the central axis of conflict in contemporary society. The rise of risk society is not an accident but rather a direct consequence of the development of modern science and capitalist production where all economic models should based on 'microfoundations'. Beck argues:

> In the past, the hazards could be traced back to an undersupply of hygienic technology. Today they have their basis in industrial overproduction. The risk and hazards, of today… are risk of modernization. They are a wholesale product of industrialization… risk may be defined as a systematic way of dealing with hazards and insecurities induced and introduced by modernization itself (Beck 1992:21).

Beck further claims that risk society leads to the demise of class society through the process of 'a social surge of individualisation', where the focus serves to obviate the larger differentials in society mediated by class and which lie at the root of health differentials among different subgroups of people (ibid:87). Risk in public health allows the state, as the owner of knowledge, to exert power over the bodies of its citizens. Michel Foucault (1972). has remarked that every educational system is a political means of maintaining or modifying the appropriation of discourse with the knowledge and powers it carries with it. Health education that emphasizes risks is a form of pedagogy which, like other forms of pedagogy, serves to legitimize ideologies and social practices. For instance, with the birth of the bacteriology pioneered by Louis Pasteur and Robert Koch in the late nineteenth century, demonstrating that specific diseases could be caused by the invasion of specific microorganisms, arose what Rene Dubos (1959) has named the 'doctrine of specific etiology'.

Dubos further explains that Pasteur and Koch's conceptualization of germ theory created experimental conditions that were sufficient to bring the host and parasite together to produce disease, and thus minimized the influence of other factors. The focus on the doctrine of specific etiology and germ theory facilitated the transformation of health into a commodity saleable in the market, which is the essence of capitalist mode of production i.e., commodification. With this commodity fetishism, health problems become problems of the body, which require consumption of some form of technological treatment, rather than a reflection of social relations and complexities. Thereafter, the emphasis in medical practice swung even more sharply towards the individual 'case'. Germ theory guided the development of both medicine and health in the twentieth century as interventions targeted the microorganisms producing disease with newly discovered 'magic bullets' of immunization and antibiotics. With focus on 'germs', the socio-economic context of exposure to the microorganisms was often lost. Germ theory's placement of blame for most sickness and disease on the individual served to exculpate society from responsibility. Discoveries came thick and fast, and scientists were soon announcing bacterial causal

factors for nonbacterial diseases such as yellow fever, malaria and, in veterinary medicine, hog cholera. The 'immediate' cause – the germ – become the sole factor of disease causation. More distal causes– of predisposition, physical and social– were ignored. It effectively diminished the role of social and economic factors in disease causation and has remained the hallmark of the dominant mode of epidemiological practice hitherto.

Risk provides space for the medicalization of society, and has become the founding stone of lifestyle approach to disease prevention and control. As an ideology it promotes heightened health awareness along the lines of personal control and change, it may prove beneficial for those who adopt a more health-promoting lifestyle (Belloc and Breslow 1972). It may, in the process, also creates the illusion that individuals control their own existence, and that taking personal actions may improve health and satisfy the longing for a varied set of needs. Risk, therefore, especially when it emphasizes lifestyle risks, serves as an effective Foucauldian agent of surveillance and control that is difficult to challenge because of its manifest benevolent goal of maintaining a high standard of personal health. In the history of scapegoating of ethnic minorities when an epidemic such as smallpox or plague broke out, is an example of how the concept of risk has been used for political purposes in public health discourse Brandt 1985). In doing so, it draws our attention away from the structural causes of ill health. Vincent Navarro (2007) has argued that one reason for the higher visibility of interventions of this type is that health policy makers perceive them as more manageable and easy to deal with than the structural determinants. The assumption is that it is increasingly evident that many health problems are related to behaviour and that the greatest potential for improving health is through changes in what people do and do not for themselves (Fuchs 1972). Individual life experiences are increasingly related to the extent to which they are exposed to the hazards and risks of modern lifestyles. Zygmunt Bauman (1983) argues that consumer movements, jogging, health foods and injunction towards rational consumption produce more disciplined workers and consumers, and thus could serve the interest of capital. Moreover, excessive emphasis on consumption and health may increase narcissism and individualism, driving individuals to be more absorbed in their own bodies and consumer practices. Bauman further writes:

> The fulfilment of the duty took the form of a strictly observed bodily regime- of regular exercise, a balanced diet, a carefully structured daily and annual rhythm of activities, a consistently growing list of avoidances and self denials. The body itself turned into an object for technology; the owner of the body is now a manager, supervisor and an operator rolled into one, and the medical profession supplied him or her with ever more complex technological products to perform the functions (Bauman 1995).

As Herbert Marcuse (1972) argued that the consumer society produces needs for consumption, happiness, individuality and a good life it may not be able to satisfy, and thus risks producing dissatisfaction and potential social opposition which might become explosive during an era of scarcity and growing structural inequality. There is a tendency

of capitalism to convert public services into commodities to be bought and sold in private market. Such an ideology extends protection to the existing social order from examination, critique and restructuring, which would otherwise have threatened the status quo and those who benefit from the inequities breeding malaise, misery and death. In other words, risk successfully reduces the study of epidemiology into a discipline subservient to clinical medicine.

Epidemiologists who support risk-factor epidemiology are, however, oblivious to such weaknesses of the discipline. Fredrick Epstein (1992) for instance, thinks that the outstanding contribution of chronic disease epidemiology is the development of the risk factor concept which has made possible the prediction of disease in overtly healthy people with precision. Maurice Backett et al (1984) go further and argue that the key value of this approach is that the greatest benefit occurs to those at the highest risk. They thus claim that risk-factor epidemiology has the same ideological basis as the World Health Organization's Health for All Strategy. Although Backett's understanding of the Health for All strategy seems rather idiosyncratic, it is nevertheless true that the risk-factor approach has been put forward by the WHO as an appropriate framework for the selective provision of health services (Hayes 1991; Walsh and Warren 1986). The claims of Epstein and Backett do not appear at all justified when one considers the serious limitations of this approach as compared to classical epidemiology with its inbuilt population perspective. The study of suicide, for instance, exposes many of the limitations of the risk-factor approach. Without the formulation of an alternative research strategy, the epidemiological investigation of suicide amounts to further refinement of components such as methods of determining historical trends, characteristics of populations at risk, and variables associated with the waxing and waning of rates (Hooper and Guttmacher 1979).

The fundamental weakness of this approach is that it is based on a very narrow definition of risk, emphasizing only one aspect of risk, that is, individual risk. Individual behaviour alone is at the centre of all discussion regarding the cause and solution of ill health. The views of Joseph Califano (1979) point to the individualistic nature of the approach of the ten leading causes of death, at least seven could be substantially reduced if persons at risk improved just five habits: diet, smoking, lack of exercise, alcohol abuse and the use of hypertension medication. Today, heart disease, cancer and automobile accidents are posited as civilizational medical problems. They are conceived of as necessary consequences of economic growth and industrialism. However, Navarro (1986) points out that it is not enough to study the distribution of disease as an aggregate of individual phenomena, even if it is based on a multicausal approach. Risk-factor epidemiology, in effect, reduces epidemiology to the role of identifying, measuring, ranking and predicting risk factors relating to individual behaviour, totally disregarding the potential contribution of epidemiology based on a population perspective.

The limitations of risk-factor epidemiology are so evident that one must view its continuing influence with great concern. Its role in the context of underdeveloped countries with large

sections of poor populations in the grip of both communicable and noncommunicable disease is especially doubtful (1994). On the other hand, risk-factor epidemiology has been of great value to the clinical medicine community because it emboldens their claim to the practice of so-called scientific medicine. The continuing boom of risk-factor epidemiology can be explained in terms of the fact that it poses no challenge to the clinical perspective on health and disease, and, in fact, shares with it a common language of individualism.

In order to escape from the nosology of morbid essences, clinical epidemiology builds its science and practice on the closed grounds of what becomes, in principle, an observed occurrence within the individual body. Notions of causation are compressed and limited to the boundaries of the individual realm, where disease is treated in isolation from social reality. Anything that cannot be shown to interact with the organism to produce a morbid state is increasingly excluded. The local space of disease is also immediately a causal space (Foucault 1972). The problem of disease is tackled by breaking the immediate causal link. Thus, clinical epidemiology brings to focus only the most immediate and the local, and prescribes a solution that is based solely on the elimination of symptoms and restoration of normal signs. Foucault contrasts this medical thought with epidemiological tradition and perception which sees the problem of disease as a 'nucleus of circumstances', 'a complex set of interactions', in which the only individuality is a 'historical individuality' (Dubos 1959; Rosen 1979).

Medical practice under the influence of clinical epidemiology is an individualized treatment mode which locates the cause of disease in the individual and his deficiencies. While the risk-factor approach shifted the focus from the population to the individual and his lifestyle choices, clinical epidemiology further strengthened the case of individualism by focusing on the clinical aspects of cure of a particular individual patient, to the total neglect of larger etiological issues. Here medicine assumes that disease is pathological process of body and it is based on:

> The physician's instinctive assumption that his task is to counteract or reserve some observed or assumed pathological process. It seemed logical to assume that, if the progress of the pathological change was accompanied by deterioration in the patient's health, reserving or arresting this change would be the equivalent of a cure (Coulter 1973).

In fact, the detailed study of etiology in clinical epidemiology is confined to the investigation of individual cases or cases of rare diseases (Armenian 1991). The answer to the problem of ill health is then, expected to be found in the same professionalized and individualized treatment, not in a reordering of the social, political and environmental world. It promotes a conception that overlooks the social constraints against 'choosing'. In this view of health, 'it is always individuals who become sick, rather than social, economic or environmental factors which cause them to be so' (Doyal 1981). Evan Stark (1977) commented:

> Disease is understood as a failure in and of the individual, an isolatable 'thing' that attacks the physical machine more or less arbitrarily from 'outside' preventing it from fulfilling its essential 'responsibilities'. Both bourgeois

> epidemiology and 'medical ecology' . . . consider 'society' only as a relatively passive medium through which 'germs' pass en route to the individual.

In this context, failure becomes personal failure and social crises, such as structural unemployment, increasing poverty and increasing precariousness of middle class living, are collectively individualised' and transformed into the risk burdens of individuals Sennett 1998). The aim of capitalist medicine is to reduce a collective phenomenon to an individual one. In this respect, self-care strategies, far from conflicting with the ideology of medicine, are strengthening that ideology so long as they remain at the level of individual response and responsibility (Navarro 1977).

The concept of responsibility has become pervasive and operates at the level of individual actors. The notion of individual responsibility makes an assumption of individual blame as well. The radical individualist model, therefore, encourages attention to individual behaviour and inattention to the social preconditions of that behaviour. In the case of smoking, these preconditions include a powerful cigarette industry; social and cultural forces, including norms that sanction smoking; social and economic forces that induce stress and thus tobacco addiction, and projection of an identity or image by all forms of media, advertising, literature, movies, folklores, etc. The idea that the smoker is free to smoke or not smoke is actually a false notion of individual freedom. Ignoring the socio-cultural environment in which the individual makes his choice, the conclusion drawn is that the individual voluntarily 'chooses' to smoke; thus the responsibility of the ill health resulting from her/his so-called voluntary action also falls on the individual. To focus on individual life-styles is to assume an independence and freedom of the individual that is an illusion. John Last (1988) has critiqued the dominant influence exerted by clinical epidemiology in the field of public health. He notes that neglect of the population perspective and medicalization of the concept of epidemiology will have adverse consequences for public health because 'medical graduates may not know how to assess the health problems of the communities in which their practices are is located, and what is worse, they may not care'. Expressing his difference with the new development within epidemiology Carl Shy attempted to restate the mission of epidemiology thus:

> By essentially assuming that risk factors for disease in individuals can be summed to understand the causes of disease in populations, academic epidemiology has limited itself to a narrow biomedical perspective, thereby committing the biomedical fallacy of inferring that diseases in populations can be understood by studying risk factors for disease in individuals. Epidemiology should be redefined as a study of the distribution and social determinants of the health of populations. This definition provides a stronger link to the primary mission of public health and places an appropriate emphasis on the social, economic, environmental and cultural determinants of population health Shy 1997).

But the new health consciousness entails further 'medicalization' of culture, in particular, of how the problem of health is understood. Medicalization refers to the extension of the range

of social phenomena mediated by the concept of health and illness, often focusing on the importance of that process for understanding the social control of deviance. As Illich (1975) notes that by naming the spirit that underlies deviance, authority places the deviant under the control of language and custom and turns him from a threat into a support of the social system. Aetiology is socially self-fulfilling.

The medical naming of that spirit increasingly circumscribes social existence. Deviant behaviour is defined in terms of sickness, and normality in terms of health. Alcoholism, substance abuse, obesity, problems with sexual violence and child abuse, all have become matters for medical diagnosis, and the label of illness has been attached to them (Conrad and Schneider 1988). This is ironic since the problems of ill health and disease in the third world countries are entirely of a different order, located in hunger, poverty and infection, all of which have social bases.

Medicine as a therapeutic or clinical science locates the problem of disease in the individual body. The individual is both the locus of perception and intervention, more firmly so since the end of the nineteenth century when, as Foucault traces the transformation (the beginning of which he dates to the close of the eighteenth century), the very foundation of medical knowledge becomes lodged in the 'sovereignty of the gaze' fixed on individual signs and symptoms, and then in deep anatomical structures. It is through the observation of individual signs and symptoms that it became 'possible to designate a pathological state . . . a morbid essence . . . and an immediate cause' (1973). In addition, with the development of pathology, the medical understanding of disease turned even more fully toward 'the deep, invisible, solid, enclosed, but accessible space of the human body'. Thus what is known about disease is now a matter of positive knowledge of the individual. What is seen is what is known, and what is known becomes the space for intervention. Locked into a particular way of seeing, an imprisonment reinforced by institutional structures, medicine knows and acts upon disease bounded by an immediacy of perception which is physical, mechanical, biochemical visual.

The spectre of a medicalized and medicated society, where already psychoactive drugs, sleeping aids and common pain relievers have become the standard response to almost every conceivable malaise, must at least raise questions about the wisdom of such heavy reliance upon medical problem-solving.

The use of psychology in the field of health awareness remains locked in a prison of reductionism. The modification of medical notions of causality is entirely one-dimensional, towards psychologism, towards host resistance and adaptation. Even when the psychological environment of the ill person is taken into account in the treatment of the disease, it is merely the immediate personal environment that is considered and not the social environment. Russell Jacoby (1975) has written much on contemporary psychology; the context is most often reduced to the immediate one of interpersonal relations and 'psychological atmospheres'. He further notes: 'A social constellation is banalized to an immediate human network. It is forgotten that the relation between "you and me' or 'you and the family" is not exhausted in the immediate: all of society seeps in' (p136). Nevertheless,

the study of the individual reduces the social context to the immediate context of interpersonal relations and psychological dispositions. Don Ardell (1977) observes:

> The manner in which you organize your bedroom or work space, the kinds of friendship networks you create and sustain, and the nature of the feedback about yourself which you invite by your actions, are all examples of the personal environment, or spaces you consciously or unknowingly set up for yourself (p 63).

In the reduction of 'social relations to immediate human ones', the society in which experience is lodged remains hidden; the part is isolated from the whole. Central to the self-care and awareness model is the concept of individual responsibility. This notion appears in virtually everything that has been written on these subjects Crawford 1980). Ardell (1977:94) summarizes its importance:

> All dimensions of high level wellness are equally important, but self-responsibility seems more equal than all the rest. It is the philosopher's stone, the mariner's compass, and the ring of power to a high-level wellness lifestyle. Without an active sense of accountability for your own well being, you won't have the necessary motivation to lead a health enhancing lifestyle.

Asserting a claim to individual responsibility partially delegitimizes existing authorities and throws open a new political terrain. As Robert Crawford (1980) notes that like political language, individual responsibility is highly problematic. It risks all the myopia of classical individualism. It promotes a conception of universalization of market- based social relations, with the corresponding penetration in every single aspect of life which overlooks the social constraints against 'choosing'. The responsibilization functions as a technique for self-management and self- regulation of social risk such as illness, unemployment and poverty (Lemke 2001).

Navarro (1976: 126) has commented:

> … it strengthen the basic ethical tenets of bourgeois individualism, the ethical construct of capitalism where one has to be free to do whatever one wants, free to buy and sell, to accumulate wealth or to live in poverty, to work or not, to be healthy or to be sick. Far from being a threat to the power structure, this lifestyle politics complements and is easily co-optable by the controllers of the system, and it leaves the economic and political structures of our society unchanged, Moreover, the life-style approach to politics serves to channel out of existence any conflicting tendencies against those structures that may arise in our society .

Navarro states that self-care and changes in lifestyles are supposed to be the most important strategies to improve the lifespan of the individuals. Moreover, behaviourists, psychologists and 'mood analysers' are put to work to change the individual's behaviour. The basic cause of sickness or ill health supposed to be located within the individual and not in the system. The solution, therefore, is intervention, primarily behaviour modification, and not structural change of the economic and social systems and fundamental economic relationships. In this

way, broad socio-economic dimensions are systematically excluded from the analysis and, instead, risk is considered largely in behavioural terms.

Behaviourism, carried to an extreme, has led to unscientific and reactionary theories such as behaviour modification, which uses unethical and even brutal means to change behaviour. For example, Knowledge Attitude and Practice Studies (Rao 1974) (KAP Studies) from India was conducted for introduction or imposition of various methods of contraception. The interventionist concept of motivation was used to change the attitude of the people towards such contraception. The psychology used in the family planning programme and in the development of health modernity, is biased and has been manipulated for the purposes of imposition. The misuse of concepts of motivation and conditioning on the poor people is a glaring example. Behaviourism in psychology, such as the theories of John Watson (1929) and Burrhus Skinner (1945), must be criticized as mechanical, as the reduction of the psychological process of human functioning to the physiological process of behaviour alone. On the other hand, there is the metaphysical theory of Freudianism which focuses on an unconscious mind, divorced from social and individual reality and consciousness, which is seen as the basic source determining human affect, attitude and behaviour.

III

Around the beginning of the 20th century the subject matter of social psychology fluctuated between notions of 'group mind', on the one hand, and 'instinct', on the other. Emile Durkheim (1987), Gustave Le Bon (1903), Edward Ross (1908), Gabriel Tarde (1899) and Wilhelm Wundt (1912/1973) theorized in various ways about collective representations, group mind, collective mind and collective consciousness, which is the composite of 'those mental products created by the community of human life and are, therefore, inexplicable in terms of merely individual consciousness'. The most familiar proponent of the social instinct view was William McDougall (1908) for whom; mental activity is fundamentally grounded in the biological makeup of the person in his/her terms the force of instinct. He proposes that the vast share of social life is governed by inherent instincts, such as reproduction, parenting, pugnacity, gregariousness, acquisition, and habit. In contrast, for Ross, 'social psychology… studies the psychic planes and currents that come into existence among men in consequence of their association' (Ross 1908). However, Floyd Allport (1924) replaced the biologically based orientation of McDougall and argued that social psychology does not have a distinct identity, but is a branch of general psychology and is 'science of the individual'. Allport succeeded not only in integrating the behaviourist orientation of the day, but also simultaneously replaced McDougall's instictivism. Though the theoretical foundation of social psychology is based on the supposed explanatory repertoire of hedonism, utilitarianism, egoism, irrationality–rationality, sympathy and imitation, there are separate vigorous and autonomous traditions both of an experimental and non-experimental nature within the discipline.

Early experimental social psychology was indistinguishable from general experimental research. Frederic Bartlett (1932) work on remembering thereby influenced both the

methodology and theoretical orientation adopted by Allport and Postman (1947) in their studies of students. It also influenced Jamuna Prasad (1935) and Durganand Sinha (1952) work on the circulation of rumours at the time of the Indian earthquake in 1934 after the occurrence of other natural disasters in the subcontinent. In those early days, both in Britain and America, a separate and autonomous experimental social psychology could scarcely be said to have existed; it was part and parcel of a more general experimental psychology. In recent times, however, social psychology has witnessed an increasing concern with 'socializing' social psychology.

James House (1977) distinguished three domains of social psychology, identified primarily by the level of analysis within the new practice. The first, christened 'psychological social psychology' (hereafter PSP), is dominated by the experimental tradition, which anchors itself in the experiences and behaviour of individuals, and attempts to understand these in terms of the immediate milieu. Such an approach, by definition of the scientific paradigm within which it operates, is ahistorical and encourages concentration on behaviours. PSP is concerned with the search, elicitation and application process. In PSP, the 'social' is regarded as one of a number of ways in which cognitive processes can be studied with a rigorous and precise procedure in controlled laboratory conditions. Like all other methods, it too has its strengths and weaknesses, the latter seemingly outweighing the former. This is due not only to the experimenter's bias or demand characteristics, but above all to the fact that the external validity is often ignored and, when examined, often found wanting because the social side of the interaction has not been analysed for its psychologically relevant features.

Experimental social psychology (hereafter ESP) seems unnecessarily imprisoned within the confines of laboratories. Even here, however, only the immediate influences of individuals on the behaviour of one another in a dyad or groups are taken into consideration. Lawful connections between the recorded influences and resulting behaviour are treated as ahistorical invariances, and the societal, historical dimensions of the observed 'social' behaviour are excluded (1994:41). Alternatively, if they are brought into consideration, they are translated into the language of variables and thus stripped of their societal, historical concreteness. Treated as variables, the societal, historical dimensions of individual activity become indistinguishable from and irrelevant to psychological laws, which are presumed to have an existence independent of them. The interpersonal relational structures investigated by social psychology are thus understood as constructed from independent, immediate and reciprocal influences of individuals upon one another (and their lawful transformation into behavioural patterns), and as isolated (or in principle isolable) from the condition of actual societal life (ibid: 41-42). Social psychology does not challenge the limits imposed upon it by an ahistoric, nomothetic model (Holzkamp cited in ibid:41).

The second face, symbolic interactionism, is a recent position in sociology, which adopts a more phenomenological basis. It focuses on the dynamics of human interaction in the development of the mind. The foremost proponent of this face of social psychology is George Mead. As Charles Mills remarked, in Mead we find 'a theory of mind . . . which

conceives of social factors as intrinsic to mentality' but realizes fully the selective character of mentality' (1991:65). Mead's thinking revolved around a vigorous effort to shatter a deterministic conception of man, a conception that sees man marvellously but mechanically fashioned before the conditions and forces of an overwhelming universe. He desired to reformulate mind and self in the light of behaviouristic and pragmatic methods to integrate the individual. For Mead, both the self and the mind were clearly social in nature; the self enabling the human being to carry on a process of communication with himself and the mind being the behaviour that takes place in this inner communication (Blumer 1991:146). Mead's view was that the self and the mind are products of participation in group life. Individuals are dependent upon one another for satisfaction of their needs, thus necessitating a commonality of expectations. This occurs through symbolic interaction, which is aimed at achieving common interpretations. In this way, individual needs are brought into the social sphere and cause modifications of interpretations, which, through compromise, achieve reciprocity of understanding that makes possible optimal satisfaction of the participants' needs.

Symbolic interactionism has attracted much criticism, for instance, that it tends to be ahistorical and noneconomic, especially in its approach to social problems Meltzar et al 1991:37). 'Symbolic interactionism either ignores or has a faulty conception of social organization and social structure' (Gouldner cited ibid:38). Another criticism is that society is reduced to individual processes of interaction and communication. In so far as it is not subjectified as a supraindividual system of interpretations, society functions solely as the negative side of the personal interpretative system, and thus appears as a kind of foreign, blind and meaningless resistance to the meaning-giving activity of human subjectivity. The total separation of subjective and social determinants is consequently reproduced but, as it were, from the other side; the restriction and obstruction of subjective and intersubjective systems of interpretation and expectation by society therefore appear as an inexplicable accident (Tolman1994:45). It can be concluded that although symbolic interactionism and similar positions make some interesting and important moves of a phenomenological sort, they do not bring us significantly closer to a scientific understanding of the relationship between society and subjectivity.

The third face of social psychology, which is called sociological social psychology (SSP) sociology, anchored in classical sociology begins with social structure and explores its relationship to individual experience and behaviour. The analysis, even in this avatar, does not begin at the level of societies but at the level of organizations, institutions and communities. This understanding is anchored in the writings of Karl Marx (1977J, Emile Durkheim (1953) and Max Weber (1947), were centrally concerned with problems of social structure and personality. Marx saw man as basically a rational, purposive producer. His understanding of man and society was a thoroughly sociological one, which viewed man's primary social relationship in the process of production as conditioning the structure of society. Weber the 'founders' of sociology was similarly concerned with relationship

between position in social structure and individual values, motives and beliefs but in contrast to Marx argued that values, motives and beliefs play an autonomous role in society and can indeed be major causes of dramatic changes in social structure. Steven Lukes (1967: 134-56) argued that Durkheim's concept of anomie, like Marx's concept of alienation involves the relationship between 'social phenomena' and individual 'states of mind' or what are termed here, social structure and personality.

In contrast to Marx, Sigmund Freud (1953) saw man as dominated by unconscious and irrational instincts, with the nonproductive death instinct being predominant. For Freud, society was mostly a product of his own psychologizing, and the structure of society was derived from the working of various psychological mechanisms, for example, Oedipus complexes, instincts, etc. The contrast occurs here – Marx placed emphasis on social factors and Freud on psychological ones. It is alleged that while psychological sociology is sensitive to macrostructures, it is weak on the psychological side- how individual thought and behaviour are shaped by material conditions and socialisation processes. Henri Tajfel (1978) has pointed out repeatedly that all these various interpretations of the social have one thing in common: the result of such studies are invariably expressed in terms of individual responses or the average of such responses (which comes to the same, the only difference being that averages disguise as much as they reveal, even if a sigma is added). As a rule, the social is introduced in such studies as an independent variable whose meaning is taken for granted and remains unanalyzed (Holzkamp cited in ibid). While institutions, processes or events are, of course, the result of human actions, once established, they become autonomous of individual.

Two themes especially emerge when one looks back over the various approaches to social psychology. One, the waxing and waning of naive empiricism/positivism and its association with the rise of experimental social psychology, and two, psychological sociology with its scathing attacks on the former approach. All the paradigms within social psychology have in common a protest against positivism. Taken together, they offer a powerful critique of social psychology as practised in the past. The dominant practice of social psychology continues to forge along the old path, using positivism/empiricism as the guiding methodology. It is apparent that mainstream social psychology concentrates on individual responses, which do not enable us to go beyond the individual. This, of course, means that generalizability is limited. In sum, modern psychology is found to be practised as 'a science dealing with alienated man, studied by alienated methods' (Fromm 1970:69).

Thus, there is a need for a strong theoretical base, a critical psychology which challenges many of the theories and practices of mainstream psychology. This critical psychology can be broadly similar to the attempt made by the Frankfurt School. Erich Fromm 1967; 1970), Wilhelm Reich (1966), Rueben Osborn (1965), Herbert Marcuse (1955) and Jean Paul Sartre (1968) made attempts to combine Freudianism with historical materialism, but how much they succeeded is debatable. Fromm, the only psychoanalytically trained member of this school (though he drifted later on) extensively argued for using psychoanalytic typology for

analytic social psychology. He said that analytic social psychology is thoroughly compatible with historical materialism, since both are materialist sciences which do not start from 'ideas' but from earthly life and needs. It investigates one of the natural factors that are operative in the relationship between the economic base and the formation of ideologies.

Thus, analytic social psychology enables us to understand the ideological superstructure in terms of the process that goes on between society and nature (Fromm 1970:180). In other words, critical social psychology studies the social character- which is practice of life as it is constituted by, the mode of production and the resulting social stratification. The social character is the structure of psychic energy which is moulded by any given society so as to be useful for its functioning. Empirically the important task for such an approach would be in revealing the nature of human needs, the satisfaction of which makes human beings more alive and sensitive and factitious needs created by capitalism which tend to weaken them to make them more passive (Fromm 1967:216). Fromm had been critical of others who had used psychoanalytic concepts for a social theory on the ground that they had no clinical experience (ibid:210). This criticism is against Marcuse who is alleged to have distorted psychoanalysis. Marcuse considers psychoanalysis as set of 'metapsychological' rather than a clinically oriented 'technical discipline', the main contention of Fromm for its distortion, is to limit the incompatibility of conjoining Marx and Freud (Nayar 1991). The importance of Marcuse is for his dexterity in linking individual psyche with the social structure through needs and not for his psychoanalytic concepts. The concepts in psychoanalysis were taken to add a missing link in Marxist approach (Marcuse 1968: 159-200).

The need for such integration is necessitated a critical theory of society which would demonstrate that individuals would collectively regulate their lives in accordance with their needs and lay the foundation for a transformation of economic order (ibid: 141-42). Following the Marxian concept of praxis, for Marcuse, knowledge of essence of an object or situation through reason would enable man to change the object in the light of his interest and needs and ensure his freedom (ibid:75-87).

Domination and freedom are contrary to each other. When the individual is provided with goal and purpose and means to strive for and attain, domination takes place. For Marcuse, domination can take many forms; to require an individual to do something by physical force, to coerce him by threats of disagreeable consequences, to condition the psyche by subjugating. The systematic propaganda, to socialize or indoctrinate the individual so that it makes choices within the framework of a 'performed mentality', to plant certain desires in her by subliminal advertising and such other measures. It becomes apparent that psychoanalysis and its concepts have been given undue prominence in linking psyche with society. If we look into Fromm's own analysis of Marx's contribution to the knowledge of man, it would be possible to point the incompatibility of Marxist and psychoanalytic thinking(Fromm (1970:68- 84). But Marcuse's attempt at understanding the concept of essence and the process of domination, again through need is more relevant and paves the way for critical social theory which integrates psychological correlates of social structure

(Nayar 1991:24). In any case, the issue that has been brought to limelight by these two viewpoints notwithstanding the weaknesses of relying on psychoanalysis for achieving it is the integration of missing individual in the critical social theory despite the fact that both view suffer from being too much pessimistic. But Philip Wexler (1983:69) notes differently:

> Despite the facile homologies, the mirroring of social processes at the microscopic level, and the absence of description of social psychology of social interaction- of the mediating process between the social matrix and the intro-individual dynamics, the Marxist Freudians, on the other hand, do provide a critical model of the relation between the social structure and the functioning of individual. However, the Marxist Freudians remain at the periphery of American and English criticism of social psychology. This peripheral place, despite the accomplishment of Marxist-Freudians, is, in part, justified (though they have probably been ignored by liberal social psychologists for different reasons.

A critical social psychology should include a description and analysis of precisely that intermediate level of social processes which the Marxist-Freudians omit: how are the reproduction and transformation of social relations and the individual life processes which constitute them are accomplished in social interaction? Existing deterministic models of social sciences have more or less perpetuated the status quo. A critical psychology may be an attempt to include that mediating process.

IV

The dominant model of public health has strong and tenacious philosophical roots in the positivist tradition of research, which provided the breeding ground for the liberal conception of the social world where individuals are relatively free agents with needs, desires, 'rights' and so on. The individual is abstracted from her/his social location and the solutions prescribed for disease are essentially reductionist. The abstracted individual is completely robbed off her/his collective identity. The existing social institutions as well as institutional changes are explained in terms of relatively free individuals exercising their choice. Behaviour modification, self-help and self-care have become the guiding principles of public health. Although the social and economic influences on choice of occupation, lifestyle, sanitary conditions and a range of other factors that affect health are remain outside the control of the individual. The result was an overemphasis on the determination of specific etiology, development of curative medicines and preventive vaccines, and promotion of individual responsibility.

Psychological dispositions and market fetishism strengthen the case for biomedical and individual-centric approaches. This effectively obviates the dynamics of interaction between the individual and her/his environment with its consequent impact on health, and promotes individual risk and responsibility. It also meant that the sphere of the state's responsibility shrank progressively, away from the social sector in general, and public health in particular.

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References

Allport Floyd (1924): *Social Psychology* Macmillan, New York.

Allport Gordon and Leo Postman (1947): *The Psychology of Rumor* Holt, Rinehart & Winston, New York.

Ardell Don (1977): *High Level of Wellness: An Alternative to Doctors, Drugs and Disease* Rossdale Press, Emmaus, p.63

Armenian Haroutune (1991): 'Case Investigation in Epidemiology', *American Journal of Epidemiology,* Vol.134, (1991), p.1068.

Backett Maurice, Michael Davies and Angele Petros-Barvizian (1984): *The Risk Approach in Health Care: With Special Reference to Material and Child Health, Including Family Planning* World Health Organization, Geneva.

Bartlett Frederic (1932): *Remembering: A Study in Experimental and Social Psychology* Cambridge University Press, 1932.

Bauman Zygmunt (1983): 'Industrialism, Consumerism, and Power', *Theory, Culture and Society,* Vol.1, pp.32-43.

___ (1995): *Life in Fragments,* Polity Press, Cambridge, pp.169-70.

Beck,Ulrich (1992): *Risk Society:* Towards a *New Modernity Sage,* London.

___ (1994): 'The Reinvention of Politics: Towards a Theory of Reflexive Modernization', in Ulrich Beck, Anthony Giddens and Scott Lash (eds) *Reflexive Modernization: Politics, Tradition and Aesthetics in the Modern Social Order,* Polity Press, Cambridge.

1995): *Ecological Politics in the Age of Risk* Polity Press, Cambridge.

(2006): 'Living in the World of Risk Society', A Hobhouse Memorial Public Lecture given on Wednesday 15 February 2006 at London School of Economics, *Economy and Society*, Vol.35, (2006), pp.329-45.

Belloc Nedra and Lester Breslow (1972): 'Relationship of Physical Health Status and Health Practices', *Preventive Medicine*, Vol.1, pp.409-21.

BlumerHerbert (1991): 'George Herbert Mead', in Ken Plummer, (ed.)

Califano Joseph (1979): *Healthy People: US Surgeon General's Report* ,Washington DC.

Conrad Peter and Joseph Schneider (1988): *Deviance and Medicalization: From Badness to Sickness* C.V. Moshy, St. Louis.

Coulter Harris (1973): *Divided Legacy: A History of the Schism in Medical Thought,* Vol. IV (Washington DC: Wehanwken Book, 1973), p.476.

Crawford Robert (1980):'Healthism and the Medicalization of Everyday Life', *International Journal of Health Services,* Vol.10, p.376.

Crossley Michele (2000): *Rethinking Health Psychology* Open University Press, Buckingham, Philadelphia, p.1.

Doyal Lesley (1981): *The Political Economy of Health Pluto* Press, London, p.35.

Dubos Rene (1959): *The Mirage of Health: Utopias, Progress, and Biological Changes:* Harper Collins, New York, p.106.

Durkheim Emile (1987): *Suicide* Translated by John Spaulding and George Simpson Free Press, New York.

(1953): *Sociology and Philosophy* (Glencoe Illinois: Free Press of Glencoe, 1953).

Epstein Fredrick (1992): *Contribution of Epidemiology to Understanding Coronary Heart Disease* Oxford University Press, Oxford.

Ewald Francois (1993):'Insurance and Risk', in Brain Massumi, (ed.) *The Politics of Everyday Fear* University of Minnesota Press, Minnesota, p.226.

Farberman Harvey (1991)'The Foundations of Symbolic Interactionism: James, Cooley, and Mead', in Ken Plummer (ed) *Symbolic Interactionism, Foundations and History*, Vol.1, Edward Elgar Publishing, p.65.

Foucault Michel (1973):*The Birth of the Clinic: An Archaeology of Medical Perception* Tavistock, London, p 90.

___ (1972): *The Archaeology of Knowledge and the Discourse on Language* Pantheon, New York.

Freud Sigmund (1953):*Civilization and Its Discontents* Hogarth Press, London.

Fromm Erich (1970): *The Crisis of Psychoanalysis: Essays on Freud, Marx and Social Psychology* (London: Penguin, 1970), p.69.

___ (1967):'Humanist Psychoanalysis and Marxist Theory', in Erich Fromm (ed.) *Socialist Man* Penguin London.

Fuchs Victor (1972):'Health Care and U S Economic System', *Milbank Memorial Fund Quarterly*, Vol.50, pp.211-37.

Giddens Anthony (1990): *The Consequences of Modernity* Polity Press, Cambridge.

___ (1991): *Modernity and Self-Identity* Polity Press, Cambridge.

(1994): 'Living in a Post-traditional Society', in Beck, Giddens and Lash.

Hayes Michael (1991):'The Risk Approach: Unassailable Logic?', *Social Science and Medicine,* Vol.33, pp.55-70.

Hopper Kim and Sally Guttmacher (1979): 'Rethinking Suicide: Notes toward a Critical Epidemiology', *International Journal of Health Services,* Vol.9, p.417.

House James (1977):'The Three Faces of Social Psychology', *Sociometry*, Vol. 40, pp.161-77.

Illich Ivan (1975): Medical Nemesis: *The Expropriation of Health Pantheon*, New York, p.118.

JacobyRussell (1975): *Social Amnesia: A Critique of Contemporary Psychology from Adler to Laing*: Beacon Press, Boston.

Khan Kausar (199):'Epidemiology and Ethics: The Perspective of the Third World', Journal of Public Health Policy, Vol.15, pp.218-25.

Last John (1988):'What is Clinical Epidemiology', *Journal of Public Health Policy,* Vol.9, p.162.

Le Bon Gustave (1903): *The Crowd,* T. Fisher Unwin, London.

Lemke Thomas (2001):'The Birth of 'Bio-politics', Michel Foucault's Lecture at the College de France on Neo-liberal Govermentality, *Economy and Society,* Vol.30, pp.190-207.

Lukes Steven (1967):'Alienation and Anomie', in Peter Laslett and Walter Runciman (eds) *Philosophy, Politics and Society, (*Oxford: Basil Black, 3rd series, 1967), pp.134-56.

Marcuse Herbert (1955): Eros and Civilization Beacon Press, Boston .

___ (1968): *Negations: Essays in Critical Theory, Cap on Hedonism*, Penguin, London, pp.159-200.

___ (1972): *Counter Revolution and Revolt,* Becon Press, Boston

Matarazzo Joseph (1980):'Behavioural Health and Behavioural Medicine: Frontiers for a New Health Psychology', *American Psychologist*, Vol.35, p.815.

___ (1972): Behavioural Health Challenge to Academic, Scientific, and Professional Psychology', *American Psychologist,* Vol.37, pp.1-14.

Marx Karl (…): *'Grundrisse'*, in David McLellan, (ed.) *Karl Marx*: *Selected Writings* Oxford University Press,

McDougall William (1908): *An Introduction to Social Psychology,* Methuen, London.

Meltzer Bernard, John Petras and Larry Reynolds (1991):'Criticisms of Symbolic Interactionism', in Ken Plummer (ed.) *Symbolic Interactionism Contemporary Issues* Vol.2, Edward Elgar Publishing, p.37.

Navarro Vincent (2007):'What Is a National Health Policy?', *International Journal of Health Services, V*ol.37, (2007), p.2.

___ (1977): 'Political Power, the State, and Their Participation in Medicine', *Review of Radical Political Economy,* Vol.9, p.69.

___ (1976): *Medicine under Capitalism* Croom Helm, London, p.126.

___ (1986): *Crisis, Health and Medicine: A Social Critique* Tavistock, London.

Nayar K.R. (1991): *Interdisciplinary Approach in Social Science in Health: A Re-examination of the Linkages between Social Psychology and Health,* Working Paper, (New Delhi: Jawaharlal Nehru University, 1991).

Osborn Rueben (1965): *Marxism and Psychoanalysis* Delta, New York.

Prasad Jamuna (1935):'The Psychology of Rumour: A Study Relating to the Great Indian Earthquake of 1934', *British Journal of Psychology,* Vol. 26, pp.1-15.

Rao Kamala Gopal, *Studies in Family Planning in India* Abhinav Publications, New Delhi.

Reich Wilhelm (1966):'Dialectical Materialism and Psychoanalysis', *Studies on the Left,* Vol.4, pp.5-46.

Rosen George (1979): 'The Evolution of Social Medicine', in Howard Freeman, Sol Levine and Leo Reeder, (eds), *Handbook of Medical Sociology* ,(Englewood Cliffs: Prentice-Hall, 3rd edition.

Ross Edward,(1908): *Social Psychology* Macmillan, New York..

Sartre Jean Paul (1968): *Search of a Method* Vintage, New York.

SennettRichard (1998):*The Corrosion of Character: The Personal Consequences of Work in the New Capitalism* W.W Norton.

Shy Carl (1997): 'The Failure of Academic Epidemiology: Witness for the Prosecution', *American Journal of Epidemiology,* Vol.145, p.479.

Sinha Durganand ( ): 'Behaviour in Catastrophic Situation: A Psychological Study of Reports and Rumours', *British Journal of Psychology,* Vol. 43, pp.200-9.

Skinner Burrhus (1977): 'The Operational Analysis of Psychological Terms', *Psychological Review,* Vol.52, pp.270-77.

Stark Evan (1977):'Introduction to the Special Issue on Health', *Review of Radical Political Economics,* Vol.9, p.v.

Stone George, et al (eds) (1979): *Health Psychology: A Handbook–Theories, Applications and Challenges of a Psychological Approach to the Health Care System:* Jossey-Bass Publishers, San Francisco and London p.53.

Tajfel Henri (1978): *Introducing Social Psychology* (: Penguin Books, Harmondsworth.

Tarde Gabriel (1899): *Social Laws: An Outline of Sociology t*ranslated by Howard Warren Kessinger Publishing, New York.

Tolman Charles (1994): *Psychology, Society and Subjectivity* Routledge, London and New York, p.41

Walsh Julia and Kenneth Warren (1986): *Strategies for Primary Health Care* Chicago University Press, Chicago.

Weber Max (1947): *The Theory of Social and Economic Organization,* Translation by A.M. Henderson and Talcott Parsons Oxford University Press, New York.

Wexler Philip (1983): *Critical Social Psychology* Routledge and Kegan Paul, London and New York, p.69

Wundt Wilhelm (1973): *An Introduction to Psychology,* Macmillan New York (Reprinted by Arno Press, [1912]), p.5.