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Means and Meanings in Health Psychology

Conclusions

Over the past 20 years, health psychology has achieved a consensus about the use of theoretical models but persists with overlapping and redundant theoretical constructs. Increasing emphasis on investigating methods of behaviour change are driving the field to use more experimental, longitudinal research designs but we need to improve our ability to specify replicable behaviour change interventions. The quality of our theoretical frameworks and methods of investigation will determine our success: in working with other disciplines, obtaining funding to conduct our research, answering our research and practice-based questions and in developing a cumulative science.

References

Abraham, C. & Johnston, M. (1998) (editors) Self-Regulation and Health. Special issue of *Psychology & Health,* 13.

Campbell, M., Fitzpatrick, R., Haines, A., Kinmonth, A. L., Sandercock, P., Spiegelhalter, D. & Tyrer, P. (2000). Framework for design and evaluation of complex interventions to improve health. *British Medical Journal,* 321, 694–696.

Johnston, M. (1994) Current Trends in Health Psychology. *The Psychologist*, 7, 114–118.

Michie, S., Johnston, M., Abraham, C., Parker, Lawton, R., & Walker, A. (2005) Making psychological theory useful for implementing evidence based practice: a consensus approach. *Quality in Health Care,* 14, 26–33.

Schwarzer, R, (1992) Self-efficacy in the adoption and maintenance of health behaviours: Theoretical approaches and a new model. In R. Schwarzer (ed) Self-Efficacy. Thought Control of Action. Washington: Hemisphere.

Walker, A., Grimshaw, J.M., Johnston, M., Pitts, N., Steen, N. & Eccles, M.P. (2003) PRIME: PRocess modelling in ImpleMEntation research: selecting a theoretical basis for interventions to change clinical practice. *BMC Health Services Research 2003,* 3: 22

Challenges and Prospects for a Socially Activist Health Psychology

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In reflecting on the current state and future prospects for health psychology it is necessary to start with a broad canvas. The broad aim of health psychology is to promote the health of society and especially the health of the weak and the vulnerable. It means challenging the gross inequities in health and healthcare that exists in our societies. This challenge can take place at different levels although much of health psychology has focused at the individual and clinical level. In this short contribution I would like to argue that there is a need to expand our interest to the community and societal dimensions of health and illness.

Since its inception health psychology has had as its primary aim the development of theories and methods to contribute to a healthier society. Unfortunately this contribution has been limited by a very narrow definition of the social (Campbell & Murray, 2004). Health promotion has been defined and practiced in a proscriptive and controlling sense as being techniques to encourage more individuals to desist from unhealthy behavioural practices such as smoking, excessive eating and drinking and to encourage healthy practices such as healthy diet and exercise. The focus was on the individual whose behaviour was largely under the control of certain cognitive processes. Although this in turn might be influenced by various social norms its meaning within the broader social and cultural context has tended to be ignored. There is a need to expand our focus from cognitive processing to consider the social meaning of health and illness and the social, material and political world within which we live.

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Challenges and Prospects for a Socially Activist Health Psychology

Health psychology has tended to regard communities and societies as collections of individuals with particular characteristics rather than as collectives with their own particular dynamics. I would argue that if health psychology is to achieve its full potential it will be necessary for it to develop an understanding of collective psychology as well as a greater awareness of social and political reality.

Humans are social beings - we are born, live and are enmeshed in a social world. We develop shared ways of thinking and interacting. We identify with certain social groups and not with others. Our health practices are part of our way of interacting with our social and material world. They cannot be extracted from that world. It is not a social world of equals but rather a social world driven by inequalities in power and wealth that ensure the maintenance of substantial inequalities in health. It is well-established that social groups and societies with the most power and wealth are also those with the best health. Evidence of this relationship between wealth and health is now well-established and is a major challenge to a health psychology designed to promote a healthier society.

There is also the massive gap in wealth and power between the developed and developing nations. The ongoing campaign to Make Poverty History reflects the growing awareness of this inequality. At the same time, as Nelson Mandela emphasized at the time of the G8 summit, developing countries do not want charity but social justice. Charity is an individual emotion expressed by one person to another who is in distress but it is premised upon a limited gap in wealth and power between them. It means little for a tyrant to proffer succour to a slave. In the same way, it means little for the capitalist developed world to offer aid to the developing world that it continues to plunder and to exploit. Or indeed in the developed world for the wealthy and powerful to give to charitable organizations when their proportion of wealth continues to increase and the numbers of people living below the poverty line continues to increase (Paxton & Dixon, 2004). Rather, in the developing world, as in the developed world, the campaign is about social justice - the reduction in these power inequalities and the creation of a healthier society for all.

Cutting across these different forms of intervention is the issue of social values. Health psychologists are part of an educated elite in society. As such we often identify with the interests of those with wealth and power despite having limited power ourselves - for example the impact of government control over our research activities constrains our opportunity to develop an independent research agenda. The challenge is for psychologists to reassess their connections in society. The Italian Marxist Antonio Gramsci discussed the important role of organic intellectuals - those with strong connections with their particular communities. Their task was to join “in active participation in practical life, as constructor, organizer, 'permanent persuader' and not just a simple orator'. In the same way, health psychology needs to carefully identify those communities it works with such that our contribution can have maximum impact on reducing these health inequalities.

But where does this locate health psychology. I would argue that it provides a starting point for developing a socially activist research and intervention strategy. Health psychology can research and intervene at different levels:

1. Science: Health psychology can reflect about the adequacy of our theories and methods. It can investigate the character and highlight the gross inequalities in health and the role of ideological, social, cultural and material factors in perpetuating those inequalities. This action can extend beyond the scientific domain to the community and political domain. Health psychologists can contribute to the broad debate about the social and political factors that contribute to ill-health. They can also challenge local beliefs when they accept established orthodoxy. Importantly, they can challenge those scientific models that individualize health complaints.

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2. Community: Health psychology can participate in community organizing activities to strengthen the power of local communities. There has been ongoing debate about the meaning of communities and especially between those who define it in terms of geography or locality and those who prefer to define it in terms of interest. I would argue that it could be both. A community is not a community unless it has some awareness of itself and conversely this social and community awareness grows with social agency. Health psychologists can participate with community groups in organizing for a healthier society. This can range from assistance with self-help groups through to participation in community agitation for better living and working conditions.
3. Political: Health psychologists can contribute to those collective movements designed to reduce social and political inequalities and improve the health of those most deprived. They can investigate the factors that hinder and promote collective engagement.

In developing these interventions the work of health psychology can be strengthened by participatory and collaborative research. Through participation in the work and lives of communities health psychologists can begin to understand their problems and the opportunities for social change and the creation of healthier lives. At the same time through various forms of work with communities health psychologists can begin to recognize the importance of broader social struggles. Both overlap although sometimes there can be confusion. Community action is important for challenging community injustices but critical health psychologists recognize the limitations of this work. This is not to argue that such community health activities are worthless but that rather they must be placed within the wider socio-political and cultural context. In themselves they can provide substantial improvements in the health of deprived communities. But learning to live in deprived conditions is no substitute for transforming those conditions not only on a local but also national scale. As Black activists used to cry, it is necessary 'to keep our eyes on the prize'. Further discussion of these issues is developed elsewhere (Murray, 2004; Marks et al, 2005).

Health psychology has great potential for contributing to a healthier society but we must not be complacent or exclusive. We need to recognize the urgency of remedying health issues for those who are most afflicted and we need to connect with both those who are most affected as well as colleagues in other disciplines if we are to be effective.

References

Campbell, C., & Murray, M. (2004). Community health psychology: Promoting analysis and action for social change. *Journal of Health Psychology*, 9, 187–196.

Marks, D.F., Murray, M., Evans, C., Willig, C., Woodlall, C., & Sykes, C. (2005). *Health psychology: Theory, research, practice. Second edition.* London: Sage.

Murray, M. (Ed.) (2004). *Critical health psychology*. London: Palgrave.

Paxton, W., & Dixon, M. (2004). *The state of the nation: An audit of injustice in the UK*. London: Institute for Public Policy Research.