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How Can We Advance Health Psychology?

Christine Horrocks and Sally Johnson

Health psychology and the development of critical action

The first part of this book aims to locate health psychology in its contemporary context. This is in terms of the development of health psychology in general, and critical health psychology in particular. The three chapters in Part I explore this context in relation to the development of language-based approaches, community health psychology and critical approaches to health psychology in general. Furthermore, Part I, as well as the book as a whole, aims to develop the critique of mainstream health psychology by specifically focusing on contexts which impinge upon health and illness leading to inequalities in health. In doing so, our contributors engage in recent developments in critical health psychology, offering insights into potential courses of action with the aim of improving health.

Health psychology is a relatively young sub-discipline of psychology. In order to develop its credibility within the broader scientific community it adopted the main standards and methods of psychology at the time of its inception (Murray & Chamberlain, 1999) and these continue to dominate. Adopting these standards and methods also enabled it to gain credibility within medical science as it spoke in the familiar language of ‘prediction and control’ (Murray & Chamberlain, 1999, p. 5). This acceptance has been advanced through its accommodation of psychological and social dimensions within the biopsychosocial model. The main way in which this framework is put into practice is through the testing and elaborating of theoretical models such as the Theory of Planned Behaviour and the Health Belief Model, and the investigation of mechanisms such as psychoneuroimmunology. Approaches such as the Theory of Planned Behaviour aim to investigate a combination
of hypothetical constructs which represent ‘biological’, ‘psychological’ and ‘social’ variables (Crossley, 2008). However, it has been argued that these approaches only pay lip service to social and contextual aspects of health and illness. This is because they invariably investigate social cognitions such as attitudes and control beliefs (Mielewczyk & Willig, 2007) which are, by their very nature, individual perceptions of social phenomenon. The linkage of certain attitudes and beliefs to a range of health behaviours has achieved a degree of success. However, the multifaceted and complex nature of health behaviour is underexplored in these approaches (see Mielewczyk & Willig, 2007 for an extended critique of the Theory of Planned Behaviour).

Such critiques of traditional approaches to health psychology have increasingly emerged to the extent that critical health psychology is now a distinct movement. The developing critique of psychology as a discipline over the past 20 years (see for example, Fox & Prilleltensky, 2009) provided the conditions for a similar critique of health psychology. This was in conjunction with insights from earlier anthropological, sociological and psychological work on health and illness (see, for example, Herzlich, 1973; Blaxter, 1983) which emphasised, for instance, the importance of social representations and culture in understanding health behaviour. At the forefront of the development of critical health psychology were publications such as Material Discourses of Health and Illness, edited by Lucy Yardley, in 1997; Qualitative Health Psychology: Theories and Methods, edited by Michael Murray and Kerry Chamberlain, in 1999; and Rethinking Health Psychology, by Michelle Crossley, in 2000. These publications coincided with the First International Conference on Critical and Qualitative Approaches to Health Psychology, which led to the formation of the International Society of Critical Health Psychology which now holds biennial conferences. This organisation, together with a growing body of work, shares a common dissatisfaction with the positivist nature of mainstream health psychology and, in particular, its focus on the individual and lack of serious consideration of the broader context.

Those engaging in critical health psychology take a variety of different theoretical (including social constructionism, post structuralism, feminism, Marxism) and methodological (including discourse analysis, participatory action research, narrative analysis) approaches. A key aim is ‘to (re)conceptualize “health behaviour” in such a way as to invite meaning and context into any analysis of health-related phenomena’ (Mielewczyk & Willig, 2007, p. 825). This reformulation involves investigating health-related activities (rather than behaviours) which can be understood only through their relationship with wider social practices and hence context is all important. In particular this includes contextual aspects such as the social, political and cultural dimensions of health and illness. Critical health psychology’s initial focus was on critiquing mainstream health psychology; however, recent
debates have moved on to consider how such a reformulation of health psychology might take place (see the collection of papers in The Journal of Health Psychology volume 11, part 3, 2006 and Crossley (2008) for an extended discussion of recent debates). In particular, these debates have centred on how this movement can contribute to social change and action, and the potential for action is the overarching theme of this book.

In Chapter 1 Sally Johnson elaborates on the recent debate between critique and action which centres on differences of opinion about how, and to what extent, action is, or should be, the goal of critical health psychology. This involves a ‘call for action’ on the one hand versus a focus on critique on the other. However, she avoids engaging in a polarised debate about the merits or shortcomings of each and explores how a number of language-based approaches might simultaneously focus on working to achieve improvements in health while retaining a strong sense of critique. In particular she explores how feminist post structuralist theorists’ emphasis on the negotiation of gender-related discourse and/or practice can be both limiting and potentially detrimental to health and well-being whilst also offering opportunities for empowerment and change. This is illustrated by drawing on her analysis in two different studies which explored women’s accounts of negotiating the embodied experiences of both pregnancy and breastfeeding. Through this kind of analysis, she argues, it is possible to reflect upon constraining discourses, which once identified can then be worked upon. She discusses various ways in which this could be achieved, for example, through further participatory action research, but argues that this needs to be done simultaneously through health psychologists’ engagement as scholar–activists facilitating ‘receptive social environments’ (Campbell et al., 2010).

The potential of the scholar–activist in critical health psychology is developed further by Michael Murray in Chapter 2. Murray discusses the historical development of the scholar–activist tradition. This arose as a reaction against the ‘scientific–practitioner’ approach which dominated clinical psychology, situated as it was within a biomedical framework in the United States in the 1960s. The model of community psychology which arose in the 1970s was based upon an activist model of engagement and an identification of the need to work at a community level in order to challenge social injustice and inequality. He also explicates the Christian aims and revolutionary history of a more radical approach to community action which arose in South America in the 1950s and 60s and led to the development of participatory action research. Though psychology has not always appropriated these early ambitions, certain versions of community psychology have more recently reclaimed them. Murray argues that because of the way in which health psychology developed, with its narrow focus on the individual, it is only recently that the value of connections between health and community...
psychology, with the aim of promoting health, have been made. Community health psychology has evolved, as has community psychology, with a more or less accommodating approach to critical engagement. The more critical approaches advocate the connection of intra-community processes with the broader socio-political context. Murray further argues that, this evolving movement fosters connections with developments in critical social and health psychology as well as in community psychology. He goes on to outline a number of ways in which community health psychology can be developed, in particular, through the involvement of the critical scholar–activist, documenting challenges this presents.

Wendy Stainton Rogers contextualises her chapter (Chapter 3) with a summary critique of mainstream psychology’s continuing preoccupation with social cognition to explain health-related behaviour change. She then elaborates on what critical health psychology can offer in terms of serious consideration of context. She juxtaposes traditional health psychology’s focus on the individual and health behaviours against recent recommendations made by NICE (National Institute for Health and Clinical Excellence – the British Government-sponsored body which, at the time of writing, provided guidance on the best ways to promote health and prevent and treat illness) on behaviour change interventions at individual, community and population levels. Stainton Rogers was part of the group who developed the guidelines, along with more traditional health psychologists, and academics and lay members from a diverse range of disciplines and interest groups. What is interesting to note, she argues, is that social cognition hardly gets a mention in the guidance. The importance of the ‘socioeconomic and cultural context’ in which behaviour takes place, and, especially, the need to ‘identify and attempt to remove social, financial and environmental barriers that prevent people from making positive changes’ are much more to the fore. She argues that given the make-up of the group this is not surprising, but more fundamentally they show a sense of unease with the underpinnings of mainstream health psychology and its individualistic approach to health. She advocates that to make a difference we need to tell better stories in health psychology and that critical health psychology is contributing to this.

Social identities, intersectionality and advancing health psychology

Psychologists are increasingly concerned with the effects of categories such as gender, social class, race/ethnicity and sexuality on health and well-being (Cole, 2009). Attempts to understand the effects of social categories and related identities have taken various forms. Typically in traditional approaches
to health psychology, categories such as gender and socio-economic status are conceptualised as one of a number of variables within a larger conceptual model and are therefore underexplored. Another approach is to identify the psychological characteristics associated with particular social groups as mediators of health behaviour (see for example, Lee et al., 2008; Zimmerman & Sieverding, 2010), but, as discussed earlier, these kinds of studies are based on individual perceptions of social phenomenon with scant regard to the social context. In critical approaches to health psychology social identities move centre stage. They are seen as one of the key contexts in which health-related activities are played out. It is the meanings and performances related to social identities which are the focus of analysis. In Part II contributors elucidate on meanings derived from our social positionings, concomitant identities and the implications of these for health and action. The notion of intersectionality was developed by feminists and critical race theorists to conceptualise analytic approaches to considering the meaning and consequences of occupying a range of different social categories simultaneously (see for example Cole, 2009). Though it is not our intention to develop specific frameworks around intersectionality, authors of the chapters in this part discuss intersectional aspect of social identity, such as gender, social class, age and sexuality, in their consideration of this particular context of health-related activities.

In Chapter 4 Katy Day focuses on social class, arguing that this should be a central concern to health psychologists because of health inequalities which have been linked to class. In this chapter Day critically reviews recent mainstream psychological literature on socioeconomic status and health-risk behaviours. She also considers recent representations of class in the British media. She argues that both psychology and media representations promote images of working class people as feckless and simply not exercising agency in order to reduce risk-related behaviours. She then considers what critical psychological perspectives offer to an understanding of social class. She argues that these perspectives invariably regard our actions and experiences as inseparable from the social context. She then goes on to explore contemporary critical research on working-class identities, drinking and diet. In doing so Day highlights how social class and gender intersect. She argues that research on class and health needs to move away from a narrow focus on considering socioeconomic status alone, as class encompasses much more than this, including social identity, values and discourse. Not only this, but research needs to consider the intersection of class with other social identities such as gender, race, regionalism and sexuality. In addition, such research should be undertaken across the range of classes, not just with the working class. By identifying problems with the class system and its implications for health, Day argues that critical health psychologists will be in a better position to act
as agents of change in taking this critical agenda to wider audiences such as policy makers.

In exploring another key social category, gender, Christine Horrocks’ chapter (Chapter 5) discusses the mounting interest in men’s health in developed countries. She outlines a range of health inequalities and growing concern regarding men’s health. However, she argues that these inequalities are not monolithic, and a range of other factors such as socioeconomic status and ethnicity intersect to produce inequalities between men as well as between men and women. Horrocks explores explanations for men’s propensity towards health-damaging behaviours. She considers the ‘life style choice’ explanation but critiques this by drawing on the concept of hegemonic masculinity which many theorists now use to explain men’s health ‘choices’. She argues that this dominant version of masculinity creates a sense of reality for many men and that this formulation places gender as a situated social and interactional accomplishment. Horrocks also critically discusses the ‘gender mainstreaming’ approach in which a gender-sensitive approach to health policy, research and services development is promoted. Drawing on the work of Bakhtin she situates men’s health-related behaviour as arising out of human action which is situated, relational and participatory rather than an individual choice. She criticises aspects of the gender-sensitive approach which are based on the accommodation of hegemonic masculinity by arguing that in Bakhtinian terms these are ‘monologisms’ which function to shut down dialogue as to why men are not using normative routes into services. She outlines how Bakhtin’s notion of the ‘carnivalesque’ (which aims to reveal, undermine and even eradicate the hegemony of an ideology) could be used to challenge hegemonic masculinity and more substantially tackle male-related health inequalities than has been the case thus far.

A consideration of gender is further elaborated in Bridgette Rickett’s chapter (Chapter 6) on women and occupational risk. In reviewing the literature on occupational health, Rickett notes the absence of data for women in statistics on occupational accidents, injuries and illness as well as in psychological theorising and research which has mainly emanated from studies with male populations. In addition, she shows how dominant psychological approaches to occupational health do not substantially consider the political, historical and social world workers inhabit. She argues that there has been recent recognition of these omissions, and there is now a growing awareness of including gender sensitivity in policy. This is in conjunction with a body of research which aims specifically to explore women and occupational risk more substantially. In particular, she discusses the potential of research which focuses on discourse, gender identity and occupational risk. She draws on an illustration from her own research with female door supervisors (bouncers) which explores the intersection of gender, social class and heteronormative sexuality.
In this, and her other research on women’s occupations in work spaces considered dangerous, Rickett concludes that women’s attempts to avoid harm and damage are often compromised by organisationally shared understandings of women and their capabilities. Importantly, her research indicates that by striving to challenge unfair gendered expectations and ideologies that hinder being successful and respected in their jobs, women are often forced to compromise their health and safety at work.

In Chapter 7 Kate Milnes reviews and critically evaluates the dominant social cognition to the study of sexual health and its promotion. She argues that because of its individual focus on attitudes and related sexual health intentions, this approach is often disempowering and neglects the material, cultural and ideological context of people’s sexual lives. As a result, she suggests that interventions based upon this model have limited potential for bringing about change or creating possibilities for action. Through an analysis of sexual health promotion materials available on the internet, Milnes considers how sexual health ‘choices’ are shaped by dominant constructions of youth, gender, class and sexuality. She therefore argues that taking a critical approach to sexual health promotion involves conceptualising sex and sexual relationships as ‘situated practices’ rather than as individual behaviours. This reconceptualisation creates possibilities for action while still acknowledging the constraints that cultural, structural and material contexts place on people’s sexual lives. By providing opportunities to deconstruct and critique dominant discourses around gender, sex and sexuality and providing spaces and resources to explore alternative discourses, she believes that critical approaches to sexual health promotion have the potential to engage people in an active process of negotiation with regard to their sexual health and well-being.

**Modernisation and democratisation in healthcare**

Accepting the need to incorporate wider political contexts and agendas into our appreciation of health psychology means it is crucial to identify how the current global economic and political climate is placing healthcare services and their delivery under pressure. Governments are looking for ways to limit and reduce healthcare spending while at the same time engaging in a dialogue that offers assurances around maintaining levels of service. There is growing interest in the delivery of ‘lean healthcare’ (see Waring & Bishop, 2010) and ongoing debates regarding proposed reforms and restructuring, with claims that managerialism has replaced professionalism in the social organisation of healthcare (Kitchener, 2000). Indeed, Martin et al. (2009) argue that healthcare and other public services are under pressure as governments globally...
view them as ill-suited to contemporary economic and social requirements. Efforts to reform health service organisation and delivery include introducing markets, endeavouring to improve collaboration between providers and workforce reconfiguration.

In their chapter (Chapter 8) Paula Nicolson and colleagues explore the organisational configuration of National Health Service Trusts in the UK. Interestingly they identify that organisational configuration, specifically in relation to leadership, is seldom written about within ‘health psychology’. This is indeed interesting in light of the centrality of psychological thinking within the leadership research literature and the concomitant emphasis in critical health psychology on exploring power relationships. Their work reveals a complex picture which both challenges and identifies ongoing hierarchical power and gender-based struggles with differences in leadership styles having the potential to impact on healthcare delivery and patient-care. Moreover, in their analysis individualistic accounts of leadership are usurped, being overtaken with a more fluid and discursively located performance that embraces the critical agenda. Yet this chapter also comfortably engages with a more intra-psychic interpretation of experience which describes how organisations infiltrate our consciousness. Hence we experience and hold an intellectual/cognitive and emotional sense of an organisation; this then raises questions about how organisational healthcare cultures, particularly in such turbulent times, are influenced and reproduced. Arguably, the rhetoric of healthcare ‘modernisation’ in the UK, and similar policies elsewhere, are legitimatory discourses that become adopted or resisted impacting on the success or failure of efforts to reconfigure professional boundaries and healthcare more generally.

Foucault’s philosophical analyses exposed the unacknowledged assumptions and regulatory practices in healthcare. Interrelationships between power, knowledge and the body are exemplified in the power of medicine and notions of the ‘clinical gaze’ where the body is an object of inquiry and the individual a ‘case’ needing to be worked upon (Henderson, 1994). Concerns around the distribution of knowledge in healthcare and what this tells us about the nature of relationships and interaction has been extensively commented upon. However, with ‘modernisation’ come new modes of governance in healthcare and ever changing relationships that warrant scrutiny. These more recent moves towards modernisation link into shifting boundaries around professional expertise and increasing confidence in systems and auditable rules and procedures exemplified in, for example ‘care pathways’ which are care management technologies that chronologically map out activities in the healthcare process (see for example Pinder et al., 2006). Another modernising move is the notion of the ‘expert patient’ which, under the guise of democratisation, has emerged in UK health policy (Department of Health,
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Work to transform the healthcare professional/doctor–patient relationship from a professional-led interaction to one that is more of a healthcare professional–patient partnership in which ‘expert patients’ are able to articulate their individual needs and thus receive appropriate treatments seems unassailable as a definitive goal. Of course there is sound reasoning for developing patient expertise: with the growth of web-based health-related information, interactive forums and consumer websites people have been transformed into ‘reflexive consumers’ of healthcare (Henwood et al., 2003).

In Chapter 9, Victoria Lavis and Christine Horrocks present research looking at the healthcare professional–patient interaction, critically assessing entrenched professional power and structural constraints that might define, and to an extent determine, engagement with an ideology that places patients as experts who have insights into their specific healthcare needs. Their work looks beyond a somewhat consumerist view of the expert patient to one that embraces a respect for the person in their situational milieu. Indeed their work suggests that professionals may cling to their power to control patients and information, not listening to or even dismissing the patients’ efforts to theorise or explain their health issues. Interestingly, Tang and Anderson (1999) suggest that professionals need to recognise the relationship between their power and knowledge before they can share expertise with patients. This was evident in Lavis and Horrocks’ research where training was pivotal in bringing about a change in the construction of the patient. There was a shift from ‘directive’ practices, where patients were expected to comply with the healthcare professional’s prescribed course of action, to ones that had a far more ‘participatory’ focus where the patient was able to identify pathways and take control.

Taking up the critique agenda of this book such apparent success should not blind us to the recognition that, as Fox et al. (2005) suggest, ‘if the “expert patient” is to be understood as a reflexive project of self-governance, then it is indeed a “technology of the self”, a disciplining of the body in relation to systems of thought’ (p. 1308). Within these observations is embedded the usual individualising with people positioned as responsible for self-management of health and well-being. Notions of empowerment, sharing of power and user-led healthcare do offer avenues for action and change by resisting the imposition of power, but it is important to also envisage other implications. Significantly, without doubt all patients may not wish, or be able, to lay claim to the material and/or technical competence necessary to take responsibility for their health.

Similarly, in Chapter 10, the notion of democratisation and complexities with unforeseen implications are taken up by Catriona Macleod, who focuses on the rhetoric of ‘choice’ and the issue of advocacy in relation to women and abortion in South Africa. She convincingly outlines how an ideology of choice
obscures the stigma associated with abortion and the social conditions where women live their lives. She points to the ‘psychologisation’ of abortion and the emergence of ‘post-abortion syndrome’ whereby instead of women being portrayed as autonomous decision makers with regard to their health and well-being they are positioned as inadvertently being subjected to psychological harm as a consequence of abortion. Out of this concern materialises a route for anti-abortion activists to claim a somewhat moral standpoint in terms of denying women access to abortion – women are being saved from ensuing guilt and remorse. However, modification is needed to appreciate that the landscape is complex, with Macleod arguing for a ‘reproductive justice’ approach which foregrounds the contextual nature of women’s lives situating abortion within wider social, political and cultural practices. Importantly her work makes the reader aware of the need to avoid simplistic and homogenising explanations which assume equal access to health resources with liberatory practices, and efforts with regard to democratisation, needing to be far more than rhetorical pronouncements.

Making a change: health inequalities and community well-being

In many respects the chapters in Part IV (the final section) of the book bring together and harness the change and action-oriented promise of critical health psychology to ‘make a difference’. Elsewhere, Murray (2004) eloquently but succinctly explains that health psychology can adopt strategies that more effectively position it in ways that promote health through social rather than individual change. He argues that working with participants and communities, rather than attempting to impose a particular framework, opens up possibilities for a process of ‘collaborative change’. Hence as has already been outlined he advocates a more action-oriented role for scholars and researchers that embraces their co-action in not only the process of knowledge construction but also in their potential to impact in the arena of people’s lives and wider political contexts.

The first chapter in this part by Bregje de Kok (Chapter 11) begins with a clear exposition of critical health psychology’s commitment to be positioned with the oppressed and disenfranchised and work in ways that address inequalities. Using her work in Malawi which she accurately describes as ‘resource poor’ country de Kok explains how such non-western contexts have been largely ignored by critical, discursive approaches. In this chapter the resultant problematic of discursive approaches with regard to the explanation and inclusion of more structural and material factors is bravely tackled. The micro approach taken in much discursive work is situated as accountable but also
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hugely effective in bringing about change when deployed to this end. She uses her own work exploring the constructions of infertility in Malawi to showcase the action potential of discursive psychology. Consequently, in de Kok’s work discursive psychology bestows insights into interpersonal issues with various social actors using discursive devices in response to infertility. However, she does not leave it there – de Kok goes on to suggest ways that her work can be used to develop health promotion strategies and inform and improve communications between professionals and the professionals and their clients. Highlighted is the need for ‘actionable understandings’ (Murray & Campbell, 2004) which echo sentiments which underscore the need to challenge and subvert social injustices through our scholarly work and activism.

Nigel King’s chapter (Chapter 12) offers an uplifting and skilfully drawn account of connections between the natural world and our engagement with its potential to enhance our lives. Situating his work within wider environmental, evolutionary and psychological thinking offers a convincing analysis that points towards the beneficial properties of community located ‘green exercise’ projects. Working with communities in deprived areas in the North of England he presents an analysis that reveals the prospective benefits for health and well-being inherent in community allotment projects. Evident is the way that people’s environments shape the nature of their existence with participation in allotment gardening providing openings for new ways of being. His work makes visible the importance and value of collectives with the sharing of knowledge, produce and experience adding to the recuperative value of ‘being outdoors’ and in contact with the natural world. King highlights the macro level linkages of his work and the way that participation in ‘green exercise’ connects to wider environmental campaigns. Stressed also is the more localised impact, with the protection and extension of urban green space essential and critical to health and well-being.

We end the book with a chapter by Rebecca Lawthom and colleagues (Chapter 13) who carefully outline the nature of participative methodologies in critical community psychology. Taking up the ongoing critique of individual approaches to health and well-being that pervade this book and other work in the domain of critical health psychology, Lawthom et al. advocate a ‘values-based approach’ where social justice, collaboration and social and community processes are the focus, embracing a public health and ‘wellness’ approach. The way that community psychology views the prevention of ill health as residing in wider social context is convincingly made with issues and problems facing disadvantaged and oppressed people and communities having deep historical roots. As Prilleltensky and Nelson (2002, p. 12) explain oppression is ‘a state of domination where the oppressed suffer the consequences of depravation, exclusion, discrimination, exploitation, control of culture, and sometimes even violence’. Lawthom et al.’s work demonstrates action that goes well beyond the
meme political rhetoric of participation (Milewa et al., 1999), illustrating that taking joint action that ensures community participation is truly collaborative and meaningful. A series of projects which employed creative arts are presented within their community psychology framework. Health and well-being messages are shared and discussed in ways that focus on the social and relational aspects of community life thus avoiding problem-based individualising accounts. Their work convincingly demonstrates the value of building on the strengths of people and communities providing very useful examples that can serve as beacons for those of us who are unsure and/or inexperienced in this sphere.

Again we are able to see that health and well-being and community participation are more than rhetorical concepts used to fulfill a political ideology. Work is ongoing that advances our understandings and practical application of health psychology beyond critique into the domain of action to bring about change. Still, Cleaver (2002), when reflecting on participatory approaches distinguishes between efficiency arguments, where participation is a tool for achieving better outcomes, and equity and empowerment arguments whereby participation increases individuals’ capacity to improve or change their lives. She encourages consideration of how the structures of participatory projects secure the interests of those experiencing inequalities asking what are the ‘linkages’ between participation and the ‘furthering of their social and economic good’ (p. 54). Throughout this book there is evidence of work that makes manifest such linkages; we should nonetheless heed the cautionary note in Cleaver’s observations while at the same time taking encouragement from the examples in this collection and beyond that have infiltrated to some extent the bastions of more mainstream health psychology. Finally, we hope that the collection of chapters in this book will help in the (re)telling of health psychology and advance stories that will provide insights into how the adoption of theories, methods and practice informed by more critical approaches to health psychology can make a difference.

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