

Social Construction of Health

Changing Paradigms

The science of health has been characterised by positivism and extreme rationalism, divested from its social and economic context. The use of social sciences is still confined in the prison of reductionism for with the increased interaction of the disciplines of medical sociology and psychology with health, there is a greater adherence to the quantitative method, nowhere more evident than the interaction of behaviourism to health. This, in turn, obfuscates both the causes of disease and ill health in a society and therefore, the quest for solutions. This study tries in its different sections to expose the handiwork of such deterministic sciences.

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The ahistorical progression of the science of health divested of its social and economic moorings reveals a commitment to a science characterised by positivism and extreme rationalism. Above all, it reveals a manifest commitment to methodological individualism which continues to dominate the understanding of epidemiology up to the present.

As the disciplines of medical sociology and psychology interact with health, a similar reification of the quantitative method is seen, at the expense of the development of a theory of a society which contours the occurrence of disease. This is nowhere more evident than the current marriage of behaviourism to health. Self-care, self-help and modification in individual lifestyles, are the main concerns. Such an ideology obfuscates both the causes of disease and ill health in a society and therefore, the quest for solutions. Despite the broadening, the use of social sciences is still confined in the prison of reductionism. This study tries in its different sections to expose the handiwork of such deterministic sciences.

Theoretical Derivation

Thomas Kuhn in his book, *The Structure of Scientific Revolution* (1962), argues that the principal characteristic of any field of scientific enquiry, during any particular epoch in its development, is the fundamental paradigm that organises the practice of 'normal science' during that epoch. Hence, astronomy, some 500 years ago passed from the paradigm of geocentricism to that of heliocentricism and beyond.

Yet, if one were to inquire about the fundamental paradigm currently in practice, in the study of health, silence is likely

to follow. At the very most, social scientists, whose primary orientation is disciplinary (e.g., economics, sociology, psychology) rather than substantive (e.g., health) would respond with paradigms from their respective disciplines; moral hazard, (sick) role, pluralism and so forth. To move closer still, pathology and medicine do have their own paradigms, but like those imposed by social science, beg the substantive issues of 'health' itself.

To first gain some intellectual distance on the subject, however, a brief look at the development of paradigm structures in psychology of intelligence could be useful. The classical paradigm in the study of intelligence by Binet was that of a universal, genetically fixed endowment of cognitive capacity – specifically, the innate ability to solve extrinsically defined problems. That is, 'intelligence' (according to this paradigm) was (and is) assumed to be qualitatively invariant across culture and secularly invariant through societies over time; moreover, in a particular individual, cognitive capacity was assumed to be largely fixed genetically, and the degree of its achievement was determined by the individual's social and cultural context. Intelligence testing, at its best, was aimed at measuring the endowment of such 'intelligence' whereas learning theory, and, in its more applied form, schooling are assumed to be directed at the attempt to achieve the maximum use of the differentially distributed, but qualitatively universal, cognitive capacity.

Beginning with Piaget, however, the validity of the notion of 'intelligence' as an analytical entity having a real empirical correspondent is no longer universally accepted. Instead, according to Piaget and his followers, 'intelligence is merely a

continuous interaction between perception and cognition, each in its turn altering the other' [Ginsburg and Opper 1969]. Whereas Piaget's contribution lies in his apparently correct recognition that 'intelligence' is not an endowed entity, the weakness of his viewpoint and that of his followers, lies in their view of 'intelligence' as a universal process. That is, his lifetime of research has been devoted to verifying that in all societies the same stages of cognitive development are experienced. In sum, whereas the scholars of the Binet School perceive 'intelligence' as a universal entity, Piaget and his followers see it as a universal process, similar in all societies, culminating, as one psychologist has put it, in the form of a swiss scientist [U Neisser 1976].

Over much the same period as the development of Piaget's work, a third group of psychologists has, in effect, attempted to supplant this paradigm and pursue empirical research on the premise that 'the fundamental categories of psychological processes in man are of an historical character and that psychology must be understood as a historical science' [A Luria 1971]. As Berry notes:

Over the past 70 years, there have been sporadic but recurrent assertions of the notion that people raised in different cultures are different intellectually have different cognitive competencies. These assertions appear to go beyond the usually accepted notions that there are *qualitatively* differing cognitive competencies appropriate to the requirements of a particular culture. Whether all peoples have access to all dimensions, (but produce a different pattern of scores on them), or the same people have access to the some unique dimensions, is immaterial; what matters, is the assertion of more than a single

universal dimension called (in the West) 'intelligence' [Berry 1972].

Continuing on this track, then, the scientific effort is directed to the identification of the 'quantitatively differing cognitive competence' and most important, to the understanding of the mechanism by which different societal forms generate and promote different 'cognitive competencies'. The present endeavour is not for the elaboration of the development of intelligence psychology, but rather the demonstration of that which is to be argued in the case of 'health'.

Individuation of Health and Medicine

The discussion of health and medicine began to emerge in early Greek society with its own theories and practitioners. Health was achieved when the four humours – namely: blood, phlegm, yellow bile and black bile – were in balance in the human body. Hippocrates wrote in *Airs, Waters and Places* that:

Whoever wishes to investigate medicine properly should proceed thus: in the first place to consider the seasons of the year and what effects each of them produces. Then the winds the hot and cold, especially such as are common to all countries and then such as are peculiar to each locality...One should consider most attentively the waters which the inhabitants use...the mode in which the inhabitants live, and what are their pursuits, whether they are fond of drinking and eating to excess, and given to indolence, or are fond of exercise and labour.¹

He further pointed out that human well-being is influenced by the totality of environmental factors, living habits or lifestyles, climate, topography of the land, and the quality of air, water and food. It seems obvious that the Greeks had adopted an internal view on health and believed that medical intervention and prevention in the social and physical environment were necessary for health. Roman medicine accepted the Greek pattern. However under the great physician Galen, the empirical content of medicine was on the rise and transition from religious to scientific orientation in the conception of health and disease began. Medicine was integrally involved with the development of mechanistic science. Starting with Kepler and Galileo's observations of the solar system, the centuries old dialectic between the 'Platonic – Pythagorean tradition and

Renaissance Naturalism versus the Mechanical or Natural Philosophy began to be resolved in favour of the latter' [R S Westfall 1977]. Renaissance Naturalism or Vitalism had upheld the union of spirit and matter in the world; it saw underlying essences reflected in all of nature. In supplanting medieval religious metaphors about disease, however, the discourses of Enlightenment provided for their secular replacement. In the case of the human body, the new metaphor was the machine. Early medical scientists such as Vesalius and Harvey saw the body merely as the homologue of machine, i e, structured similarity. Harvey noted 'from the structure of the heart, it is clear that the blood is constantly carried through the lungs into the aorta as by two clack (valves) of water bellows to raise water' [Westfall 1977:90]. The domination of Renaissance Naturalism can be seen in Harvey's view of the heart as 'the beginning of life'. He wrote:

The mechanism of circulation was less important in understanding the body than was the vitalistic idea that the heart and blood together forming a single functioning unit which is the very seat of life [ibid:9].

Descartes utilised Harvey's work on circulation as the basis for a truly mechanistic perception of the body. The first apparent scientific paradigm for health originated with the development of the machine model of the human body [Reiser 1978; Shylock 1969]. This new science of the Renaissance began for the first time to map out in detail the internal workings of the human body. The mechanistic view analysed living things as sets of mechanical parts such as cogs and pulleys driven by a heart-pump. People were considered machines and a sick person were compared with an ill-made clock. Empiricists like Hobbes, Bacon and Descartes provided the philosophical and ideological groundwork behind such a model of a human being. Descartes believed that the human body worked like a machine, a machine that performs all the physiological functions of a man:

I want you to consider (he concluded) that all these functions in this machine follow naturally from the disposition of its organs alone, just as the movement of a clock or another automate follow from the disposition of its counter weights and wheels; so that to explain its functions it is not necessary to imagine a vegetative or sensitive soul in the machine, or any other principle of movement and life other than

its blood and spirits agitated by the fire which burns continually in its heart and which differs in nothing from all the fires in inanimate bodies [Westfall 1970:93].

Descartes argued that the human body not only worked like a machine but also that the mind and the body of a given individual could be separated into two substances – one 'corporeal' or material and the other 'incorporeal' or immaterial.² With this conception, 'health' came to be seen as the perfect working order of human organism, likening the human organism to an automaton (a self-propelling machine) [Rossdale 1965]. Moreover, the methodologies of pathology and diagnostics that developed from this view (and continues to dominate in the practice of medicine today) consider illness to be both natural (biological) and occurring on an individual basis. Treatment, therefore, is pursued on an individual bio-chemo-surgical basis, relegating the recognition and implications of social causes of illness to secondary importance, though even this secondary recognition must be viewed as an 'ad hoc modification' [T Kuhn 1962:78]. The Aristotelian paradigm with its belief in the organic unity of living things, was gradually replaced by 'mechanistic medicine' which ultimately made possible those aspects of medicine which have been genuinely successful either in prevention or cure of disease or in providing symptomatic relief.

But the adoption of a mechanistic paradigm limits the nature and boundaries of what is conceived as the medical task. Thus, scientific medicine ultimately became curative, individualistic and interventionist, objectifying patients and denying their status as social beings [L Doyal 1981]. For Jewson, scientific medicine has to pass through three basic stages (which he sees as corresponding to three successive modes of production of medical knowledge), viz: 'bedside medicine', 'hospital medicine' and 'laboratory medicine' [N Jewson 1976]. As Doyal (1981) notes: 'these stages provide a useful means by which to understand both the development of medical thought and practice and also its relationship to broader social and economic changes.'

'Bedside medicine' which dominated Western Europe from the Middle Ages until the late 18th century was available to 'minority groups' such as the wealthy and worked on a patronage system with patients choosing those particular doctors whom they believed could help them the

most [N Jewson 1974:369-85]. Until then, the 'new science' (science, i.e., after renaissance) had little impact on medical practice and patron/doctor relationship was the very important determinant of the content of medical treatment. The patient's choice or in Jewson's terminology, 'sickman' was the centre of medical concern, the patient being treated as a whole.

By the beginning of the 19th century, with the advent of the Industrial Revolution the concomitant process of mass urbanisation, 'hospital medicine' [Jewson 1976] came into existence and dramatic changes occurred even in medical practices. Mass urbanisation led to unhealthy cities and the consequence was the establishment of big hospitals for catering to the health needs of the working population. Client-centred therapy was losing its dominance now, and even doctors excluding lay persons, midwives, etc., were becoming more organised in their profession.

Patients were no longer individuals with their own particular set of symptoms and problems, but came increasingly to be seen as 'cases' – the disease became more important than the sick person [K Figlio 1977]. It was the loss of the self in the complex social system where professionalism or

individualism was on the rise. 'Hospital medicine' shifted during this period to diagnosis and classification and the Aristotelian flavour, which had characterised the theoretical base of individual centred therapy, was sidelined. Ilich has beautifully described the significance of this process:

If 'sickness' and 'health' were to lay claim to public resources, then these concepts had to be made operational, ailments had to be turned into objective diseases. Species had to be clinically defined and verified so those officials could fit them into wards, records, budgets and museums. The object of medical treatment as defined by a new, though submerged, political ideology, acquired the status of an entity that existed quite separately from both doctors and patients [Ilich 1976].

Thus, with the advent of 'hospital medicine' the emphasis shifted from a belief in disease as a disturbance of the total system to what is called 'localised pathology'. This was the period of development of new instruments and sophistication in descriptive anatomy and pathology where statistical analyses were used. The development of statistical tools substantially aided this process. The methods that

developed as a consequence diminished the role even of the social, economic and environmental factors.

With the development of the germ theory of disease, in the late 19th century, the emphasis in medical practice swung even more sharply towards the individual 'case' [Doyal 1981:33]. The Germ Theory's placement of blame for most sickness and disease on micro-organisms served to effectively diminish the role of social and economic factors in the disease causation that has become the hallmark of the dominant mode of epidemiological practice to the present day. Scientific medicine or 'hospital medicine', focused on the biological problems of the individual in order to understand and treat most diseases. The diagnosis of illness was made on an individual basis, and treatment or therapy was also individually prescribed [N Coullins 1977]. Laboratory medicine was observed as the final victory of the mechanistic worldview in the latter half of the 19th century. As Doyal (1981) puts it:

At that time, a struggle for supremacy between vitalism, (a belief in the inviolability and unity of living organism) and mechanicalism (which perceive organism merely as sets of inner-related parts) was

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on, and finally mechanicalism got the upper hand. By the middle of the 19th century, mechanism had become dominant and experiments and vivisection had replaced comparative anatomy as the basic method for advancing medical knowledge.

At the same time, doctors became more active interventionists in the physiological processes rather than being passive observers. Medicine was on the way to gaining full recognition as a science. As Doyal (1981:33) further notes:

In latter half of the 19th century, both histology and physiology were developed extremely rapidly, and individual cell came increasingly to be seen as the central focus for understanding ill health. Cell theory and controlled clinical trials did not immediately provide any new therapy, but they did form the basis for 20th century developments in clinical medicine.

This biological reductionism, instrumentalism, elementalism or positivism widened the gap between the doctor and the patient. It has been observed that this version of the natural world was a victory of the industrial bourgeoisie, which established the positivist conception of science, and of medicine [V Navarro 1986]. Medicine has been characterised by what Jewson calls a shift from person-oriented to an object-oriented cosmology. As Doyal puts it: 'it is always individuals who become sick, rather than social, economic or environmental factors which cause them to be so' [Doyal 1981]. Stark has 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 [E Stark 1977].

There are problems with this approach, which still dominate contemporary medicine. The physician deals with an individual patient (already a socially determined process) [B Stern 1980]. The patient is not an abstract being, but of a certain age, sex, race and class and has internalised a specific historical experience from childhood to adulthood [W Reich 1970, 1972]. The taking of a purely medical history individuates the patient; however, the disease or injury from which the patient is suffering, is received as part of a collective experience in a particular historical, cultural and social setting. These latter circumstances are as much a part of the

cause, and should be part of the treatment, as purely medical facts. (The medical facts themselves are social historical facts). Thus, the essence of scientific medicine's treatment of disease discourages a proper understanding of disease by excluding from consideration the most relevant internalisation of the external world by the patient. As Wartofsky puts it: 'Human ontology cannot be reduced to an asocial or ahistorical biology without doing violence to the very specificity of human biological structure and function itself' [M Wartofsky 1975].

By abstracting disease from its social framework and reducing it to the biological sphere, social conditions could be and were ignored. Scientific medicine became consistent with and indeed legitimated capitalist development by integrating a model of healing with the social structure; in so doing, scientific medicine has obscured the relationship between disease and the nature and form of social development. Today, heart disease, cancer, and auto accident are posited as 'diseases of civilisation' [J H Knowles 1977]. They are conceived of as necessary consequences of economic growth and industrialism, when it is uncertain that this is so [Eyer and Sterling 1977].

The major concern of scientific medicine, consequently, is to render the body more functional in its struggle to adapt to the potentially antagonistic forces of nature. In contrast to the World Health Organisation's (WHO) definition of health as 'physical, mental, and social well-being, not merely the absence of disease or infirmity', health tends to be defined in functional rather than in experimental terms, as the absence of disease. The defining of health and illness in a functional way is an important example of how a capitalist value system defines people primarily as producers. It is concerned with their 'fitness' in an instrumental sense, rather than with their hopes, fears, anxieties, pain or suffering [Doyal 1981]. In the therapeutic relationship, the task of the patient is to understand the signs and symbols of the problems as the physician reads them and thus to accept the medical definition of both the problem and the solution. Taussing (1980) calls this process:

The creation from a 'phantom-objectivity' with regard to disease, a process of 'denying the human relations embodied in symptoms, signs and therapy', a process by which 'we not only mystify social relations, but we also reproduce a political

ideology in the guise of a science of apparently 'real things' – biological and physical thinghood'.³

Further Taussing concludes:

Medical practice is a singularity important way of maintaining the denial as to the social facticity of facts. Things thereby take on a life of their own, sundered from the social nexus that really gives them life, and remain locked in their own self constitution.

From the many factors that contribute to disease – social, environmental, physical, psychological – 'western' medicine tends to isolate a single physical factor and label it the 'cause'. Dubos (1959) explains that Pasteur and Koch's conceptualisation of germ theory created experimental conditions that were sufficient to bring the host and parasite together to produce disease and thus minimised the influence of other factors. The focus on the doctrine of specific aetiology and germ theory facilitated the transformation of health into a commodity, amenable to sale in the market, fulfilling the basic need of the capitalist system for 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. Navarro explains this beautifully as the 'need for consumption, consumption that reflects a dependency of the individual as something that can be bought, either a pill, a drug, a prescription, a car, or the pre-packaged moon' [V Navarro 1976].

Epidemiology and Health

This does not mean that nothing was done in the field of 'public health'. The devastation wrought by industrial and urbanisation process was impossible to ignore even in the first half of the 19th century and outside hospitals, the relationship between disease and urbanisation and living working conditions was becoming widely accepted. The socio-political and socio-economic events set the stage for the development of modern epidemiology, sociology, geography, psychology and anthropology.

The development of epidemiology is rather different from other social sciences. Its 'greening period' [A M Lilienfeld and D E Lilienfeld 1980] is placed in mid-1800s a few decades before the classics of Durkheim and Weber were published. Lilienfeld and Lilienfeld describe Louis as an important founding father of modern

epidemiology. As early as 1833 he pioneered the importance of statistical methods in medicine. The construct of mortality is even older. Graunt, a London haberdasher published the *Bills of Mortality in 1662* [K J Rothman 1981]. In those early days, the discovery of the aetiology of infectious diseases was an important purpose of epidemiology and its development was closely connected to that of public hygiene and vaccination policy. Gradually, its scope and purpose expanded beyond the area of treatment to the prevention of disease as well. After the second world war, the emphasis on population-based epidemiological research came to be on the rise.

Traditionally epidemiology has been associated with disease prevention and the Oxford dictionary defines epidemiology as 'that branch of medical science which treats epidemics' (The Compact Edition of the OED 1971). The term epidemic can be replaced with the phrase 'major public health problems.' The roots of today's epidemiology have been detected in the work of William Farr who established a tradition of careful application of vital data to problems of public health and other broad public concerns. At the time, work by sanitarians like Farr, Edwin Chadwick and John Snow and particularly Chadwick's immense investigation published in 1842 as *The Sanitary Conditions of the Labouring Population of Great Britain*,⁴ illustrated the close relationship between poverty and disease, a connection which was stressed in contemporary debates as the public health questions. Many of the major accomplishments of public health resulted from epidemiological studies in the classic tradition of John Snow's investigation of cholera, and it is at this level that the science and model of epidemiology have perhaps most clearly demonstrated their worth. Thus serious physical hazards have been identified, legislations have restricted these hazards and demonstrable improvements in the health of the population as a whole have been observed. Even here however, the overriding requirement that epidemiological study examine only those factors which are conventionally regarded as objective, has effectively eclipsed many other aspects of the conditions under study. It has appeared to be enough to investigate the connections between a given illness (or range of illnesses) and the factors which are suspected of being associated with the conditions under consideration. Epidemiology as applied to public health at the

macro level in future may thus proceed in one or two ways: either the major 'medical' issues of the day will be faced (through a recognition that events in the real world have a socio-economic setting which must be articulated and addressed via more stringent attention to underlying theoretical, contextual, as well as methodological development in epidemiology) with the corollary that political involvement is unavoidable or epidemiology will become apparently methodologically sophisticated, but effectively irrelevant, aside in the tide of history [C K Cassel 1983].

In the dominant paradigm of understanding regarded epidemiology is regarded as 'essentially an inductive science' (ibid), and in epidemiology the casual concept is essentially a reductionistic, mechanical one (the concept of disease agent/risk factor). It is disease-centred (disease being a biomedical concept) and concerned with biological inferences. Thus epidemiology as presently constituted fails to face up to the question of how to promote health at the most basic and essential levels.

There is perhaps no more obvious illustration of medical care of a basic level than that of the sort discussed by Rifkin (1985) in her text on community health initiatives in the developing world. There seems little doubt in these contexts about which conditions – both of the environment at large, and of the individual in particular – constitute the present major threats to health and well-being [M King 1966], but there remains considerable dissension concerning priorities between those embedded, for instance between the technologically complex and status laden medical tradition of scientific medicine, and those involved in 'low technology' health care. In this context Rifkin (1985) cites Ross as distinguishing three types of community health development, viz, the 'external' approach, the 'multiple' approach and the 'inner resources' approach. These approaches, as generally perceived, involve progressively more grass roots commitment and correspondingly less professional or 'expert' diagnosis and mobilisation with regard to health 'needs' and 'problems' (so progressing from 'top down' to 'bottom up' approaches and planning). Of these approaches, it might at present be argued that epidemiology as usually understood, services and informs the 'top down' approach; epidemiology enables 'experts' to act (with whatever level of 'community' consultation or involvement) on 'problems' identified in professional terms. Social epide-

miology, as this type of research is called, received emphasis during the war on poverty programmes of the early 1960s and, at the same time, gave some scientific justification for their inauguration and continuance [Israel 1978; I Waldron 1977]. Studies indicated differences in occurrence, severity, and length of specific illness based upon a person's income, race, age, and especially class. While these findings became widely accepted within the discipline of epidemiology, unfortunately they had very little impact on medical education. Yet, just associating a relationship between social characteristics, disease incidence, and health status does not fully explain the totality of those relationships. To the extent that social epidemiology was content to remain on a descriptive level, it became merely a form of demography [ibid].

Although the recognition of the social basis of many diseases and ill health goes far back in medical history, the greatest boost probably came with the publication of the *Chadwick Report* in England and the *Shattuck Report* in the US in middle of the 19th century. Since that time social epidemiology and environmentalist approach to health (which is considered the second paradigm in the discussion of health, for it is clearly in conflict with the biological and individual orientation of the classical school) came to be the predominant methodology. While social epidemiology allows for the use of 'multifactorial' explanation for disease occurrence, it still tends to rely upon a notion of specific aetiology and sees social and economic factors as contributive rather than causative.

The parallel between the social epidemiologist and the Piaget's school is quite striking. Both go beyond bio-individualism in recognising that 'health' in the one case and 'intelligence' in the other arise out of developmental process in which the individual interacts with the social environment. Both, however, generally assume the respective processes, and indeed 'health' and 'intelligence' themselves, to be universal – independent of the form of society in which they are investigated. Whereas Piaget normatively conceives of intelligence as the highest stage of universal cognitive competence, the social epidemiologists accordingly conceive health as a lack of break down in a universal notion of human organismic integrity. Both these assumptions are being seriously challenged in their respective disciplines.

Epidemiology is a discipline, which is concerned with health and its maintenance

in a population. By definition it is interdisciplinary in nature and calls for skills beyond disciplinary grids, which many social science approaches fall short of, whether in sociology, anthropology or psychology. Although the social basis of epidemiology was recognised, the actual operationalisation of this was in the form of discrete disciplinary inputs such as Medical Sociology, Medical Anthropology, Health Psychology, etc. In disease-centred epidemiology, social factors are hardly used in conceptual frameworks. In exposure-oriented epidemiology, current practice is that the factors under study are conceptualised by a specialist, e.g. nutritionists, immunologists, who are trained not to understand the phenomenon of health in its entirety, but to offer intervention and solution and not provide explanation when medicine is put into practice. The role of social sciences in health was however to provide explanations and offer solutions in the practice of medicine. Nevertheless, in spite of its limitations one cannot overlook the positive contribution and the changes wrought in the approach to health by areas such as medical sociology.

Medical Sociology and Health

There were works in the area of medicinal sociology in which the sociological study of illness and medicine were covered. Strauss differentiated between sociology 'of' medicine and sociology 'in' medicine. Sociology of medicine focuses on the study of medicine to illuminate some sociological concern (e.g. patient/practitioner relationship, the role of professions in society). Sociology in medicine, on the other hand, focuses primarily on a medical problem, e.g. the sociological causes of disease and illness, reasons for delay in seeking medicinal aid, patient compliance or non-compliance with medical regimens, etc [R Strauss 1981]. The conceptual dichotomy between these two approaches is more apparent than real. For legitimising the cause of public health, exponents like Virchow in Germany and Chadwick in England emphasised the role of economic, social, political, psychological and cultural factors in health and illness. Virchow, a social medicine physician, called for measures such as free public education, separation of church and state, higher wages, progressive taxation, cultural autonomy for natural minorities, agricultural collectives and full employment [Ackerknecht 1953]. Rosen (1955) traces

the term 'medical sociology' back to early 1900 Germany, related to Grotjahn's *Social Pathology* published in 1911. But it is clear that the emergence of medical sociology as an organised discipline occurred in the years after second world war, i.e., in the late 1950s.

The 'boom' in medical sociology, the sharp increase in systematic development of the field in terms of both quality and quantity occurred during the 1970s. One thing should be made very clear and that is, medical sociology is, in a sense, synonymous with dominant American sociological paradigms. The prominent figures included Talcott Parsons, Evert Hughes, Robert Merton and August Hollingshead. Their interest in medicinal sociology derived from broader sociological issues. Parsons's work on medicine as a social institution and illness as a deviance, was an illustration of a larger theory of society; Merton used medicine as an example of a profession in the study of professions; Hughes's work was done within the framework of occupational sociology; and Hollingshead's main focus was on social class [S W Bloom 1979]. Parsons took a structural functionalistic perspective while the Chicago School stressed symbolic interactionism [V L Olesen 1975]. Parsons's functionalist orientation suffers from a particular form of ahistoricism. In capitalist society, functional health, subordinated as it is to the process of accumulation, refers only to the capacity to contribute to that process, not the capacity to perform any role or task, productive or not.

In the attempt to sketch the hopes and aspirations of medical sociology, both in the past and in the present, one is immediately confronted by an essential problem, i.e., the difficulty of finding a valid definition. Medical sociology can be described as the study of social factors in health and illness (referring to illness as the experience of becoming and being ill and its behavioural counterparts) and of the constructions of medical reality of social factors in health care. Older definitions of medical sociology as sociology of medicine and sociology in medicine [Freeman, Levine and Reeder 1979] and more recent emphasis on health and illness itself [D L Patrick and G Scambler 1982] are combined in this description.

In general terms, it can be argued that the main goal of medical sociology is to improve the conditions of living for human beings. This includes analysing inequalities in the distribution and frequency of dis-

eases as well as in the provision and utilisation of health care services. It had been hoped that demonstrating inequalities would prove to be a challenge to get rid of them, and that medical sociology could provide not only the findings but also the scientific prerequisites for working and practicable solutions in health and social policy that were indicated by such findings. The analysis of medical institutions, of the providers of health care, and of their socialisation, as well as of health behaviour of people, was to bring about predictive statements that would facilitate planning. Thus, many medical sociologists aimed at improving the efficacy of medicine and its institutions by analysing them, a task, which is in accordance with the humanitarian commitment of medical sociology.

This implies that medical sociology cannot be pursued without an orientation to values. This branch of knowledge, therefore, could be expected to base itself on the ethic of humanitarianism, and to be committed first of all to the social welfare of persons in time of health as well as of illness. This would inevitably lead to conflicts both with medicine and with its most important and most powerful representatives, the physicians. Nor was it surprising that medical sociology, in its striving to emphasise the social dimensions of illness, turned out to be receptive to, if not even in occasions enthusiastic about psychosomatic medicine as well as the mental health movement in general. In spite of a considerable body of empirical findings, one still has a limited understanding of unequal distribution of diseases. After Parsons it was perhaps justified to expect a 'grand theory' to be attainable also in medical sociology. But it has restricted itself to 'theories of middle range' and to even narrower hypotheses, which in the last years have tended to hide behind the pretentious concept of 'models'.

The health services system has not achieved greater efficacy and efficiency as a result of medical sociological research. The scientific parochialism that is common in this field is indeed deplorable. What are needed then, are cross-cultural surveys that would lead to such questions. There are a number of authors who recognise this to be a real dilemma, but even among the most critical, medical value scales are often accepted without question. A similar situation exists in the field of social policy. Gouldener notes:

The state...does not only require a social science that can facilitate planned inter-

vention to resolve certain social problems, it also requires social science to serve as a rhetoric, to persuade resistant to undecided segments of the society that such problems do, indeed, exist and are of dangerous propositions [A W Gouldner 1971].

Evaluation in this case, according to Gouldner, serves to prove the inefficiency of former elites and of traditional procedures. The welfare states are using it to unmask the competitor. However, in welfare states the process does not go beyond that. It satisfies itself just by maintaining the status quo. Medical sociology then becomes a mere instrument of propaganda for the welfare state or a producer of ideologies, as formulated by the German sociologist Lepsius.⁵ Gouldner's insights, which he may owe to his experiences in health services research, are highly relevant for medical sociology. They reveal a vast potential, but also hidden dangers in medical sociology. Since many medical sociologists have so readily adopted medical conceptions of values, it should not be difficult to induce them to adjust to other ideologies provided only that they can be convinced – or can convince themselves – that all is done only 'for the patients' best'. In the foregoing, I have discussed some substantive aspects of medical sociology. What remains is a critical analysis of the literature itself, that is to say, a review of the publications as such. Medical sociologic writing has turned out to be a rather one-sided affair. After some tentative steps in different directions, the scientists have concentrated on a few selected areas, much like directing a wide stream into narrow channels while leaving the rest of the country, by far the larger part, untouched, a dry and unexplored waste. The torrents of publications on the topics of death and dying, health behaviour, or labelling theory, which have flooded the fields of medical sociology, are an example.

Feminist critics have viewed the medical profession as a largely patriarchal institution that used definitions of illness and disease to maintain the relative inequality of women by drawing attention to their weakness and susceptibility to illness and by taking control over areas of women's lives such as pregnancy and childbirth that were previously the domain of female lay of practitioners and midwives. The dominant current in medical sociology failed to provide spaces for such criticisms. Most critiques advocate the 'empowerment' of patients, encouraging people to 'take back control' over their own health by engaging

in preventive health activities. These were the trends of medical critique in 1970s and into the 1980s. It remains the dominant approach in 1990s for feminist writers, for those who adhere to a Marxist perspective on health and illness and proponents of the consumerist approach to medicine. The problem with the orthodox critiques such as those of Ivan Illich is the rather black and white portrayal of scientific medicine, as largely detracting from, rather than improving people's health status, of doctors as intent on increasing their power over their patron rather than seeking to help them, and of patients as largely helpless, passive and disempowered, their agency crushed beneath the might of the medical profession [D Lupton 1997]. 'The asymmetry of relationship is exaggerated to the point that the lay client becomes not the beneficiary but the victim of consultation' [Atkinson 1995]. In their efforts to denounce medicine as an oppressive force, orthodox critics undermine the positive contributions of medicine. They also fail to acknowledge the ambivalent nature of the feelings and opinions that many people have in relation to medicine or the ways by which patients willingly participate in medical dominance. This complicity inevitably incorporates latent conflict and resistance, 'a shifting balance between manifest collaboration and tacit opposition in relations between those who come for help and those who profess to provide it' [de Swaan 1997]. So, there is no struggle for power between the dominant party (doctors) and the less powerful party (patients), but rather, there is collusion between the two to reproduce medical dominance. Foucault's writings emphasise the positive and productive rather than the repressive nature of power [Lupton 1997]. Further, Foucault argued that the very seductiveness of power in modern societies is that it is productive rather than simply confining:

What makes power hold good, what makes it accepted, is simply the fact that it doesn't weigh on as a force that says no, but that it traverses and produces things, it produces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network, which runs through the whole social body, much more than as a negative instance whose function is repression [Foucault 1984a quoted by Lupton 1997:98].

From this perspective, medical power may be viewed as the underlying resource by which diseases and illness are identified and dealt with. The power that doctors have in relation to the patient, therefore,

might be thought of as a facilitating capacity or resource, a means of bringing into being the subjects 'doctor' and 'patient' and the phenomenon of patient's illness. From this perspective, doctors are not considered to be 'figures of domination', but rather 'links in a set of power relations', 'people through whom power passe(s) who are important in the field of power relation' [Foucault 1984b quoted by D Lupton:99]. Unlike orthodox critiques, Foucauldian perspective argues, therefore, that it is impossible to remove power from members of the medical profession and hand it over to patients. Power is not a possession of particular social groups, but is relational, a strategy that is invested in and transmitted through all social groups [Lupton 1997]. The orthodox critiques tend to view members of the medical profession as consciously seeking to gain power and status and limit other groups' power, largely by eliciting the state's support. In contrast, Foucauldian scholars tend to argue that the classical gaze is not intentional in terms of originating from a particular type of group seeking domination over others. There is not a single medicine but a series of loosely linked assemblages, each with different rationalities [T Osborne 1997:100]. People are constantly urged to conduct their every day lives in order to avoid potential disease or early death. As a result, 'sociologically speaking everyone lives under the medical regime, a light regime for those who are not yet patients, stricter according to how dependent on doctors one becomes' [de Swaan 1997].

Neither the orthodox critique nor the Foucauldian perspective has adequately taken account of the mutual dependencies and the emotional and psychodynamic dimensions of the medical encounter, preferring to rely upon a notion of the rational actor. Yet, as I argued, a recognition of the 'irrational' and contradictory aspects of the relationship that lay people have with members of the medical profession goes some way to explaining why it is that 'power, after investing itself in the body finds itself exposed to a counter attack in the same body' [Lupton 1997].

Psychology and Health

The day to day practice of psychological researchers in mainstream, bourgeois psychology is governed by 'variable model'. Under this model, the subject matter of psychology is conceived of as a universe of actually or a potentially measurable variables, the relation among which forms

the basis for all of the discipline's scientific propositions and laws. The rise of capitalism was at the same time the rise of the middle class, the 'bourgeoisie'. The prevailing social scientific theories and their underlying philosophy will reflect these bourgeois values. Psychology in general, and health psychology in particular, is not an exception. Health psychology is the offshoot of this bourgeois, positivist psychology. It is claimed that psychology and medicine have a long history of collaboration and at least psychology's involvement in health and illness go 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, but had been replaced by chronic illness, said to be closely related to particular types of individual behaviour and lifestyles that developed with the growth of a consumerist bourgeois culture. This was the first set of events that deepened the involvement of psychologists in health care. The second set of events which helped to shape the new subdiscipline 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 to the person so that she/he can learn to gain control over those responses. Researchers such as Brown and Miller indicated that 'increased physical control could be learned for involuntary as well as voluntary responses' [Stone 1979].

These three are considered important causes in the development of the new subdiscipline of health psychology. In simple terminology, health psychology is an attempt to understand relationships between what people think, feel and do about their health problems. As far as definitions are concerned, there have been several definitions proposed, perhaps the most frequently quoted one is by Joseph Matarazzo (1980), 'health psychology, is 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'. This definition was modified to include psychology's contribution to the health care system and health policy formulation [Matarazzo 1982]. Psychology claims to be an interdisciplinary field of scientific enquiry. But it remains one, which investigates person-oriented health problems such as smoking, obesity, dental hygiene, etc, with a reductionist paradigm of individual psychology [Matarazzo 1980].

With the development of health psychology, a new popular health consciousness pervades the western countries and even among the elite of the developing countries. This new health consciousness is more inclusive and the more general heightened awareness and interest in health often includes environmental and occupational health concerns as well as a concern for personal health enhancement. A focus on personal health and individual lifestyle modifications may co-exist with and even act to stimulate attempts to change social conditions detrimental to everyone's health. As Katz and Levin (1980) and Gartner and Riessman (1977) point out with respect to self-care and self-help, there are numerous examples of politically activated groups that identify with these increments. As an ideology that promotes heightened health awareness, along with personal control and change, it may prove beneficial for those who adopt a more health-promoting lifestyle [Belloc and Breslow 1972]. But it may, in the process, also serve the illusion that individuals control their own existence, and that taking personal action to improve health will somehow satisfy the longing for a much more varied complex of needs. This is important: lifestyles only explain a small proportion of the morbidity and mortality between social classes. Yet the focus on 'lifestyles' serves to obviate the larger differentials which are mediated by class. Such an ideology, contributes to the protection of the social order from the examination, critique and restructuring which would threaten those who benefit from the malaise, misery and deaths of others.

How health is popularly understood is in large part reflected in a society's therapeutic. In turn, those therapeutics further structure cultural understanding [Friedson 1972]. Popular notions about health, in other words, help produce and are partially reproduced by the therapeutic mode. The new health consciousness entails further medicalisation of culture, and in particular, a medicalisation of how the problem

of health is understood. Medicalisation 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 notes:

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 [Illich 1975].

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, child abuse, opiate addiction, obesity, problems with sexual functioning, and violence have all 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 is 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 19th century when as, Foucault (1983) traces the transformation (the beginning of which he dates to the close of the 18th 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' [Foucault 1983:90]. And 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' [ibid:195]. 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). In escaping from a nosology of morbid essences, it builds its science and chemical practice on the closed

grounds of what becomes, in principle, an observed occurrence within the individual body. Notions of causation are compressed as well, limited to the boundaries of the individual in which disease takes its only meaningful existence. Anything, which cannot be shown to interact with the organism to produce a morbid state, is increasingly excluded. The local space of the disease is also, immediately, a causal space [ibid:189]. The solution to the problem of disease is directed towards breaking the most immediate cause link. Thus, medical perception pushes causal understanding toward the immediate and local, and solution toward the elimination of symptoms and the restoration of normal signs. As Foucault states, 'the space of the disease is, without reminder or shift, the very space of the organism' [ibid:191]. Medicine has become 'a science of the individual'. Foucault contrasts 'medical thought with an epidemiological tradition and perceptions' (1983:22-36) which see the problem of disease as 'a nucleus of circumstances', a 'complex set of intersections', in which the only individuality is a 'historical individuality' [Dubos 1959:113-43; Rosen 1979:23-50].

In sum, medical practice is an individualised treatment mode, a mode which defines the client as deficient and which reconstructs the individual's understanding of the problem for which help is being sought. That reconstruction individualises and compartmentalises the problem, transforming it into its most immediate property: the answer to the problem is then logically held to be found in the same professionalised and individualised treatment, not in the reordering of the social, political and environmental world. The response to individual disease experience, not denied here, thus becomes the field upon which selective explanation are authoritatively communicated and dominant social relations thereby reproduced. The spectre of a medicalised and medicated society, where already psycho-active 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. Despite the broadening, the use of psychology in the field of health awareness remains locked in a prison of reductionism and the modification of medical notions of causality is entirely unidimensional, towards psychologism, towards host resistance and adaptation. Jacoby has written much on

contemporary psychology; the context is most often reduced to the immediate one of interpersonal relations and 'psychological atmospheres'. He notes:

A social constellation is banalised 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 [Jacoby 1975].

But, the study of the individual reduces the social context to the immediate context of interpersonal relations and psychological atmospheres. Ardell observes:

The manner in which you organise 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 [Ardell 1977].

In the reduction of 'social relations to immediate human ones', the society in which experience is lodged remain 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. Ardell summarises 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 [Ardell 1977:94].

Asserting a claim to individual responsibility partially delegitimises existing authorities and throws open a new political terrain. To the extent that individual responsibility and related terms like self-help are experienced as symbols of empowerment, they may become one of the few ways that people conceive of themselves as actively political at all [Gartner and Reissman 1977].

However, like political language, individual responsibility is highly problematic. It risks all the myopia of classical individualism. It promotes a conception, which overlooks the social constraints against 'choosing'. Finally, as currently employed, the notion of individual responsibility promotes an assumption of individual blame as well. Self-care and changes in lifestyles are supposed to be the most important strategies to improve the life

span of our individual citizens [Navarro 1976:126]. And behaviourists, psychologists, and 'mood' analysers are put to work to change the individual's behaviour [ibid]. The basic cause of sickness or ill-health is located within the individual and not in the system. And the solution, therefore, is intervention, primarily behaviour modification, and not the structural change of the economic and social systems, which work to transform 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. The predominant orientation of major research done in the health field as quoted in George C. Stone is related to behavioural aspect of health. Topics on mental health still dominate the studies. Other areas categorised in one survey include abortion, fertility, population control, accident, smoking, cancer, heart disease, psychosomatic illness, pain, death, etc [G Stone 1979:60-61].

As far as theoretical developments in this field are concerned, there is no complete and comprehensive theory of the health system. However Parsons' sick role behaviour and rationality principle have found favour with this group. Sick role behaviour refers to what a person does to keep from getting sick, how she/he investigates the need for treatment and how he/she acts after being designed as sick [ibid:69]. The problem with this approach, which has already been discussed, is its personal and process orientation as opposed to situation and context orientation. The Health Belief Model (HBM) which developed in the 1950s provided theoretical support to the sick role approach. It focuses only on the rationality-irrationality of a person when she or he is sick. In essence, the theory says that the likelihood of taking a particular action is a function of perceived threat and perceived benefits while adding modifying factors which influence these actions [ibid:73].

Numerous studies follow the Health Belief Model. The basic thing this model talks about is why people seek health care. According to a review provided by Rosenstock and Krischt (1979), it becomes apparent that the effort is to explain preventive health behaviour in purely psychological terms. Most of these studies show

racial differences and class differences in the utilisation of health services. The explanation of the variance in utilisation is more astounding: among 'coloured' or among the poor, there is a low perceived susceptibility and low health motive. Other components in this model include readiness to use services, orientation to care, perceived severity, etc.

This abstract conceptual belief considered responsible for preventive health behaviour is open to question. Health Belief Model remains within the classical paradigm of medicine in which compliance, patient adherence, etc, are important concepts for understanding preventive health behaviour [Krischt and Rosenstock 1979:190]. Its weak explanatory power is reflected in the studies [Quah 1986]. As a consequence, its methodology is also its weakest component. Coburn and Pope mention that: "Many of the studies, which we have examined, show responses of school college students and, in some others, factory workers using mailed questionnaires to which response rates are terrible low" [Coburn and Pope 1974; k Wurtele 1982].

This is the prevailing situation in western countries in general and in the epitome of bourgeois culture, in the United States of America. Psychology, even in the field of health, is used as exploitative tool for intervention or victim blaming.

People of other cultures often claim that western psychology is a subtle form of colonialism. Organised groups of ex-mental patients claim that scientific appraisals and treatments have abused them. People of 'colour' find that scientific testing procedures are systematically biased against them. Black feminist activist, Bell Hooks claims that the white culture (including that of social science) has no right to speak for the Black woman. And even studies from India, such as *KAP Studies* [K G Rao 1974], *Studies on Medical Students* [P Ramalingaswamy et al 1972] and development of *Health Modernity Scales* [A K Singh 1984] show the biased nature of this empiricist and positivist social science. The KAP studies were 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 concept of health modernity, which is located in 'rational' and 'irrational' principle which tends to neglect structural issues in the utilisation of health services, is very much value

loaded. These instances therefore indicate that psychology is indeed reductionist, mechanical, interventionist and empiricist and thus a tool in the hands of capitalist material world. The question then arises, is whether there is a psychology which is not bourgeois in nature, or can be used for the purposes.

The question to be posited is, should there have been a subdiscipline called health psychology. Isolated perfunctory studies do not provide sufficient case for formulating such a sub-discipline. Behaviourism in psychology, such as the theories of J B Watson and B F Skinner, must be criticised 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 attitude and behaviour. Thus, there is a need for a strong theoretical base, a critical social theory broadly similar to the attempt made by the Frankfurt school.

Erich Fromm, the only psychoanalytically trained member of this school extensively argued for using psychoanalytic typology, for an analytic social psychology. He said that analytic social psychology has its place within the framework of historical materialism. He 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 super structure in terms of the process that goes on between society and nature [Eric Fromm 1970]. In other words, critical social psychology studies the social character, which is the 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 that 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 need, the satisfaction of which makes human beings more alive and sensitive, and synthetic needs created by capitalism which tend to weaken them to make them more passive and slave to their greed for things [Eric Fromm 1967]. 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 Herbert Marcuse who is alleged to have distorted psychoanalysis. Marcuse considers psychoanalysis as a set of 'meta psychological' speculation 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 [K R 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 the Marxist approach [Marcuse 1968]. The need for such an integration is necessitated by 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 the 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; Marcuse 1964]. Domination and freedom are contrary to each other. When the individual is provided with a goal and a 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. Systematic propaganda, to socialise or indoctrinate the individual so that she makes her choices within the framework of a 'performed mentality', to plant certain desires in her by subliminal advertising and such other measures, all constitute coercion.

It becomes apparent that psychoanalysis and its concepts have been given undue prominence for linking psyche with society. If one looks 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]. Fromm's 'social character' is very relevant for social psychology and it can be used even in the health field. 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 [K R Nayar 1991:24]. In any case, the issue that has been brought to the limelight by these two viewpoints, not withstanding the weaknesses of relying on psychoanalysis for achieving it, is the integration of the missing individual in critical social theory despite the fact that both viewpoints suffer from being too much pessimistic and as Wellmer puts it, 'as a protest impotent in practice'.⁶ But Wexler notes differently:

Despite the facile homologies, the mirroring of social processes at the microscopic level, despite 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 [Wexler 1983].

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 psychological 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 accomplished in social interaction? A critical psychology is an attempt to include that mediating process.

It is open to decide what kind of social sciences can be utilised to enrich the discipline of public health and enable it to have strong moorings in population based services. Existing deterministic models of social science have more or less perpetuated the status quo. A critical psychology can be the meeting point for health and epidemiology. **EPW**

Notes

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