Psychology for Nursing & Healthcare Professionals

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Psychology for Nursing & Healthcare Professionals

Developing Compassionate Care

Sue Barker

Contributors

Janet Scammell, Gareth Morgan
Andrew Santos, Beverley Johnson
Gemma Stacey-Emile & Hamed Al Battashi

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SAGE Publications Ltd
1 Oliver's Yard
55 City Road
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SAGE Publications Inc.
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SAGE Publications Asia-Pacific Pte Ltd
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Editorial assistant: Charlène Burin
Production editor: Katie Forsythe
Marketing manager: Camille Richmond
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1 Introduction to Psychological Theory

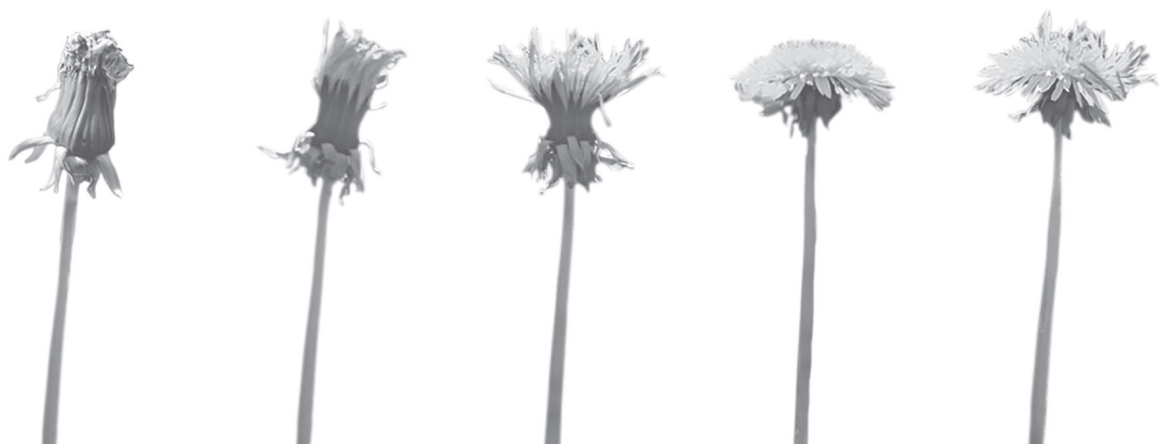
Sue Barker

I experience, I feel; I am human
I notice your suffering, I feel your suffering; I am sympathy
I sense your suffering, we share your suffering; I am empathy
Your pain is my pain, your comfort is my comfort; we share kindness
Together we are compassion!

Learning objectives

This chapter will introduce five perspectives of psychology and will explore how these perspectives offer differing understandings of the way people think, feel, behave and interact with others and their environment. These perspectives provide a basis for the subsequent chapters in order to develop a psychological understanding of compassionate care as experienced by care practitioners so as to enhance their performance of compassionate care. This chapter's learning objectives are to:

- Describe the five perspectives in psychology
- Identify a variety of research methods used in psychology
- Recognise the role of psychology in order to understand and explore care



Activity 1.1 Critical thinking

Take a few minutes to consider why an understanding of psychology might be useful in your development of your caring skills.

Some suggestions are made at the end of the chapter.

Introduction

This chapter initially explores the five dominant psychological perspectives and considers how each of them may offer an explanation of caring practices. These will be referred to throughout the book. It will establish definitions of psychology and the research methods used to develop an understanding of people, particularly how and why they think, feel, behave and interact with others and how this differs between individuals. Research methods will be concisely described, identifying the major research approaches in psychology.

In order to explore any concept, a definition is required. So, despite psychology being explored throughout this book, an initial definition needs to be identified. I previously defined psychology in the following way:

> Psychology is a seeking to understand why people behave, think and feel the way they do, individually and in groups, in all areas of life including health. Psychologists seek not only to predict behaviour but also to change behaviours to enhance wellbeing and quality of life. (Barker, 2007: 2)

This is a simplistic definition but it can be used as a working definition. Many other authors have developed their own definitions but all have until recently been very similar, for example:

> Psychology is the study of behaviour and mental processes. Behaviour includes all of our outward or overt actions and reaction, such as talking, facial expressions and movements. Mental processes refer to all the internal, covert activity of our minds, such as thinking, feeling and remembering. (Ciccarelli and Myer, 2006: 4)

The most recent definition I could find, whilst identifying a focus on behaviour, extends my initial definition to include wider phenomenological experiences:

> The study of the nature, functions, and phenomena of behaviour and mental experience. The etymology of the word implies that it is simply the study of the mind, but much of modern psychology focuses on behaviour rather than the mind, and some aspects of psychology have little to do with the mind. (Colman, 2015: 724)

In the past, we have seen a move from philosophy exploring the nature of people through the Enlightenment and the development of scientific psychology to psychology stretching to include elements of philosophy. I believe that psychology (understanding people) and philosophy (the love of wisdom) have always been intimately related – and we are moving towards a greater acceptance of this.

Psychology has a number of different ways of trying to understand the person, which can support practitioners in their compassionate care practice. One of the methods used is termed **perspectives**. These perspectives have changed over the years but the most commonly used now are:

- Biological
- Psychodynamic
- Behavioural
- Cognitive
- Humanistic

Each of these perspectives has a different explanation or theory related to a person and their behaviour. These influence not only psychological understanding but also how this understanding can be developed (research) and applied to acts of care.

Biological psychology

Biopsychologists are often accused of **reductionism**, which means that they reduce the person by examining their individual biological components in order to understand them and their behaviour, instead of attempting to understand them as an **embodied** whole.

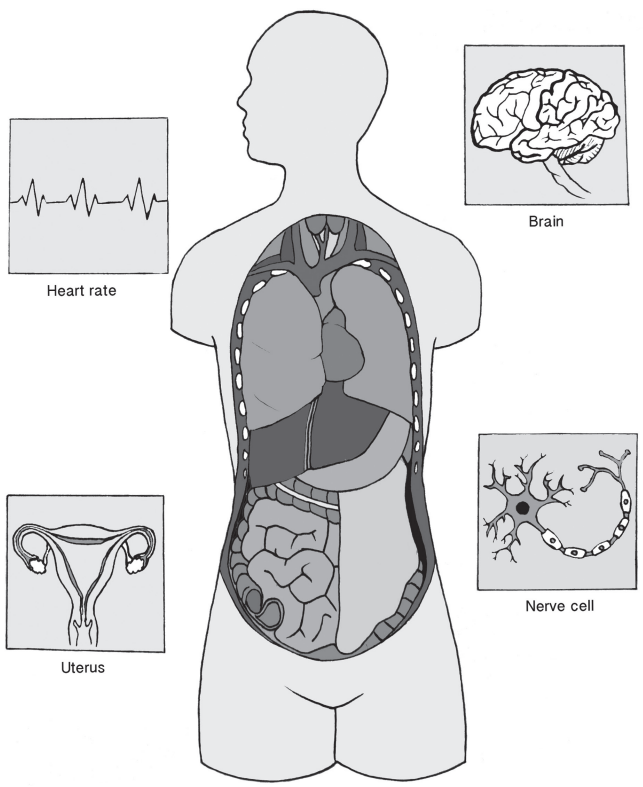


Figure 1.1 Sense of reduced body

Their explanations of human behaviours are through anatomical or physiological changes such as chemical reactions in the nervous and endocrine systems.

An understanding of biological functioning or the physiological influence on behaviour is important for most caring practitioners. Not responding to a physiologically produced behaviour could lead to death: for example, a person clutching their chest struggling to stand up, walk or talk may be having a 'heart attack' (myocardial infarction) which requires urgent attention.

Case study

Miriam Walker – student nurse

I was asked to monitor the well-being of an elderly lady, Mrs Beverley Crosland, who had just been admitted to an assessment ward. Her husband was with her. Mrs Crosland appeared confused and agitated and she was saying she wanted to go home. Her husband was very worried. He said Beverley's concentration, attention and memory had deteriorated dramatically over the past week. Mrs Crosland was also groaning at times as if she was in pain. Whilst monitoring Mrs Crosland, her pulse rate appeared a little raised, along with her temperature, breathing and blood pressure. Mrs Crosland and her husband were unable to explain what they thought was wrong, although Mr Crosland implied he was concerned that his wife was developing dementia as he had heard about it on the television.

Despite my concerns, as the signs may have been indicative of dementia, I explained to both of them that I needed to ask a few more questions and she may need to have some tests before a decision could be made. Mr Crosland remained anxious and Mrs Crosland was becoming more confused with each question I asked.

At this point, I stopped following the assessment questions in the order they were set out and sat down next to Mrs Crosland rather than the other side of the table where I had been sitting to write down their answers. I passed the assessment questions to Mr Crosland and asked him to complete them as best he could. He appeared pleased to have a role to undertake and conscientiously started filling in the forms.

I then asked Mrs Crosland to tell me what she would like to be doing at the moment whilst holding her hand. She tried to think and then started to clutch her abdomen. I said 'Does your tummy hurt?' and I reached to touch her abdomen. I asked 'Do you need to go to the toilet?' She then said she could not go. I asked if Mr and Mrs Crosland thought she could be constipated and they both agreed she could be. They both were happy with a doctor conducting an examination to check.

After a physical examination, it was found that Mrs Crosland was constipated and she was offered an enema to allow some rapid relief. Mrs Crosland's agitation reduced and her mental functioning slowly returned to what was normal for her. She was also prescribed a laxative for a couple of weeks and given information on diet, exercise and her other medications.

In the case study of Miriam Walker, in which she believed she offered compassionate care, it can clearly be seen that what are understood to be psychologically important mental processes, such as attention, concentration and memory, are strongly influenced by biological functioning.

Biopsychologists, like human biologists, identify biological functions that produce certain behaviours but their focus is different to biologists. Biopsychologists seek to

understand psychological issues: issues related to the mind or spirit. It could be said that the biopsychologists are interested in how biology supports and influences a person's thoughts, feelings and behaviour to produce individual differences whereas a biologist's focus is on describing or understanding the structure and function of the biological apparatus of the individual. Both can use an empirical, positivist, scientific approach to gaining knowledge (research).

Therefore biopsychologists and biologists explore the following but examine them through different 'lenses' – to use an optical analogy:

- Genes
- Anatomical differences
- Development through the lifespan
- Biological systems such as
    - The Nervous System
    - The Endocrine System

Biopsychologists explain behavioural change and individual differences through changes in the nervous system, endocrine system, or anatomical or genetic structure. There are numerous factors that could influence this functioning, such as:

- Development and maturation
- Infection
- Mutation
- Nutrition
- Disease
- Trauma
- Environmental factors

They suggest that people develop through a sequence of bodily maturation and growth determined by the endocrine and nervous systems. Therefore behaviour could be explained, in the absence of disorder or disease, by the maturational stage of development, genetic makeup, hormonal state and neural readiness (Barker, 2007). All of these will be influenced by environmental factors such as nutrition, stimulation, protection from disease, etc.

Genes

Each cell of the human body contains a nucleus. This nucleus usually has 23 pairs of chromosomes. These chromosomes contain the genetic code for the person and are composed of deoxyribonucleic acid (DNA). This genetic code provides the **genotype** for the person: the colour of their hair, their potential height, etc. What is seen of the person is said to be their **phenotype**, that is, the genotype that has been influenced by the environment.

Nervous system

There are two major parts in a human nervous system: the central nervous system (CNS) and the peripheral nervous system. The central nervous system is the brain and

spinal cord; these are 'central', in the centre of the body. The peripheral nervous system is the large number of nerves surrounding the central system or at the outer limits of the body.

The peripheral nervous system has three parts:

- Cranial nerves (CN)
- Spinal nerves (SN)
- Autonomic nervous system (ANS)

All three (CN, SN, ANS) transmit information from the senses to the central nervous system and take commands from the central nervous system to various parts of the body. The cranial nerves link with the brain, the spinal nerves to the spinal cord, and the autonomic nervous system primarily controls the internal organs.

The autonomic nervous system can be further divided into three components:

- Sympathetic nervous system
- Parasympathetic nervous system
- Enteric nervous system

The sympathetic system prepares the body for action whereas the parasympathetic system prepares the body for rest. The enteric system regulates the digestive system and is influenced by both the parasympathetic and sympathetic nervous systems.

Endocrine system

The endocrine system is a collection of glands that secrete hormones into the body. The major endocrine glands are described in Table 1.1.

Biopsychologists study how each of these areas influence the behaviour of the person in their search to understand that behaviour. There is clear scientific evidence to support the theory that the nervous system and endocrine system communicate with each other. This is achieved through chemicals produced from these systems. Neurotransmitters (in the nervous system) influence the production of hormones (endocrine system) as nerves infiltrate the glands and hormones circulate in the body, thereby changing the chemical environment of the nerves.

Table 1.1 Endocrine glands and their principal effects

Gland	Principal effect
Pineal gland	Regulates seasonal changes and puberty
Hypothalamus	Regulates hormones released from the pituitary gland
Pituitary gland	Produces a number of hormones which stimulate growth and development
Thyroid	Involved in metabolism and blood homeostasis
Adrenal glands	Regulate metabolism and body hair. Help maintain blood sugar levels
Pancreas	Involved in the metabolism of sugars
Gonads	Stimulate the development and maintenance of sexual characteristics and behaviour

Source: Barker (2007: 6)

Summary of biopsychologists

Biopsychologists seek to understand individual behaviour using an **empirical, positivist,** scientific approach. They explain how people develop and how their behaviour changes through a maturational sequence as the nervous and endocrine systems develop to fulfil genetic encoding (genotype) or not (phenotype). The case study of Miriam Walker offers an understanding of the importance of care practitioners having a biological understanding of behaviour and behaviour change in order to allow them to offer appropriate care. We will find that other perspectives offer us an understanding of the importance of how we provide that care.

Activity 1.2 Reflection

Think of a time when you cared for someone and they appeared sad, unable to concentrate, found it difficult to organise themselves or were anxious. These are psychological 'symptoms'. Thinking back, did they have a physical health problem that might have caused these symptoms?

As this is a reflection, there is no outline answer at the end of the chapter.

Psychodynamic psychology

Introduction

This perspective in psychology relates to the theory developed by Sigmund Freud, but his dynamic theory of the mind has been adapted and developed by others since its inception. Theorists in this field include Alfred Adler, Erik Erikson and Carl Gustav Jung (students of Freud but by some considered neo-Freudians), along with Melanie Klein and Anna Freud.

Freud lived from 1856 to 1939 and his work has become a significant part of both psychological and Western societal thinking. Freud had a classical education that included philosophy. He studied at the Brentano School at the same time as Edmund Husserl (see Chapter 5) and both view the mind as having psychic energy. Freud went on to study medical science and was particularly interested in neurology but later trained in clinical medicine, became a doctor and practised medicine. He spent some time in psychiatry and developed private practice with people with mental health problems. Through his wide educational base, personal crises and his observation of patients, Freud developed a new and influential theory of the mind.

A key component of his theory was centred around the inner or unconscious conflicts that motivate a person's behaviour. However, he does suggest that some of these motivating conflicts (desires or thoughts) can become conscious through therapeutic techniques such as **free association, dream interpretation** and **transference**. Despite the contemporary significance of scientific development of knowledge and Freud's use of introspection and observation of patients, his psychodynamic theory has become part of everyday thoughts and the way of understanding the world.

Freud developed a structure of the mind, which is generally accepted by all psychodynamic theorists. The mind includes three components (see Figure 1.2):

- Id
- Ego
- Superego

Id

This is the part of personality or mind that a person is born with. It is the largest part of the unconscious structure of the mind. The **id** holds the sexual and aggressive instincts of the person and demands instant gratification. It is sometimes referred to as the 'psychic energy'.

Ego

This part of the personality or mind is the largest part of the conscious mind but at least half of it is **preconscious**. The **ego** develops in childhood and fulfils a function of balancing the desires of the id with the social constraints of the world which are internalised by the superego.

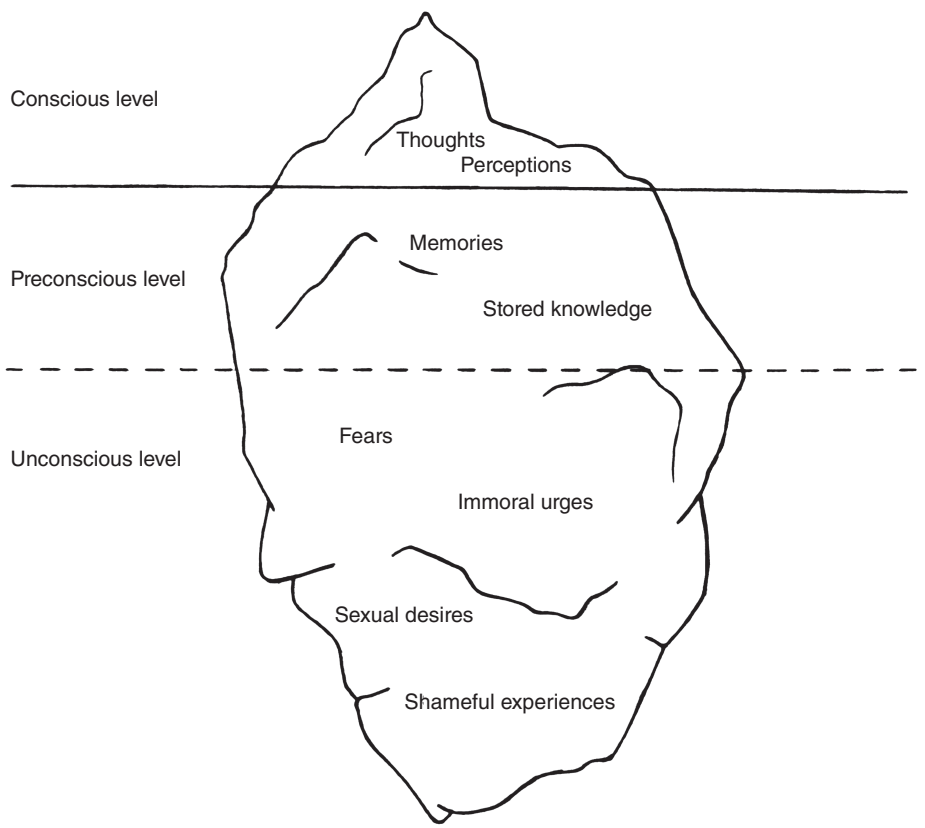


Figure 1.2 The psychodynamic mind represented as an iceberg

Superego

The **superego** is often referred to as the **conscience** of the person, which is considered to develop at about the age of five. The superego uses guilt and pride to persuade the ego to comply with social norms. The superego is partly conscious but also exists in the preconscious and unconscious.

Freud's theory also included a developmental process by which the structure of the mind and development of the personality were achieved. He suggested that children are born with the id but develop the ego and superego through psychosexual developmental stages. Freud identified that early childhood experiences go on to influence personality later in life (see Chapter 2 for theories on development).

Freud said that all behaviour is meaningful: no behaviour is accidental, whatever the behaviour. Any behaviour exhibited which the person's conscious mind had not intended is seen as unconscious thoughts breaking through to consciousness. These are generally referred to as 'Freudian slips'. Freudian slips, or **parapraxes**, are part of everyday language in Western societies. These Freudian slips are generally considered to have a sexual connotation: for example, the carer passes a cup of tea to a man she is caring for and he responds, 'Thank you for the *breast*s … Tea, tea.' He had intended to say, 'Thank you for the *best* cup of tea,' but his noticing her breasts provoked him to say 'breast' instead of 'best'.

Activity 1.3 Reflection

Spend a few moments thinking of a time when you or someone else made a comment that made you feel embarrassed because it was not what you or they intended to say.

- Did it have a sexual interpretation?
- Can you identify what caused you or them to make the statement?

As this is a reflection, there is no outline answer at the end of the chapter.

Freud describes the mind as a dynamic structure in continuous conflict between the desires of the id and the social constraints of the superego. The ego's role is to resolve some of these conflicts and it will use mental defence mechanisms to achieve **equilibrium**. Mental defence mechanisms do not resolve anxieties or problems but allow the person to perceive them differently and manage their behaviour.

There is no agreed number of mental defence mechanisms; some suggest that there are just 9 and others propose 35. Nonetheless there is some agreement on their characteristics:

- They are unconscious, distinct and dynamic
- They can be adaptive or pathological
- They manage instincts, **drives** and feelings (Stewart, 2005)

In Table 1.2, you will find some examples of mental defence mechanisms, giving examples of how they may be seen in care practices.

Table 1.2 Freud's Mental Defence Mechanisms

Name of defence mechanism	Description	Example
Repression	Forcing a threatening memory/feeling/wish out of consciousness and making it unconscious	You feel sexually attracted to one of the people you are caring for but force this desire out of your consciousness
Displacement	Transferring feelings from their true target onto a harmless substitute target	One of the people you are caring for keeps calling you by the name of someone you do not like, but instead of reminding them of your name you go home and shout at your partner
Denial	Failing/refusing to acknowledge/perceive some aspect of **reality**	This can be observed when a family member refuses to acknowledge their loved one is dying
Rationalisation	Finding an acceptable excuse for some unacceptable behaviour	A person you have been supporting at great emotional expense makes a complaint about the amount of support they are receiving. You feel angry but say that this is due to their ill health
Reaction formation	Consciously feeling/thinking the opposite of your true (unconscious) feelings/thoughts	You strongly dislike a family member of a person you are caring for and so you become extremely considerate/polite towards them – even going out of your way to be nice to them
Sublimation	A form of displacement in which a substitute activity is found as a way of expressing some unacceptable impulse	You have been trying to encourage an older person to attend a hospital appointment. At the end of the shift, you feel very frustrated and so take yourself to the gym
Identification	Incorporating/introjecting another person into one's own personality – making them part of oneself	You are working with a woman who is being abused by her neighbour. When you suggest that she speaks to the police, she refuses as she says it is her own fault because she is demanding and stupid. The neighbour is working really hard and does a lot for her
Projection	Displacing your own unacceptable feelings/characteristics onto someone else	You find you are not able to relate to one of the people you are caring for and instead of saying that you do not get on with them, you say that they do not get on with you
Regression	Reverting to behaviour characteristic of an earlier stage of development	When asked to clean the kitchen for the second time that day, you lose your temper
Isolation	Separating contradictory thoughts/feelings into 'logic-tight' compartments	A person you have been caring for has taken their own life but you talk about it without any display of emotion

Source: Adapted from Barker (2007: 11)

In the case study of Miriam Walker, we can see that she may be using a number of mental defence mechanisms to facilitate compassionate care. Miriam may be **repressing** any irritation that she may feel at not being able to complete the paperwork; she may be **identifying** with Mr and Mrs Crosland's anxieties.

Summary

Freud offers a psychodynamic theory of the mind or personality and its development. He described mechanisms (mental defences) that a person might use to manage the

continuous internal conflict of the different components within the mind. He steps beyond the dichotomy found in medicine and like Husserl identifies a mind that is embodied but also a distinct consciousness which has its own energy. This perspective offers care practitioners a different way to understand the people with whom they work and themselves. This will be further explored as the book progresses.

Behavioural psychology

Introduction

The behaviourists use scientific (experimental) methods to understand people's behaviour and behavioural change. Most of their theories have developed from animal experiments and models. They propose that all of a person's behaviour, including their personality (all individual differences), is learned. There are a number of processes by which this happens and they have become the building blocks of learning from a foundational level, called **habituation**, to more complex learning, called **social learning theory**.

Habituation

Habituation can be seen as the lowest form of learning on the hierarchy of learning. It is a process where the organism becomes 'used to' the presence of a stimulus, and is seen in the simplest of animals such as sea anemones. As with other types of learning, instead of habituation occurring, sensitivity can occur. For example, a person is sitting in a room with a ticking clock (Figure 3.1). After a little while, the person becomes 'used to', they habituate to, the noise of the clock and no longer notice it. For some, habituation does not occur and the person becomes more and more conscious of the ticking: they are **sensitised** to it.

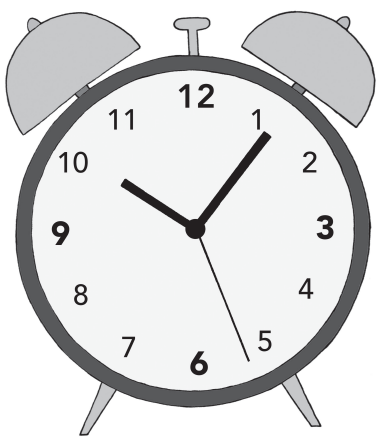


Figure 1.3 Clock

Classical conditioning

Classical conditioning is learning through **association**. This happens when one **stimulus** is presented with another and eventually they produce the same effect. This type of learning is usually considered **reflexive** learning, where the organism's reflex responses are being trained. The most famous experiment to demonstrate this was Pavlov's salivating dog study.

Ivan Pavlov (1849–1936) studied the digestive system of dogs. He recognised that dogs could be trained to salivate by pairing or associating another stimulus with food. Salivation is a reflex response to food. This **reflexive response** to food was **conditioned** to occur when a bell rang. The theory was later applied to people. It was found that pairing one stimulus with another stimulus could provoke a reflexive response in people. This is also called the **stimulus–response theory** of learning.

This has many applications in health and social care. For example, an older person with dementia has, from early learning, associated certain rituals with going to sleep.

They are then in the care environment facilitated to dress in their night clothes, the lights are turned down and the curtains closed (stimuli) so that they feel it is bedtime and fall asleep (response).

Operant conditioning

Learning can also occur by providing a reward or punishment when certain behaviour is enacted. This is called **operant conditioning**. This approach is widely used in schools, with animals and in society in general. For example, a child is given a star (**reward**) for their chart if they do something 'good' to encourage them to do it again but they have one removed (**punishment**) for 'bad' behaviour to stop it from happening again.

This type of learning was initially developed by Edward Thorndike (1874–1949), but Burrhus Frederic Skinner (1904–90) went on to extend this work. Skinner's empirical studies were, like Pavlov's, conducted on animals but subsequent studies have found that people also respond to classical and operant conditioning, although some people, as with habituation, respond in a way that is unexpected.

Social learning theory

Another form of learning that builds on the previous levels is more complex and higher on the hierarchy of learning. This is 'social learning theory'. This theory incorporates a cognitive element to learning. The theory accepts the previously established types of learning or conditioning but states that people, and we now find some other animals too, learn by observing others' behaviour and imitating it.

Albert Bandura and his colleagues developed this theory of social learning through a number of experiments. These demonstrated that observational or **vicarious** learning could occur without the individual being personally rewarded. For this type of learning to occur, there needs to be an appropriate environment with another person to learn from. This person is usually referred to as the **role model**. There are five cognitive components that influence the likelihood of learning from an environmental situation. These are:

- Attention
- Memory
- Rehearsal and organisation of memory
- Imitation
- Motivation

Activity 1.4 Critical thinking

Think of a person you admire and would like to be associated with; to be thought to be similar to. What did they do? Why do you want to do that?

An outline answer can be found at the end of the chapter.

Effective role models

There are features that are needed for a person to be an effective role model. They are:

- The role model is seen to be rewarded
- The role model is similar enough to the observer for them to imitate
- The role model is well thought of or respected in the social environment where the behaviour occurs

Returning to the case study of Miriam Walker, this perspective will indicate that she has learned to behave in certain ways. As a student, she will have been taught communication skills and observed her **mentor** (role model) assessing patients. She will have gained rewards (operant conditioning) by her mentor passing her on her necessary competencies and showing confidence in her ability by allowing her to speak to Mr and Mrs Crosland alone. By observing Mrs Crosland's behaviour, Miriam learned that asking her questions made her agitated and she did not get the answers. Miriam also learned from *observing* Mr Crosland's (role model) behaviour how to reduce agitation in Mrs Crosland; she *imitated* this and was able to make her assessment (social/vicarious learning).

The theories of behavioural psychologist have led to focused therapeutic approaches to health and well-being and these will be explored in Chapter 7.

Summary

There are four key types of learning identified by the behaviourists, although social learning theory does start to incorporate cognitive elements. Each of these theories is highly relevant to care practitioners for their personal development but also in developing the well-being of the people with whom they work. Proponents of all four types of learning accept that all behaviour is learned.

The four types of learning are:

- *Habituation*: The acknowledgement that people can 'get used to' or accept elements in their environment
- *Classical conditioning*: The training of reflexes such as pain by association
- *Operant conditioning*: If good things happen following certain behaviour, the person will repeat the behaviour
- *Social learning theory*: Care practitioners can learn from observing and imitating others

Cognitive psychology

Introduction

The cognitive perspective can be seen as a development of behaviourism because the early theorists came from behavioural psychology. They accept that behaviour is learned and that in any situation there is a stimulus and a response. It is based on the

empirical scientific approach (see Chapter 5). Cognitive psychologists undertake experiments to determine how people process and structure their thoughts. They seek to understand what happens between stimulus and response because they recognise that not everyone responds in the same way to any given stimulus. This, in broad terms, is identified as cognition – conscious mental processing or thinking. Unlike Freud and the psychodynamic theorists, cognitive theorists do not concern themselves with the unconscious mind.

As the function of the mind and its precise link with the brain are not as clearly defined as it is with other organs in the body, it is difficult for psychologists to determine how and where information is stored and processing occurs. However, with the growth of technology and research in the area of bio- and neuropsychology, understanding is developing. Given the lack of biological models, cognitive psychologists tend to use metaphors, for example that the brain is an information processing unit like a computer. A computer goes through a logical system each time a problem is initiated. Some cognitive psychologists believe that people do the same thing, and they liken the brain to the hardware and the mind to the software.

Key influential areas in the development of the cognitive perspective are:

- Information theory
- Artificial intelligence (AI)
- Linguistics
- Neuroscience (Barker, 2007: 16)

Information processing approach

The 'information processing approach' is generally considered the major **paradigm** used in cognitive psychology to understand how people think. It is proposed that thinking is conducted in a logical, structured process. Cognitive psychologists have tried to map this process and structure. Components of this approach include:

- Set processing rules (organised ways in which information is gathered, stored, worked on and used)
- A storage facility for information (memory)
- A central processing unit which manipulates the information (a place where the information is worked on or with)

Schema theory

'Schema theory' is a cognitive theory of how people might store information and facilitate retrieval – memory. It is suggested that new information is attached to or becomes part of existing memory. A schema is a collection of information on a certain topic/area/thing. It has a **fixed component** but also has a **flexible component**. Schemas can be interrelated too, so that thinking about one schema can lead to a memory of information in another schema. For example, a 'giving an injection' schema, which may include dextral skills, syringes, needles, fluid to be injected, prescription, etc., may lead to a health and safety schema including objects like the sharps bin and skills such as washing hands (see Figure 1.4).

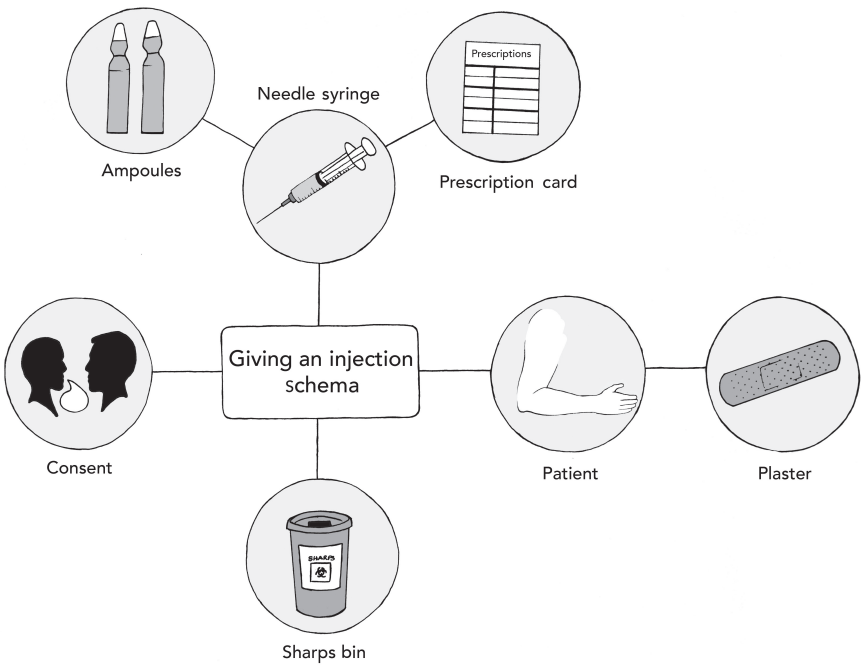


Figure 1.4 'Giving an injection' schema

Cognitive development theory

Jean Piaget (1896–1980) created a theory of cognitive development. Unlike the behaviourists, Piaget suggested that children of different ages think in a qualitatively different way to adults. His theory was built on a cognitive schema theory. He suggested that schemas were developed through a process of **assimilation** and **accommodation**.

- *Assimilation*: The process of incorporating new information into existing schemas
- *Accommodation*: Occurs when new information cannot be assimilated, at which point a new schema needs to be developed

Using this process, Piaget identified four stages of cognitive development: stage 1 also has six sub-stages. There have been a number of criticisms of Piaget's work but it continues to be influential, perhaps due to the scientific approach to its development of knowledge and understanding of the mind. This theory will be explored in more detail in Chapter 2.

The understanding of how people think is central within a number of therapeutic approaches to caring for them. These are explored in Chapter 7.

Summary

Cognitive psychologists offer a number of theories on how people think – they are particularly interested in cognitive processes and structures. These include the person's

ability to communicate, attend and remember things. The information processing approach is the most common cognitive process approach, whereas the schema theory is the most widely accepted theory of how information is stored. Cognitive psychology offers an explanation for how people make decisions about their behaviour, including health and social behaviour. Clinical therapies have developed from cognitive psychology and these will be explored in Chapter 7.

Humanistic

Introduction

The humanistic movement is considered to have started in the 1950s as an alternative to the mechanistic and positivist approach taken by the behaviourists and the conflict and distress focused on by the psychodynamic psychologists. Whilst they accepted that learning (behaviourism) was important, they also acknowledged the importance of innate potential and unconscious processes (psychodynamic). Humanistic psychologists closely associated themselves with **existential** philosophy, with its roots in phenomenology. They were opposed to **positivism** and **rationalism**. They accepted that to understand the person we need recognise their existence, not focus on what comes directly to consciousness or that which can purely be observed. They suggest that people make decisions based on their subjective experiences, and not routinely in a rational, methodical manner. Each individual is therefore unique, as their world experiences are different (Barker, 2007).

Whilst humanist psychologists were influenced by philosophy, they developed individual theories to understand the person. Despite the theoretical differences and different focus in theoretical development, they all had a similar focus, which was optimistic. They identified that the person is an individual 'whole being' with their own unique **potential**. They also offered a spiritual element to psychological theory – there was something more in the experience than what could be measured or even labelled; they accepted psyche as mind and spirit. The humanists suggested that all people are moving towards **self-actualisation**: to achieve their potential. Whilst they believed that everyone was capable of achieving their own unique potential, they identified that unfavourable environments sometimes disrupt this journey (Rogers, 1961).

Alongside this focus, there are common themes within humanistic psychology. These are:

- Personal growth, potential, responsibility, self-direction
- Lifelong education
- Full emotional functioning
- Appreciation of joy and play
- Acceptance of **spirituality** and **altered states of consciousness** (Stewart, 2005)

Maslow

Abraham Maslow (1908–70) is generally considered the first humanistic psychologist; he developed the hierarchy of needs in 1954. He wrote that all people are motivated to fulfil their personal needs, and he organised these needs into a hierarchy which can be portrayed as a pyramid (Maslow, 1954) (Figure 1.5).

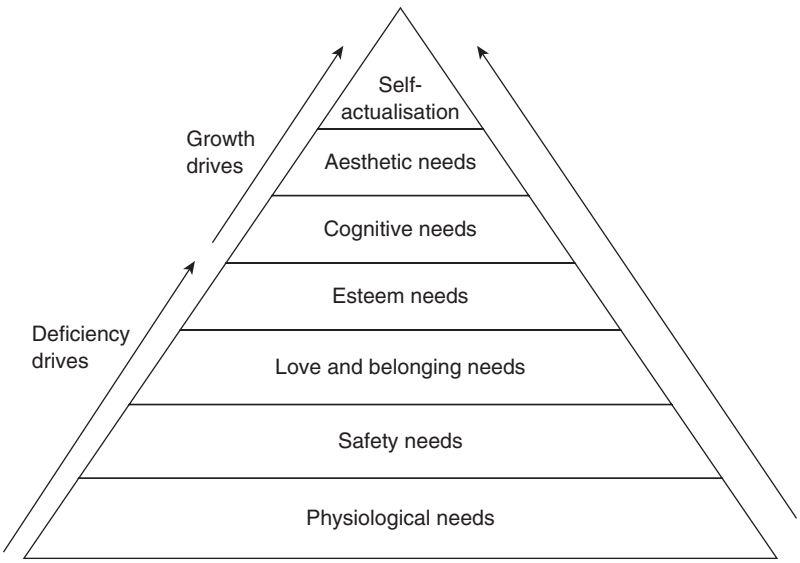


Figure 1.5 Maslow's (1954) hierarchy of needs

Maslow's hierarchy identified the order in which a person would fulfil their needs to achieve self-actualisation. He suggested that people have to work their way up from the bottom of the hierarchy to the top and they could not move to the next level until the needs of the previous one were fulfilled. The motivation to fulfil lower-level needs are identified as deficiency drives (4–7) which maintain health, and the motivation to fulfil higher-level needs are called 'growth drives' or 'being drives' (1–3). Both drives lead the person to self-actualisation, which can be visualised as a rapturous moment or peak experience:

1. Self-actualisation
2. Aesthetic needs
3. Cognitive needs
4. Esteem needs
5. Love and belonging needs
6. Safety needs
7. Physiological needs

Rogers

Carl Rogers (1902–87) developed what is now known as the person-centred approach which is advocated throughout health and social care. As with other humanists, he aligned himself with existential philosophy and regarded each person as unique. He stated that everyone is able to reach their own potential as long as they have the right environment in which they can grow towards self-actualisation.

Rogers developed a theory of self-concept which incorporated the actual self and the ideal self, and suggested that if these two views of the self were distant from each other a person would experience psychological distress – the person was **incongruent**. To gain

a close ideal and actual self (**congruent** self), a person needs **unconditional positive regard**. Rogers went on to develop client-centred therapy to enable people who had not experienced this.

For effective client-centred therapy, Rogers identified a few necessary and sufficient elements:

- Two people need to be in psychological contact
- The client is in a state of incongruence
- The counsellor is congruent
- The counsellor experiences unconditional **positive regard** for the client
- The counsellor has an empathetic understanding of the client and endeavours to communicate this to the client
- The counsellor is at least successful in communicating unconditional positive regard and empathetic understanding to the client

Other theorists such as Gerard Egan have developed therapeutic interactions and interventions for people who need help based on the therapeutic and theoretical writing of Rogers. These will be further explored in other chapters of this book. It is accepted throughout this volume that to provide compassionate care there is a need to be person-centred, so this theory will be returned to in most chapters, particularly in Chapters 5 and 7.

If we return once again to Miriam Walker, we can clearly see that she is using humanistic approaches. She is showing *positive regard* to Mr and Mrs Crosland; they are in a state of *incongruence* and she is in a state of *congruence*; however, she did demonstrate a moment of incongruence when she became anxious as to whether Mrs Crosland had dementia. Miriam is facilitating their taking *responsibility* for their well-being by offering Mr Crosland the opportunity to fill in the forms and accepting their special relationship of understanding with each other (*spirituality/altered states of consciousness*).

Summary

The humanistic perspective is a collection of diverse theories but they have similar underlying principles. These principles are that:

- The person is motivated to self-actualise – they have the desire to achieve their potential
- The person is unique – each person is different
- The person has unique potential – each person has a different set of abilities, and they have an individual sense of fulfilment
- People need positive regard to remain healthy – to be acknowledged as having intrinsic value is important for well-being

Research methods in psychology

Introduction

There are a number of research methods used in psychology. Throughout this book, different philosophical approaches will be referred to and these influence what is

considered credible or valid knowledge. Most psychologists tend to accept an empirical approach to gaining understanding and knowledge; *knowledge can only be gained through the senses or experiences*. Empirical knowledge is generally considered most credible globally but is usually viewed as scientific knowledge, achieved through the scientific process (see Chapter 5).

B.A. Carper in 1978 offered practitioners four ways of knowing, and identified empirical knowledge as only one way. The others were ethical knowing, aesthetical knowing and personal knowing. More recently, with the person-centred, compassionate care movement, other approaches to knowing are also being explored, such as intuitive knowing. As empirical knowledge is the most highly regarded, it will be considered first in this section of the chapter but other ways of knowing and understanding will be explored, as they are important if we are to ascertain how to become compassionate carers.

Empirical research

Empirical research studies are categorised into two groups: qualitative and quantitative research. Some, though, do not accept qualitative research as they focus on what 'comes to the senses', rather than the other part of empirical research of what 'is experienced' as well. They sometimes recognise qualitative approaches to be methods for facilitating ethical, personal and aesthetic ways of knowing, which are seen politically as less important. Most psychologists use the scientific approach in their search for knowledge but psychologists access research methods from a number of sources. Quantitative psychologists tend to adhere to the scientific method (used by biology, physics and chemistry), but qualitative researchers access methods from philosophy (phenomenology), sociology (grounded theory), anthropology (ethnography) and literary (narrative). It is only in the twenty-first century that qualitative research has become more accepted by psychology, with the British Psychological Society now having a section focused on this type of research.

Quantitative studies

Quantitative studies involve measuring an element of behaviour or behaviour change in a specific way: data would be collected so that it could be counted or measured. Most psychological research has been undertaken using this approach to understanding and it still has the greatest value politically. Methods include experiments, surveys and observations, but can include focus groups, diaries and interviews, where the literal data is converted into numerical data. This is the traditional scientific approach to research with a highly structured method. These studies are usually undertaken by biological, behavioural and cognitive psychologists.

Experiment and quasi-experimental methods

This quantitative method is used by positivists and accepted by the physical sciences to be valid as it has the ability to be rigorously tested. It uses the scientific procedure (see Chapter 5), and the findings are written up using the set scientific structure. This approach is where all unnecessary variables are eliminated from the experiment except those pertaining to the question or **hypothesis**. There are a number of experimental designs but the most valued is the **randomised control trial** (**RCT**). The data gained is usually converted into numbers and made sense of by using **statistical analysis**.

Survey/questionnaire research

This method is used extensively to ascertain attitudes and other such social issues. The biological or cognitive psychologists and any psychologist interested in knowledge about behaviour in large populations may use this method. It is a method for gaining a small amount of information from a lot of people. As with the experimental approach, the data gained is usually converted into numbers and made sense of by using statistical analysis.

Observational research

This method is used extensively by behaviourists to assess stimulus–response situations: they observe for antecedents, behaviour and consequences. Biological and cognitive psychologists who may be observing for changes in behaviour may also use it. Piaget, who developed the cognitive development theory (see Chapter 2), used this approach to help develop his theory, along with experiments. The data in this research design again is usually converted into numbers and analysed statistically but the technique can also be used with small numbers of people.

Qualitative studies

Some psychologists do not recognise qualitative studies as empirical but they can, and some do, use the scientific approach, just exchanging the manipulated **variables** and hypotheses for research questions. These studies, though, seek narrative forms of data to maintain **ecological validity** and retain the richness of real-world experiences. They do not seek to measure or count behaviour. They usually include data collection through self-report diaries, reflections, interviews and focus groups. They are considered richer and seek to understand the human experience, and are more suited to the humanistic and psychodynamic perspectives.

Narrative

This approach to developing knowledge and understanding in psychology can be considered to have developed in literary, historical and social arenas. This is, though, too simplistic: the humanist's movement towards person-centred approaches and psychodynamic views of the person, along with structuralism, post-structuralism and postmodern philosophies, were also important (see Chapter 5). This approach seeks to gain **stories** of specific experiences, but given the diverse nature of its development and the many types of narrative approach, it might be considered an **umbrella** term. Generally, these different types of narrative research focus on the structure and form (**syntax**) of the language, and the **content** or the **genre** of the story. Psychologists from different perspectives may primarily use one type over another: for example, cognitive psychologists may be more interested in the form and structure of the story, whereas humanists may be more interested in the content, and psychodynamic psychologists in the genre, of the story.

Narrative research is about collecting stories and gaining understanding about the person or group of people by analysing the stories – the narratives.

Phenomenology

Phenomenology and existential philosophy have had a significant impact on the development of humanistic psychology (see Chapter 5). The philosopher Husserl is acknowledged

as the founding father of phenomenology. He sought to find the essential experiences of a given phenomenon. Amedeo Giorgi, after studying Edmund Husserl and Maurice Merleau-Ponty, developed psychological phenomenology to provide researchers in psychology with a method to explore phenomena that maintained their unique character. Phenomenological research is usually conducted through lengthy in-depth individual interviews but can be undertaken by reading individual narrative descriptions of experiences of a phenomenon. It is important that the researcher maintains a state of **epoche** to elicit a description of **life world** experiences and to analyse these to elucidate the phenomenon using **imaginative variation**. The findings are usually presented as a **general structure** of the phenomenon along with **individual variations or constituents.** This research approach has been used by humanistic psychologists and psychotherapists, including those from a psychodynamic perspective.

Ethnography

This approach is used to describe and interpret cultural and social groups and has its origins in anthropology. Its focus is on describing and interpreting **cultural** groups: **culture-sharing groups**. Ethnographers explore learned patterns of behaviour, customs or ways of living. The researcher becomes involved in the culture and experiences it first-hand; they are **participant observers**. They make **field notes** and interview other people within the culture. They can also use **artefacts** – things produced by the culture. This data is then analysed and interpreted to develop cultural themes and develop a **cultural portrait**. This approach to research is of interest to social psychologists, whether they sit within behavioural, humanistic or psychodynamic psychological perspectives.

Grounded theory

Grounded theory developed from the discipline of sociology. As the name implies, this research approach aims to develop a theory of a particular situation from the **grounded** evidence, specific to the situation. The data is usually gained from interviewing people in the situation or **field**. Each interview is analysed and the next interview is conducted to build on the previously gained understanding. This is called a **constant comparative** method. The analysis is undertaken through different types of **coding** and **categorisation**. The researcher goes on to provide a theory or **storyline** that presents the central phenomenon and the social, historical and economic conditions that influence it. This research approach could be used by any of the psychological perspectives to explore different situations.

Psychologists can be seen to use every type of research approach available, and their choice of approach will depend on the perspective they align themselves with and what they are trying to understand about people. The perspectives, theories and research of psychologists will be used to explore our understanding of compassionate care and what it is, and how we can develop and maintain it in our caring relationships throughout the rest of this book.

Chapter summary

This chapter has taken us on a journey from the definitions of psychology, to an exploration of how psychology is organised and classified (perspectives), to psychologists' contemporary approaches to developing their knowledge (research).

Further study

The British Psychological Society website offers information on the different roles psychologists may take on. It offers guidance for those wishing to be a psychologist, as well as highlighting news, events and its publications. See: www.bps.org.uk/

Activity outline answers

Activity 1.1 Critical thinking

Take a few minutes to consider why an understanding of psychology might be useful in your development of your caring skills.

You may have identified a number of ways in which it could be useful, such as:

- Helping you understand the person you are working with, your colleagues, your institution or company, your lecturers, yourself
- Helping you to identify how to help the person you are caring for, the awareness of therapeutic approaches, how to support and interact with others

Activity 1.4 Critical thinking

Think of a person you admire and would like to be associated with: to be thought to be similar to. What did they do? Why do you want to do that?

- Perhaps they managed to get someone to eat who was not eating, or to talk, walk or drink.
- Perhaps they received a smile or were able to undertake a technical or complex task.

Generally, our role models are displaying behaviour and being rewarded for doing something that we would like to achieve. Our role models also need to display behaviour that we feel we can imitate; if we do not feel we can imitate it (**self-efficacy**), we will not try.

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