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Editorial Essay
Freedom, Responsibility and Power: Contrasting Approaches to Health Psychology[1]

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Abstract

In *Health Psychology in Context* it was argued that, if we are to make any sense of it, the subject matter of health psychology must be understood in the context of social, political and economic forces. That theme is continued here with a brief examination of how freedom, responsibility and power enter into the generation of conflicts, including the recent outbreak of war. The interplay of commercial and state interests in academic and health research settings is then discussed. The assumptions, values and meanings of work in health psychology are examined in that light. These are divided between four evolving approaches in health psychology: clinical, public, community and critical health psychology. A framework is presented for positioning these approaches within a system for the production of health and social care.

Keywords

freedom, health psychology, power, responsibility, terrorism, war

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The outbreak of war

AS A PSYCHOLOGIST, should I admit to feeling passionate about my work? Well, I do. I feel passionately about the relevance of psychology, economics, sociology, politics and ethics to the production of health. I believe that psychosocial processes have an enormous influence in health, illness and health care. I believe that the health system has woefully neglected psychological processes in the care of patients. I believe that health education, promotion and communication can all be significantly improved through the application of psychological research. I believe that democracy, freedom of speech and the freedom to lead a healthy life are being eroded in the name of the freedom of the market; it has been stated that: 'Presidents and prime ministers now court financiers and industrialists, not the other way around. Unelected financiers and industrialists are orchestrating the globalisation process' (Soros, 2000). I believe that the unequal distribution of wealth and power is one of the root causes of war, violence and suffering. I believe that oppressed and abused people such as those living in abject poverty, survivors of war, terrorism and ethnic cleansing deserve lives that are secure, sustained, and dignified. I believe that the economic principles of globalization serve to maintain the division of the rich from the poor, the unequal supply of education and health care. I believe that such inequalities can trigger conflicts including terrorism and war (a form of terrorism). I believe that justice for the perpetrators of, and freedom from, terrorism can never be achieved by violent means. I feel passionately about the relevance of psychology, economics, sociology, logic and ethics to the prevention and production of conflict.

Let me pinch myself, can it be true? Am I actually using the subjective case of the first person pronoun, 'I', the transitive verb 'feel' and the adverb 'passionately' in the same sentence *in a psychology journal*? The subjective case of the first person pronoun, the—in Psychology—forbidden 'I', unique 'I', thinking 'I', interpreting 'I', storied 'I', becoming 'I', ontological 'I', willing 'I', passionate 'I' is the foundation for identity and personhood. The transitive verb 'to feel' is essential to the communication of experience. And the adverb 'passionately' is a vital descriptor in declaring one's strongest beliefs and values. It is supremely ironic that these three words are banned from the discourse of the 'Science of Psychology'. In playing the Science Game, the Psychology community has for years acted mum about feelings, personal values and beliefs. Psychology is nothing like Physics, Chemistry or Biology, it is the study of the behaviour and experience of a social, reflexive, subjective, community of persons, each with his or her 'I'. It must be time to stop this foolishness.

It is not a bad idea, once in a while, when the rush of everyday living permits, to stop and reflect on what the activities of one's working and living actually mean. Are we doing any good, or would it perhaps be better for all concerned if we simply packed our bags and did something else, like offer our services to War on Want, Médicins sans Frontieres or Oxfam? In this case, when I paused to reflect, a terrifying new war broke out, casting anything that I, or anybody else, had written into an irrelevant pre-war consciousness. When the terror began, the whole world changed, and it would never be the same again.

Almost any imaginable horror could happen in the months following the attacks on the World Trade Center. By the time of going to press, 'Operation Enduring Freedom' had carried out 10 solid days of night and daytime bombing raids on Taliban positions in Afghanistan. Anthrax contaminated letters or photographs were received or handled in hundreds of other locations in at least 15 other countries creating widespread fear and panic. The FBI had warned that new terrorist attacks on US territory were imminent. Psychological operations had begun in Afghanistan using radio propaganda on the population. Demonstrations against the allied bombing raids had occurred in London and many other major cities throughout the world, most angrily in Pakistan. India and Pakistan had renewed their military actions over Kashmir. Fears of a possible nuclear conflict involving Pakistan and India were being discussed on television news channels. The horrific possibility of 2.5 million Afghani refugees spending the winter without food, water or shelter had become a distinct possibility. While failing yet to 'smoke out' Osama bin Laden and the al-Qaida organization, a blockade of daily allied bombing raids had increased the terror, the fear and the risk of

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counterattack. One British MP compared the situation to putting Frank Tyson in the ring with a five-year-old. After the allied bombings, everybody, everywhere was feeling less safe, victims having being made of us all (Younge, 2001). Only weeks previously, all of this would have been the stuff of nightmares, not a part of our everyday reality. At the time of writing, nobody can be certain what will happen next.

The destruction of the World Trade Center and Pentagon on 11 September 2001 put into vivid perspective the deep hatred that divides human societies. Live television transmission by CNN and the other news channels made this excruciating violence personal to every citizen of the western world. Whatever the perceived historical, religious or cultural factors that may be involved, sharp economic and political differences readily prime the conditions for conflicts, including wars and genocides. Seeking out and destroying identified perpetrators of terrorism in their camps is one thing; seeking out and destroying innocent citizens because they are 'Americans', 'Jews', 'Muslims' or 'Tutsis', or members of any other hate-group, is another.

A recent book, *A People Betrayed. The Role of the West in Rwanda's Genocide* by Linda Melvern (2000) describes how:

> In the course of a few terrible months in 1994, 1 million people were killed in Rwanda . . . . It was a slaughter on a scale not seen since the Nazi extermination programme against the Jews. The killing rate was five times that achieved by the Nazis . . . . The combination of revelations about the scale and intensity of the genocide, the complicity of western nations, the failure to intervene, and the suppression of information about what was actually happening, is a shocking indictment, not just of the UN Security Council, but even more so of governments and individuals who could have prevented what was happening but chose not to do so. (pp. 4–6)

Linda Melvern's devastating book about the killings of 800 000 Rwandans in 1994 has yet to be reviewed by any major newspaper, magazine or journal.[2]

Genocide, the ultimate expression of power, is part of history. In 20th-century Europe, genocide was meted out against the Armenians, the Jews, the Romany people and the Albanian Serbs. Many of the perpetrators of the Rwandan genocide still roam free. Such matters receive minimal publicity. Yet if a single western soldier is killed today in a military situation, it is front-page news: 'Macedonian mob kills Briton' (headline, *Daily Telegraph*, 'Britain's biggest-selling quality daily', 28 August 2001, p. 1); 'Soldier killed in Balkans ambush' (headline, *Metro*, 28 August 2001, p. 1). Then 14 days later, the World Trade Center attacks brought 5000 deaths and 5000 headlines. By 2 October the word 'genocide' was again being used, on this occasion in reference to the projected deaths the millions of Afghanis who could easily starve this winter in the freezing mountains while the war was waged against the Taliban (Monbiot, 2001).

But how are beliefs and values about freedom and justice to be translated into actions intended to bring about improvements? Social cognition models talk about attitudes, subjective norms, perceived control and self-efficacy at the level of the individual. They take less account of the direct effect of impulse and/or emotion; of the role of compassion or values; of joint decision making and social action; nor do they factor-in ethics (Marks, Murray, Evans, & Willig, 2000). Action designed to change society is not only a cognitive affair about logic, facts and evidence. It must also be political. It is about influence, power, economics and wealth. Not wealth itself, but its distribution and use. There is enough wealth in total for everybody in the world to live a decent life, but the increasing wealth of the few leaves less for billions of others. The 200 richest people have more than the combined wealth of 41% of the world population; an annual contribution of 1% of their wealth would provide universal access to primary education (US$7–8 billion) (Munro, 2000).

There is another freedom, the freedom of thought and expression. Those with the talents and opportunities can use this freedom to speak out, to persuade by the power of rational argument, including theory, ethics and evidence. An essential use of this freedom is the art of doubt, the ability to sceptically question, challenge and argue about anything and everything including freedom itself: what kinds of freedom, whose freedom, and on what terms?

Sen (1999) has argued that the expansion of freedom is the primary end and the principal means of human development. Sen uses

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'freedom' in reference to human capabilities and opportunities to achieve valued outcomes of five instrumental kinds: (1) political freedom; (2) economic facilities; (3) social opportunities; (4) transparency guarantees; and (5) protective security. President Bush and Prime Minister Blair have talked a lot lately about justice. How just is it for an alliance of states with the highest levels of all of these five kinds of freedom to use its economic and military might against a state with the lowest of levels of these freedoms?

In a previous article (Marks, 1996) it was argued that health psychology and its subject matter can best be understood in the context of social, political and economic forces. Having commented on the events that changed the context of everything, I am going to pursue this theme with the spotlight turned on the academic world and its dealings with commerce. I will discuss the assumptions, values and meanings of work in health psychology, health care and academia in that light. I will explore four evolving approaches, or ways of working, in health psychology and examine some implications of each. Finally, I will look at how some of these ways of working might possibly be linked and integrated into a single framework for health and social care.

Academic freedom and the free market

Current trends in academia seem trivial in context of the new war. However, these issues are of some relevance to the development of health psychology. Academic psychologists are paid to teach, do research and administration. As servants of the state, and of its industrial partners, university workers aim to maximize output in value-free knowledge products, to be used for whatever ends the state and the other paymasters desire. Carrots and sticks in research assessment and promotion exercises incentivize the acquisition of external funds from state and industry, and multiple publications in journals, the effect of which is rarely evaluated (Marks, 1995). Intensive and innocuous data collection feeding thin, salamified[3] papers within the ever-narrowing boundaries of specialist domains is the order of the day. The epidemic of super-specialization suits a system geared towards performance and efficiency, with fewer and

fewer requiring a view of the Bigger Picture. So what exactly is the Bigger Picture? Nobody knows. Bigger-Pictureology does not exist as a subject of study.[4] All one can do is to take a stab at it.

One stab says big business and universities have done a deal (Crace, 2001). The idea that science and psychology are value-free, that compassion and values should play no part in the proceedings, risks buying into this deal. Any buckling down of the intelligencia is a key step in the production of an increasingly inert consumerist society. It will be to the detriment of all if universities no longer are able to show any lead in voicing society's dissents.

Yet intellectual suppression is a real issue in the modern university (Pugh, Martin, Baker, & Manwell, 1986). It has been suggested that, in accepting support from commerce, applied science (including applied psychology) is being sold 'down the river of utility', and the scientist is becoming a serf or slave (Ziman, 2001, cited by Hewitt, 2001). Friendly town–gown relationships are a normal part of any civic university and are not an issue here. The wholesale purchase of research programmes, departments or institutes by multinational corporations is an issue. Of particular relevance to health are the tobacco and pharmaceutical industries. When universities such as Cambridge and Nottingham accept large grants from the tobacco industry to fund chairs, health and lifestyle surveys or degree programmes, while maintaining that it is in the interest of public health or social responsibility, it is not surprising if they are accused of selling themselves down the river.

Consider as an example the case of Professor Nancy Oliviera of the University of Toronto's Hospital for Sick Children who found that her drug trials did not support the sponsor pharmaceutical company's latest drug's early promise. Professor Oliviera's grants were cut off, and she became a victim of the five Ds—deny, delay, divide, discredit and dismissal (Hewitt, 2001). Professor Oliveira's employers sided with the company in discrediting her and her research. Concerns have been voiced about why any drug company or university should attempt to suppress results showing a drug is ineffective or unsafe.

In another incident, a letter to the University of Toronto, signed by 27 leading scientists,

including two Nobel laureates, said the decision to rescind a professorship offered to Dr David Healy 'besmirched' the name of the University of Toronto and 'poisoned the reputation' of its Centre for Addiction and Mental Health. Dr Arvid Carlsson, this year's winner of the Nobel prize in medicine, and Dr Julius Axelrod, the 1970 winner, joined those who branded the affair 'an affront to the standards of free speech and academic freedom'. Dr Healy, at the University of Wales in Bangor, was offered the post of director of the mood and anxiety disorders clinic at the centre after being chosen by a search committee. He went to Toronto in November 2000 to speak at a psychopharmacology seminar before some of his future colleagues. According to the executive director of the centre, Dr Paul Garfinkel, two of the points he made upset several of those colleagues: that selective serotonin reuptake inhibitors such as fluoxetine (Prozac) could lead to anxiety and suicidal thoughts; and that psychiatry, spurred on by the drugs industry, was overtreating people. Some academics have suggested that the real reason for the withdrawal of the job offer is the fear that the centre's sponsors, which include Eli Lilly, the manufacturer of Prozac, would withdraw their research support if someone who expressed negative views about one of their best-selling products joined the centre (Dyer, 2001).

In another case, in 2001, a WHO official, Dr German Valasquez, was attacked and threatened with death on three continents in an attempt to subvert his independent investigation into the pricing policies of the pharmaceutical industry. Dr Valasquez, a Sorbonne-trained economist, and head of the WHO drug action programme, is carrying out a WHO study into the unaffordable pricing of life saving drugs in developing countries. At the time of writing, Dr Valasquez was under police guard and had been advised not to talk about what happened to him (Vidal, 2001).

It is not only commerce that takes ownership of information, the state can assert its intellectual property rights equally proficiently if it chooses to. Grants from government departments may carry restrictions on publication rights that suppress open exchange of information. In this light, the idea that scholarly activity is disinterested, objective and value-neutral can be seen to be a myth. But it could be a dangerous myth, a myth that suppresses open inquiry, criticism and scepticism.

Some academics have accepted, in John Milton's words, 'bondage with ease'. Conflicts of interest, bias, contractual pressure and ghosting[5] of papers are becoming more common. At least the first two of these features were recently noted in an international journal of public health, involving, among others, health psychologists (Marks, in press). Perhaps health psychologists will be able to stand aside from some of the more virulent commercial interests by honouring our professional codes of conduct and disclosing any conflicts of interest in an open and honest manner.

It can be argued that with academic freedom comes the academic responsibility to report findings in open and transparent ways, to be wary of the bondage of ties, restrictions and conflicting interests, by presenting as impartial an overview as possible, acknowledging any conflicts or biasing influences. What must be avoided is the temptation to pretend to be objective as if there are no biases whatsoever. Bias in the form of hidden values, assumptions and theory is a normal aspect of all research whether in the sciences or the humanities. Psychology is no exception. What is most helpful is the open analysis and declaration of these biases by researchers so that end-users can take them into account in forming their own judgements and conclusions. Any claim to have no bias must arouse suspicions in any critical thinker.

Health psychology's different approaches

Returning to the health psychology scene, it is possible to discern some interesting trends that reflect differing emphases being placed on freedom, responsibility and power. These approaches have sprung up in a relatively short period and reflect different priorities and values about the nature of psychology and health, and about the theory and practice of health psychology. After millennia of pre-scientific study and a century of scientific psychology, the term 'health psychology' first appeared in the late 1970s. This was a time when discourses about health were leaning towards the idea that individuals are responsible for their own health through choices made, or dictated, by their so-called 'lifestyles'

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(Marks, 1996; Marks et al., 2000). Health psychology was given its dyadic label in 1979 when 'health psychology' occurred in a book title (Stone, Adler, & Cohen, 1979). In his influential article of the same year, 'Patient compliance and the role of the expert', George Stone (1979) argued that 'compliance' is an attribute not of the patient or client, but of the client-professional transaction. The perception of the relationship between the professional, as a provider or supplier, and the patient, as a client or consumer, as a *transaction* created opportunities for the new profession of health psychology. It was a new brand of paramedical health care with a niche market that was ripe and ready. The image and branding were no accident, and a new product of neo-liberalism had arrived.

Psychology has indulged in a lot of navel gazing about methods, in particular, the issue of qualitative and quantitative methods. Qualitative methods are relevant to health psychology if they are concerned with the phenomenology, discourse or meanings of people living in the context of a particular condition or environment, especially when viewed from a politicised perspective of gender, race, age, disability, sexuality or religion. Research methods can be viewed, not as recipes for mechanical knowledge production, but more as creative or adventurous means of inquiry (Willig, 2001). Using qualitative or quantitative methods does not make one a particular kind of psychologist, nor does a particular kind of psychologist necessarily use qualitative or quantitative methods. The criticality comes, not from method, but from the analysis of the theory, beliefs and values, and of the political positioning, which underpin praxis.

Twenty-plus years along the health psychology road, it can be seen that health psychology itself is becoming quite specialized, with four alternative approaches evolving. All four offer theory, research and recommendations for practice in health care. There are tensions between them, their value systems and ways of working. These tensions generate conflict and concern. On the other hand, if the protagonists allow it, there is the potential to complement each other in a powerful coalition of psychologists for health. Each approach is introduced in turn.

Clinical health psychology

The first and dominant approach is 'clinical health psychology' (CLINHP). CLINHP is highly research-based and targets the health care system for its expertise and services. CLINHP has a brand that is scientifically based and that is marketed under the 'biopsychosocial model'. CLINHP markets professional health psychology services within the clinical wing of the health care system and is partly overlapping with clinical psychology. CLINHP is the best established and most mainstream of the four health psychology areas as represented by the majority of textbooks, journals and academic programmes. It has been a very successful at making psychological inroads into the health care system and the medical curriculum and is the principal reason for the existence of health psychology today as a vibrant new field. The principal characteristics of CLINHP are summarized in Table 1 (column 2).

The biopsychosocial model (or BPSM) claims that health and illness are: 'the product of a combination of factors including biological characteristics (e.g. genetic predisposition), behavioural factors (e.g. lifestyle, stress, health beliefs), and social conditions (e.g. cultural influences, family relationships, social support' (Division 38, American Psychological Association, 2001). In spite of its widespread acceptance, however, there is a problem with the BPSM. It can be argued that the BPSM is not really a model in the formal sense but more a way of thinking about health and illness which has a heuristic function in justifying and legitimating research (Marks, 2002). The BPSM is seen by many clinical health psychologists as a challenge to the *biomedical model*, a rhetorical weapon with which to knock down that version of reality which says that all health and illness are the product of physical processes and reactions inside the body (Ogden, 1997).

Psychiatrist George Engel (1977) proposed the BPSM in response to what was perceived to be a 'crisis' for psychiatry with too many disparate theories and methods to be considered 'neat and tidy' like the rest of medicine. Engel discusses some problems with the biomedical model, in particular its reductionistic, dualistic, pathogenic assumptions. Engel argued that:

a medical model must also take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of the illness, that is, the physician role and the health care system. This requires the biopsychosocial model.

In making his plea for medical practice to become a more caring, considerate and patient-orientated, Engel had a valid point. But Engel left much unsaid. By some oversight, he never actually defined the BPSM, leaving it open for people to interpret it in ways of their choosing. The APA's (2001) Division 38 WebPages describes the BPSM as 'a combination of factors' that produce health and illness, as quoted above. But a combination of factors does not a model make. The BPSM is a piece of technical jargon for a set of beliefs about health and illness that values psychology and culture. In advocating the BPSM, showing off its new, invisible clothes, CLINHP risks exposure.

The existence of the BPSM and, thence, of health psychology, owes little to any particular model or scientific theory, but is based on a set of values which clinical health psychologists and others approve of. The BPSM has symbolic value in seeing psychosocial factors to be as important in understanding health and illness as DNA, cells and biology. The BPSM has given good service, as a cover-term for beliefs and values, but as a Trojan horse to reform biomedicine, the BPSM needs reconstruction. Something more solid is needed, theories which give coherent accounts of *how* it is exactly that psychosocial processes influence health and illness.

In sum, CLINHP has successfully brought to prominence the value of psychological perspectives on health, illness and health care. CLINHP is at the 'sharp end' of health care and is undoubtedly making an impact on most areas of clinical care. An immediate challenge is the replacement of the BPSM as an underpinning through the development of a set of specific theories about health and illness that are coherent and powerful. As a new health care profession it needs to demonstrate a strong evidence base, capable of impressing health service planners and policy makers that it is safe,

effective, and client-friendly. Clinical health psychologists can learn from the perspectives of:

Public health psychology

The second approach is 'public health psychology' (PUBHP). Like CLINHP, PUBHP is a component of the health care system working towards health promotion and prevention rather than treatment of illness. Individual health is seen more as an outcome of social, economic and political determinants than a simple consequence of individual behaviour and lifestyle (e.g. Carroll, Davey Smith, & Bennett, 1996). Within this approach, health psychology is viewed as an activity involving epidemiological studies, public health interventions and evaluation. The relevance of psychology to public health has been discussed for 20 years (Matarazzo, 1982; Winett, King, & Altman, 1989; Bennett & Murphy, 1997) and recently, somewhat uncritically, by a few health promotion specialists (Nutbeam & Harris, 1999; Macdonald, 2000). Public health psychology is viewed as a multidisciplinary activity seeking to integrate epidemiological studies, public health interventions and evaluation.

A recent editorial in the *British Journal of Health Psychology* drew attention to the 'opportunities, insights and challenges that come from combining the perspectives of public health and health psychology' (Wardle, 2000). Four public health issues with a psychological dimension were listed: understanding and changing health behaviours; mass communicating about health, disease and risk; teaching doctors how to communicate effectively with patients; and understanding why some sectors of society have better health than others. PUBHP is summarized in Table 1 (column 3).

In thinking about how public health psychology might be defined, one possibility would be to use an amended version of Matarazzo's (1982) definition of 'behavioural health'. Secondary and tertiary care would thus remain the province of clinical and clinical health psychology, leaving public health psychology to become a true psychology of health. This suggestion follows McDermott (2001) who argued that the amended definition should be used to redefine health psychology (considered as a single approach).

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Table 1. The characteristics of clinical, public, community and critical health psychology

Characteristic	Clinical health psychology	Public health psychology	Community health psychology	Critical health psychology
Definition	'The aggregate of the specific educational, scientific, and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, the identification of etiologic and diagnostic correlates of health and illness and related dysfunctions, and the analysis and improvement of the health care system and health policy.' (Matarazzo, 1982)	The application of psychological theory, research and technologies towards the improvement of the health of the population	'Advancing theory, research and social action to promote positive well-being, increase empowerment, and prevent the development of problems of communities, groups and individuals.' (Society for Community Research and Action, 2001)	The analysis of how power, economics and macro-social processes influence health, health care, and social issues, and the study of the implications for the theory and praxis of health work
Theory/philosophy	Biopsychosocial model Health and illness are: 'the product of a combination of factors including biological characteristics (e.g. genetic predisposition), behavioural factors (e.g. lifestyle, stress, health beliefs), and social conditions (e.g. cultural influences, family relationships, social support).' (APA, 2001)	No single theory and philosophy; supportive role in public health promotion which uses legal and fiscal instruments combined with preventive measures to bring about health improvements. Working towards general theories, e.g. health literacy improves health	Social and economic model: 'Change strategies are needed at both the individual and systems levels for effective competence promotion and problem prevention.' (Society for Community Research and Action, 2001). Acknowledges the interdependence of individuals and communities Shares some of the aims of public health psychology, e.g. improving health literacy	Critical psychology: Analysis of society and the values, assumptions and practices of psychologists, health care professionals, and of all those whom they aim to serve. Shares some of the aims of community health psychology, but with universal rather than local constituency
Values	Increasing or maintaining the autonomy of the individual through ethical intervention	Mapping accurately the health of the public as a basis for policy and health promotion, communication and interventions	Creating or increasing autonomy of disadvantaged and oppressed people through social action	Understanding the political nature of all human existence; freedom of thought; compassion for others

Continued

Table 1. Continued

Characteristic	Clinical health psychology	Public health psychology	Community health psychology	Critical health psychology
Context	Patients in the health care system, i.e. hospitals, clinics, health centres	Schools, work sites, the media	Families, communities and populations within their social, cultural and historical context	Social structures, economics, government, and commerce
Focus	Physical illness and dysfunction	Health promotion and disease prevention	Physical and mental health promotion	Power
Target groups	Patients with specific disorders	Population groups who are most vulnerable to health problems	Healthy but vulnerable or exploited persons and groups	Varies according to the context: from the entire global population to the health of an individual
Objective	To enhance the effectiveness of treatments	To improve the health of the entire population: reducing morbidity, disability, and avoidable mortality.	Empowerment and social change	Equality of opportunities and resources for health
Orientation	Health service delivery	Communication and intervention	Bottom-up, working with or alongside	Analysis, argument, critique
Skills	Assessment, therapy, consultancy and research	Statistical evaluation; knowledge of health policy; epidemiological methods	Participatory and facilitative; working with communities; community development	Theoretical analysis; critical thinking; social and political action; advocacy; leadership
Discourse and buzz words	'Evidence-based practice'; 'Effectiveness'; 'Outcomes'; 'Randomized controlled trials'	'Responsibility'; 'Behaviour change'; 'Risk'; 'Outcomes'; 'Randomized controlled trials'	'Freedom'; 'Empowering'; 'Giving voice to'; 'Diversity'; 'Community development'; 'Capacity building'; 'Social capital'; 'Sense of community'; 'Inequalities'; 'Coalitions'	'Power'; 'Rights'; 'Exploitation'; 'Oppression'; 'Neo-Liberalsm'; 'Justice'; 'Dignity'; 'Respect'
Research methodology	Efficacy and effectiveness trials; Quantitative and quasi-experimental methods	Epidemiological methods; Large-scale trials; Multivariate statistics; Evaluation	Participant action research; coalitions between researchers, practitioners and communities; multiple methodologies	Critical analysis combined with any of the methods used in the other three approaches

However there is a problem with Matarazzo's definition that states:

Behavioural health is an interdisciplinary field dedicated to promoting a philosophy of health that stresses individual responsibility in the application of behavioural and biomedical science knowledge techniques to the maintenance of health and the prevention of illness and dysfunction by a variety of self-initiated individual or shared activities.

It can readily be seen that this is an ideological position, not a scientific one.[6] This open move towards a moral position is unusually bold for a professional publication like the *American Psychologist*. In tune with the health discourses of the day, the definition places responsibility for health squarely on the shoulders of the individual. This formulation raises the question, should health psychology be so intentionally victim blaming and espouse a philosophy that is so hard to reconcile with a view about civic society having a caring role for all of society's members? Should people who show 'irresponsibility' in regards to 'the application of behavioural and biomedical science knowledge techniques' (such as smokers, drinkers, or people who eat more than a threshold amount of fatty foods) be excluded from our concern and left to reap the consequences of the 'error' of their ways?

Matarazzo's original definition of behavioural health needs to be discussed from a moral or ethical point of view. It is necessary to discuss the aims of the public health system, and the kind of system that public health psychologists, policy makers and other public health workers wish to advocate. This is a debate that has not yet to be held in health psychology. There is a need to openly debate the moral and ethical principles that underlie any attempt to persuade people to live differently than they otherwise would. PUBHP needs to clarify its mission and value system and produce a set of aims and working assumptions about the psychology of public health. To quote David Seedhouse (1998, p. ix):

Excuse me doctor/nurse/manager/policy-maker[/PUBHPist], but what are you trying to achieve here? What is the purpose of your intervention? What inspires your behaviour?

In Table 1, it is suggested that one working assumption for PUBHP could be that health literacy improves health (St Leger, 2001). If this is accepted, then one role for public health psychologists would be to offer research and theory relevant to programmes designed to increase health literacy. The senior technical advisor to the US Agency for International Development states: 'Communication . . . includes the development of an environment for community involvement to espouse common values of humankind' (Ratzan, 2001, p. 207). One wonders whether the full use of community involvement, communication science and health psychology could have done better than: 'Don't die of ignorance' (British Aids publicity campaign, 1987), or 'Slip, slop, slap' (a sun protection slogan meaning slip on a T-shirt, slop on some sun cream, slap on a hat, from an Australian health education programme in the 1980s), or 'Smoking can seriously damage your health' (British health warning on cigarette packets from the early 1970s)?

Public health is a multifaceted, multidisciplinary activity and PUBHP recognizes the expertise of other disciplines, especially in health promotion, communications and epidemiology. It has the potential to enhance the effectiveness of public health through the application and evaluation of theories of behaviour change. Promoting public health is about social processes, advocacy, negotiation, community building and social capital. Which is why public health psychologists could actively seek more communication and co-operation with:

Community health psychology
The third approach is 'community health psychology' (COMMHP) based on community research and action. COMMHP involves working in coalition with members of vulnerable communities and groups and aims at their 'empowerment' more generally, forms of social change that tackle the conditions that make them vulnerable (such as social exclusion and poverty) and that enable them to flourish in adversity. In common with PUBHP, COMMHP sees individual health as an outcome of social, economic and political determinants. It sees health as well being in its broadest sense, including not only mental and physical health, but also positive

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psychosocial aspects, such as resilience. It works mainly outside of the health care system.

COMMHP may be defined as:

Advancing theory, research and social action to promote positive well-being, increase empowerment, and prevent the development of problems of communities, groups and individuals (adaptation of a definition of community psychology published by the Society for Community Research and Action, 2001).

There are other equally important health psychology movements in Spain and South America which have a longer history. In fact it is apparent that several streams of COMMHP exist in parallel universes, and also in other languages, to CLINHP and PUBHP with relatively few links. COMMHP is summarised in Table 1 (column 4). In the Anglophone world COMMHP is represented by Division 27 of the APA, the Society for Community Research and Action (SCRA). Membership of the SCRA includes psychologists and people from related disciplines such as psychiatry, social work, sociology, anthropology, public health and political science, including teachers, researchers and activists. Community psychology is concerned with healthy psychosocial development within an ecological perspective. It focuses on health promotion and disease prevention, rather than waiting for illness to develop and to diagnose and treat the symptoms. There is an emphasis on communication: 'Communication and community grow in each other's shadows; the possibilities of one are structured by the possibilities of the other' (Rothenbuhler, 1991). Other 'c words' of importance include 10 more little 'c's' (confidence, credibility, comfort, comprehension, critiques, competence, context, counterbalancing tensions, congruence and consistency) and the three big 'C's' (Commitment, Capacity and Control) (Gittell & Vidal, 1998).

Building on the work of Putnam (1993), who saw that civic societies valued trust, co-operation and long-term relationships, is empirical work aimed towards studying the values of attachment and loyalty (Temkin & Rohe, 1997). Declarations of values and beliefs are a respected part of community psychology discourse as reflected by titles of books and journal articles, e.g. *Community building. Values for a Sustainable Future* by Leonard Jason (1997),

Value-based praxis in community psychology: Moving towards social justics and social action by Isaac Prilleltensky (2001) and *Building value-based partnerships: Toward solidarity with oppressed groups* (Nelson, Prilleltensky, & MacGillivary, 2001). Nor are values absent friends in the planning, execution and presentation of projects at conferences. This feature of COMMHP makes it different from the two approaches just described. However the isolation or separation of COMMHP from CLINHP and PUBHP is a problem that warrants intervention. COMMHP appears to be a community itself that could enter an interesting dialogue with:

Critical health psychology

The fourth evolving approach is 'critical health psychology' (CRITHP). CRITHP aims to analyse how power, economics and macrosocial processes influence and/or structure health, health care, health psychology, and society at large (see Table 1, column 5). CRITHP is concerned with the political nature of all human existence, admits compassion in theory and practice, values freedom of thought and is aware of the social interdependence of human beings as actors. The context for study is the whole of society, government and commerce. In particular it is concerned with the impact of power structures as facilitators or barriers to achieving health. The social construction of 'health', 'well being' and 'quality of life' is seen as problematic and in need of interrogation. The aim of 'health for all' is questioned as a possible fulfilment of economic and ideological functions. CRITHP focuses on the aspiration of health promotion programmes that claim to be working towards all people taking an equal share of life chances, opportunities and resources for health. Through the use of theoretical analysis, critical thinking, social and political action, advocacy, and leadership skills, the critical health psychologist draws attention to issues that warrant reparation and takes action thereon to amend the situation or at least to give it a higher profile. The critical health psychologist attempts to apply critical analysis, and evidence obtained by the other three approaches. Rhetorical argumentation is used to persuade others of the political nature of human activity, pulling open the blinds to glimpse the Bigger Picture.

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CRITHP has been the focus of two international conferences entitled 'Reconstructing Health Psychology: Critical and Qualitative Approaches', in 1999 in Newfoundland, and in 2001 in Birmingham, England. A Special Issue of this *Journal* included papers from the Newfoundland meeting (Murray, 2000). A third conference is being held in New Zealand in 2003. A Critical Health Psychology Network (www.med.mun.ca/chpn) and an International Society of Critical Health Psychology have been formed to promote the development and dissemination of the critical approach.

A platform for possible integration

Health psychology is a young and dynamic field. All four of the approaches outlined here are contributing usefully to health and social care. Like any group of siblings, there is the potential for tension, rivalry and conflict. Some may well argue that this rivalry is healthy and the tensions will never be removed. With co-operation, communication and shared learning, however, there is the possibility for some integration, of at least some of the four approaches. By working out their relationships to biomedicine, the health care professions, planners and policy makers, and to one another, there is an opportunity to make improvements to our systems of health and social care. All agree that biomedicine alone is not enough. But neither is our current vague and woolly version of the Biopsychosocial Model. Improved communication between the different approaches will enhance the effectiveness of all. In absolute numbers, health psychologists are thin on the ground. Many health psychologists use more than one of these approaches; some use three or even all four. The four styles of working complement each other and, if they are integrated to some degree, will be a powerful set of tools for the improvement of the health care system. All four approaches are represented in this *Journal*.

By working together and with the many others in health and social care, we can maximize our contribution to a comprehensive system of care, not only in formal health care systems, but by working in all domains of society. In this respect we have much to learn from our friends in sociology.

A useful framework for the determinants of health is what I call the 'health onion' (Dahlgren & Whitehead, 1991; Marks, 1996; Marks et al., 2000). The onion contains a core and four rings. In the light of the above analysis, a framework for a comprehensive system of health and social care can be constructed. Each part and ring of the onion has its own subsystem, biomedicine for the core, and different psychological approaches, health care professions and organisations for the rings (Table 2). Ethics is 'the heart of health care' (Seedhouse, 1998) and communication its mode of delivery, so both are essential foundations in all of the five subsystems. Counselling also plays an essential role at the 'sharp end' of the core and first ring, when things go wrong or when special procedures such as genetic testing, fertility treatment, of HIV testing are carried out.

The critical stance will always need to stand back and look at things at a distance. Probably one should not even try to integrate it because that neuters it. Critical thinking is the driver of social progress, innovation and change. The very essence of the beast defies integration. It is a dialectical necessity. It is the critical, sceptical approach that questions the values, underlying assumptions and power relations of academic study and social organization more generally. Its place will always be on the edge of the mainstream, looking in.

In hypothesising potential futures for the health psychology field, I see both opportunities and challenges. There is no longer any point in pretending that the field can position itself as a purely objective, quantitative, value-free, natural science. Neither can we say with any certainty that health psychology will be any more successful as a purely subjective, qualitative, value-laden human science. Nor have we yet developed a truly hybrid or eclectic approach. It is clear that the epistemological question remains wide open to explorations of many different kinds. A field this broad has the opportunity to foster all possible avenues to discovery and understanding. The need for fundamental debate about the social, political, economic and cultural context of health issues and health psychology has never been more urgent. In spite of the recent proliferation of empirical and theoretical research, the debate about its meaning for society at large has yet to be held. A space

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dedicated to this purpose is available here. Please do use it.

Coda

Founding the *Journal of Health Psychology* was a conscious step towards a more open health psychology. The Editorial Board encourages discussion and debate about the nature, mission and future of health psychology. Essays, editorials and commentaries on ideas or matters of concern are welcome from both psychologists and non-psychologists. New theory, research using innovative methods, and critical reviews, are particularly welcome. All submissions are peer-reviewed. Submissions concerning projects or studies from any of the four approaches described above are equally welcomed by the *Journal of Health Psychology*. The *Journal* aims to serve as a platform for development and integration enabling different approaches to be debated and discussed. Reports of theories, research and applications directed towards improving health, preventing and treating illness, and enhancing health care systems are particularly welcome.[7]

This Volume

In addition to a wide range of individual papers, this Volume includes three Special Issues. The first, edited by Jonathan Smith and Elizabeth Chapman, is entitled 'Interpretative Phenomenological Analysis and the New Genetics' (issue 2). The second, edited by Christina Lee and Glynn Owens, is entitled 'Men's Health' (issue 3). The third, edited by Gary Kreps, is entitled 'Health Communication and IT' (issue 6). Submissions are being invited for three new Special Issues to be published in 2003 and 2004: (1) Public health psychology; (2) Community and health psychology; (3) Food and health; and (4) Health concepts in different contexts. Please see the Call for Papers on page 2 and in the next issue.

Table 2. The health onion, its five parts, and the corresponding sub-systems of health and social care

Part of the health onion	Description	Sub-System of health care
Central core	Biological factors: age, sex, heredity	Biomedicine; Ethics Communications; Counselling (e.g. genetic, infertility, oncology, bereavement)
First ring	Individual lifestyle factors	Clinical health psychology; Primary health care; Clinical psychology; Counselling (e.g. HIV testing); Dietetics; Physiotherapy; Chiropody; Complementary medicine; Epidemiology; Ethics; Communications
Second ring	Social and community influences	Community health psychology; Community nursing; Social work; Community organisations; Environmental health; Community medicine; Medical sociology; Epidemiology; Ethics; Communications
Third ring	Living and working conditions	Public health psychology; Public health; Health promotion; Occupational health; Health & Safety; Epidemiology; Ethics; Communications
Fourth ring	General socio-economic, cultural and environmental conditions	Critical health psychology; Social policy; Economics; Medical anthropology; Epidemiology; Ethics; Communications

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Notes

1. This essay is an adaptation of a paper presented at the Second International Conference on Reconstructing Health Psychology: Critical and Qualitative Approaches at the University of Aston, Birmingham, England on 23 August 2001.
2. A review of Melvern's book will be published in a later issue of the *Journal.*
3. 'Salamification' is the practice of slicing a study into thin pieces for the purpose of publication, e.g. review (Paper 1); pilot study (Paper 2); methods and preliminary results (Paper 3); main results and discussion (Paper 4).
4. Imagine a curriculum for a new university degree set: BBP = Bachelor of Bigger Pictureology; MBP = Master of Bigger Pictureology; DBP = Doctor of Bigger Pictureology.
5. 'Ghosting' is the practice in which a company writes a paper which puts a positive gloss on the efficacy of a treatment or product that is signed by the 'disinterested' academic scientist, who did not even carry out the study or played a minimal role, in return for 'consultancy' fees. See Smith (2001).
6. Presumably, this is the justification for McDermott's (2001) removal of the moral part of Matarazzo's definition from his proposed new definition of health psychology.
7. An open letter from the presidents of the Royal Colleges on the aftermaths of terrorism is reproduced in the Appendix.

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APPENDIX

Open letter: health professions on the aftermath of terrorism

We unreservedly condemn the attacks on New York and Washington on September 11. We extend our heartfelt sympathy to the relatives, friends and colleagues of the victims.

We are concerned that all responses should take account of the magnitude and complexity of the problem of combating terrorism of all kinds and its causes.

By virtue of their skills and experience, health professionals should take part in formulating appropriate responses to humanitarian needs in this crisis taking into account lessons learned from the past. In the longer term, building local capacity in the healthcare systems of affected populations will be an important contribution.

There is a urgent need to monitor the health of the population of Afghanistan and to make this information widely known, and acted upon in a way appropriate to the people of that country.

In the aftermath of the attacks social tension is increasing. We call on health professionals to help combat racism wherever encountered in health services and promote tolerance.

In the longer term we urge that in formulating foreign policy, governments should assess the effects of their proposed actions on the health and human rights of their own people and those likely to be affected in the wider world.

Sir George Alberti, President, Royal College of Physicians of London; **Prof. Sian Griffiths**, President, Faculty of Public Health Medicine of the Royal College of Physicians; **Prof. David Hall**, President, Royal College of Paediatricians and Child Care; **Roswyn Hakesley**, RN, MPhil., President, Royal College of Nursing; **Prof. John Cox**, President, Royal College of Psychiatrists.