

## **Towards a Critical Health Psychology Practice**

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# Towards a Critical Health Psychology Practice

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## Abstract

The field of critical psychology is exerting an influence in the way various sub-disciplines within psychology operate. In this article we use a critical psychology framework to review the field of health psychology. Through the use of values, assumptions and practices we review progress in health psychology and offer recommendations for aligning contemporary practices with current thinking in critical psychology. We discuss typical expectations, critical formulations and critical practice for interventions with individuals, groups and communities along these dimensions.

## Keywords

*critical psychology, power, ethics, health professions*

## Introduction

THE PURPOSE of this article is to offer critical perspectives on the promotion of health and wellness. Within the field of psychology, health psychology has been the champion of health promotion and maintenance. In recent years, critical perspectives with respect to health and wellness have made inroads into the social sciences (see Murray & Chamberlain, 1999; Stainton-Rogers, 1996; and special issue of *Journal of Health Psychology* on Reconstructing Health Psychology, 2000, vol. 5, no. 3). Critical psychology frames health and wellness in ways that differ from mainstream health psychology (Crossley, 2001a). In this article we conceptualize health and wellness from a critical psychology perspective and formulate recommendations for interventions with individuals, groups and entire communities. By so doing, we wish to add to the growing body of literature on critical health psychology. This literature critiques and interrupts mainstream discourse which fail to address issues of power, privilege and the social embeddedness of health and illness (Marks, 2002).

Health is central to wellness. It is a precursor as well as a consequence of wellness. We conceptualize wellness in broad terms that include psychological and physical health. Wellness is a satisfactory state of affairs, brought about by the combined presence of values, resources, programmes and policies (Prilleltensky, Nelson, & Peirson, 2001a, 2001b). Each one of these four components contributes to health. We regard health as an intrinsic as well as an extrinsic value. It has merit on its own accord, but it is also instrumental in bringing about self-determination, personal growth and opportunities in life.

The way the World Health Organization (WHO) defines health is reminiscent of our notion of wellness. According to the WHO, health is more than the absence of illness, it comprises positive physical and emotional features that enable individuals and groups to pursue their goals in a context of equality and justice (Tones, 1996). We resonate with this inclusive definition, as it encompasses values of self-determination, caring and compassion, personal growth, democracy, equality and justice.

Health can be promoted, maintained and restored in micro (e.g. close personal relations, family), meso (e.g. school, work) and macro spheres (e.g. community, society). From a critical psychology perspective, each one of these contexts is suffused with power differentials that privilege the powerful and discriminate against the weak (Kawachi, Kennedy, & Wilkinson, 1999; Kim, Millen, Irwin, & Gersham, 2000; McCubbin, 2001; Petersen, 1994; Prilleltensky & Nelson, 2002). Freund and McGuire (1999) claim that power is a strong determinant of health. In their view, there is a strong connection between the two, illustrated by:

the power of workers over their work pace; the power of people to control the quality of their physical environments; the power of various groups or societies to shape health policy or to deliver what they consider healing; the power of people of different statuses to control, receive, and understand information vital to their well-being; and the power of the mass media to shape ideas about food and fitness. (Freund & McGuire, 1999, p. 7)

Power is cardinal to the entire enterprise of critical psychology. It is instrumental in the promotion of wellness, in resisting oppression and in striving for liberation (Prilleltensky & Nelson, 2002). A recent special issue titled *Power, Control and Health* (*Journal of Community and Applied Social Psychology*, McCubbin, 2001), further elucidates the inextricable relationship between health and power.

Table 1 provides a synopsis of how critical psychology values, assumptions and practices may guide the process as well as the content of critical health work (Fox & Prilleltensky, 1997). As a case in point, we note how the value of self-determination needs to be contextualized in light of disability and chronic illness. The much esteemed value of autonomy needs to be rethought, and replaced, by the value of interdependence. The value of diversity reminds us that there are many ways of being, and living with a disability should not detract from a respected and dignified life. When we value physical independence above all else and regard it as imperative to a positive sense of self, we marginalize and exclude those who cannot attain it. Critically reflecting on the values and

Table 1. Health psychology practice from a critical psychology perspective

<i>Critical psychology tenets</i>	<i>Possibilities for action</i>
<p>Values for</p> <ul style="list-style-type: none"> <li>personal wellness</li> <li>relational wellness</li> <li>collective wellness</li> </ul>	<p><i>Content:</i> Balance prevalent emphasis on autonomy with concern for caring and compassion and interdependence. Consider power differentials in hospital settings and their impact on patients' empowerment and self-determination. Social cohesion, collaboration and democratic participation at community level benefit population health</p> <p><i>Process:</i> Show caring and compassion for citizens seeking service, respect their social identities and foster their ability to pursue personal goals in light of chronic illness or disability. Involve community members in civic and health-related activities. Create partnerships with community groups to achieve justice in health care</p>
<p>Assumptions about</p> <ul style="list-style-type: none"> <li>good life</li> <li>good society</li> <li>knowledge</li> <li>ethics</li> <li>role of worker</li> <li>role of client</li> </ul>	<p><i>Content:</i> Ensure that definition of problems and health includes voice of citizens seeking help and it is not circumscribed to professional opinion. Consider role of corporate profit making in health problems. Promote focus on strengths and competencies of person as perceived and described by person seeking help. Beware of the pursuit of pathology prevalent in hospital settings</p> <p><i>Process:</i> Act as resource collaborator instead of removed expert. Engage citizens in active roles throughout the process of help or self-help. Consider alternatives to medical treatments such as health promotion activities related to diet and lifestyle. Promote non-professional interventions such as mutual-help groups. Afford people seeking help meaningful opportunities to present their point of view concerning their health. Renew informed consent often and solicit input from patients as to direction and aims of helping relationship. Respect privacy of patients in medical settings</p>
<p>Practices</p> <ul style="list-style-type: none"> <li>problem definition</li> <li>scope of intervention</li> <li>time of intervention</li> </ul>	<p><i>Content:</i> Consider approaches that go beyond reactive and indicated interventions and that are proactive in nature. Address social and economic origins of ill-health and maldistribution of resources and health in society</p> <p><i>Process:</i> Collaborate with advocacy and social justice groups in addressing the health needs of the entire population. Create solidarity partnerships with community groups affected by ill-health. Promote political education and social action leading to health promoting cultures and organizations</p>

assumptions that support our work will benefit our research, teaching and clinical practice.

Power's omnipresent character is highlighted in Table 1. Power differentials across the medical divide have to be carefully attended to by critical health psychologists. Chamberlain (2000) notes the lack of attention paid to critical perspectives in health psychology. Similar sentiments are expressed by Stam: 'In a related sense, it is strange, if not suspicious, that discussions of the deeply contested, political and social issues that make up health care today are absent from health psychology' (p. 2000, p. 276). Our own potential to abuse power in a setting that accentuates the privilege of professionals must be monitored (Prilleltensky, 1999).

Advocacy is a key feature in health settings. Patients have to negotiate their treatment with professionals who are not always sensitive to the psychological condition of the person seeking help. One of us has worked in a rehabilitation hospital with patients who had sustained various orthopaedic and neurological disorders. In one particularly memorable case, a patient had to negotiate with one of his treating therapists that it is pointless to spend his therapy time on making himself a cup of tea. He had never done this for himself prior to the stroke, and would certainly not begin to do so now—when it was extremely time-consuming and onerous. The fact that he had to make a special case and gain support from his psychologist, speaks volumes about the risk of professional appropriation of decision making. But advocacy should extend beyond the walls of the clinic or the hospital. In our discussion of roles for critical psychologists we distinguish between individual, group, community and societal interventions (Winett, 1995).

## Tasks and expectations

The term 'health psychology' first appeared in the professional literature in the late 1970s (Marks, 2002). While the initial focus was on treatment compliance and on the client–professional relationship, it has grown and evolved into a diverse field that has gained much recognition within psychology and allied health professions in the last 25 years. It is a growing field with a few journals, international confer-

ences, divisions or committees in the major psychological associations and extensive literature. Taylor offers a useful definition of the field of health psychology. According to her:

Health psychology is the field within psychology devoted to understanding psychological influences on how people stay healthy, why they become ill, and how they respond when they do get ill. Health psychologists both study such issues and promote interventions to help people stay well or get over illness. (Taylor, 1995, p. 3)

This broad-based definition reflects the dual focus on research and practice that characterizes the field of health psychology.

As noted earlier, critical perspectives within health psychology have gathered momentum in the past few years. Marks (2002) conceptualizes critical health psychology as one of four alternative approaches evolving within the field, alongside clinical health psychology, public health psychology and community health psychology. Whereas the other approaches focus on patients in the health care system (clinical health psychology), schools and work sites (public health psychology) and entire communities (community health psychology), 'Critical Health Psychology aims to analyse how power, economics and macrosocial processes influence and/or structure health, health care, health psychology, and society at large' (Marks, 2002, p. 15). Although critical health psychology brings to sharp relief the role of culture and dominant societal structures, its power analysis may be applied from the micro setting of relationships to the macro level of policy.

The importance of deconstructing the assumptions that underline research in health psychology have been noted by Chamberlain (2000) and Stam (2000), among others (Crossley, 2000). Stam (2000) questions mainstream health psychology's non-critical and non-reflexive definition of health and illness. So long as we define health as simply regaining the ability to perform, and adopt a likewise uncritical stance towards such constructs as 'adjustment' and 'quality of life', 'we deny that we are collectively, as a profession, defining a set of outcomes for others' (2000, p. 279). Only by negotiating the meaning of such constructs with affected individuals, can we hope to create

research and practice that is relevant, effective and empowering.

Writing about the proliferation of qualitative research projects in health psychology, Chamberlain (2000) warns that an increased emphasis on methodology issues often comes at the expense of critically reflecting on the assumptions which support the research. Like their quantitative counterparts, most qualitative studies in health psychology fail to adopt a critical perspective and ignore the philosophical positions of the researcher. In a similar vein, Wilkinson (2000) demonstrates how different feminist research traditions (positive empiricist, experiential and discursive) can be effectively applied to breast cancer research that is informed by a critical perspective.

Although we acknowledge the growing importance of critical health psychology research, the rest of this article will be devoted to health psychology practice. Health and medical settings continue to be the largest employers of psychologists in recent years (Stam, 2000). The services offered by health psychologists include coping with physical illness, pain management, psychosocial rehabilitation after accidents, promotion of healthier lifestyles, support groups for sufferers of chronic disease and the like. These activities fall into two broad categories: clinical services in medical settings (Belar & Deardorff, 1996; Bennett, 2000), and health promotion programmes in community settings (Bennett & Murphy, 1997). Taking into account these two major domains, Table 2 describes potential interventions for critical health psychologists. The interventions vary along timing, population and ecological levels. Across the top of Table 2 we can see different units of interventions: individuals, groups and organizations and community and society. Each unit of intervention is guided, respectively, by a set of personal, relational and collective values.

The three rows in Table 2 distinguish among clinical interventions for people who already have problems (reactive/indicated), programmes for people who are at high risk of developing health complications (proactive/high risk) and health promotion initiatives for the population at large (proactive/universal). The Table informs the analysis that follows. We discuss typical expectations, critical

formulations and critical practice for interventions with individuals, groups and communities along these dimensions.

### *Interventions that promote individual wellness*

*Typical expectations* In working with individuals, health psychologists are expected to help with a variety of issues, ranging from reactive to proactive interventions. We distinguish in Table 2 among indicated, high risk and universal populations.

Health psychologists often engage in reactive interventions in medical settings. Services offered directly to patients or through consultation with other professionals include coping with acute or chronic pain, compliance with medical treatments, rehabilitation towards restoration of physical functioning, preparation for surgery and stressful medical procedures and psychosocial rehabilitation (Belar & Deardorff, 1996; Bennett, 2000). Proactive interventions occur usually in worksites, community health centres or educational institutions. They usually take the form of programmes to stop smoking or drinking or to improve diet. We note below some reservations with respect to individual and group interventions.

*Critical formulations* Institutional settings like hospitals prescribe and perpetuate roles for all the players within it. The sick role of the patient diminishes his or her power and self-determination, whereas the role of expert of physicians increases their ability to make decisions for others. In such hierarchical places, all the actors are at risk. Some, like patients and low status workers, are at risk for reduced ability to control their lives and environments. Others, like high status professionals, are at risk for abusing power and engaging in patronizing behaviour: 'The dominance of the medical profession, for instance, is expressed and reinforced through the micro level of medical encounters. In the hospital, the consultant's round has long been an expression of power over medical students, nurses, and patients' (Hardey, 1998, pp. 83–84).

In the interaction between patients and medical professionals, the power and expertise of the latter runs the risk of diminishing the

Table 2. Ecological levels, values and potential critical psychology interventions in health settings

<i>Timing and population of intervention</i>	<i>Values and ecological levels</i>		
	Values for Personal Wellness <i>self-determination, protection of health, caring and compassion</i> Individual Wellness	Values for Relational Wellness <i>collaboration, democratic participation and respect for diversity</i> Group and Organizational Wellness	Values for Collective Wellness <i>support for community structures, social justice</i> Community and Societal Wellness
Reactive indicated	<ul style="list-style-type: none"> <li>• Self-determination in rehabilitation</li> <li>• Power sharing in treatment plans for coping with illness and chronic pain</li> </ul>	<ul style="list-style-type: none"> <li>• Assertiveness training for hospital patients dealing with professionals</li> <li>• Communication training for professionals dealing with vulnerable patients</li> </ul>	<ul style="list-style-type: none"> <li>• Securing access of minorities, refugees and the poor to all health services</li> <li>• Lobbying for funding of health services in deprived areas</li> </ul>
Proactive high risk	<ul style="list-style-type: none"> <li>• Smoking cessation with emphasis on exploitation of community by tobacco companies</li> <li>• Diet and exercise programme for overweight people with emphasis on ill effects of consumerism</li> </ul>	<ul style="list-style-type: none"> <li>• Exercise programme for disadvantaged populations at high risk for heart disease</li> <li>• Organizational interventions to reduce stress in patients and staff</li> </ul>	<ul style="list-style-type: none"> <li>• Self-help/mutual aid and support groups for people caring for disabled family members</li> <li>• Community-wide programmes to improve diet, lower alcohol consumption and increase exercise</li> </ul>
Proactive universal	<ul style="list-style-type: none"> <li>• Self-instruction guide on breast examination</li> <li>• Self-instruction guide on HIV prevention</li> </ul>	<ul style="list-style-type: none"> <li>• Organizational development to improve working atmosphere</li> <li>• Bill of rights and responsibilities for patients and staff in hospitals</li> </ul>	<ul style="list-style-type: none"> <li>• Critique and boycotts of media and corporations making profits at expense of population health</li> <li>• Promote social cohesion and egalitarian social policies</li> </ul>

self-determination of the former in multiple ways. First, they do so by prescribing treatments without adequately consulting patients or explaining the basis of the decision in accessible language. Second, by failing to elicit and patiently explore patients' lived experience of their illness, and the feasibility of adhering to the prescribed treatment within the context of patients' diverse life circumstances. Third, by creating distance and fostering asymmetrical relationships among themselves and their patients, often as a shield against doctors' own feelings of helplessness in the face of human suffering that cannot be easily alleviated. These are but a few examples of disempowering treatment of patients, which has received growing recognition in the sociology of health and illness. Numerous studies demonstrate the control of physicians over the content, length and nature of interaction with patients (Curtis, 2000; Samson, 1999; Weitz, 1996). It has also been found that many physicians promote stereotypical roles for women and that they react in a defensive and even hostile manner when challenged by their female patients (Hardey, 1998). (For an overview of encounters between health care professionals and patients, see also Crossley, 2000.) In this context, the psychologist is at risk for abusing his or her relative high status, and for being discounted by medical practitioners who run hospitals and assume ultimate decision-making powers with respect to patients.

We are not contesting the need to apply proven strategies of coping and behaviour modification to client health issues. However, we must remember that all of this takes place in a context suffused by power differentials where the perspective of the client or other health professionals, such as physiotherapists or social workers, may be lost due to their relative lack of power. There is, then, the physical construction of illness and the social construction of illness (Freund & McGuire, 1999). As Radley reminds us, 'it is not just what it means to be ill that is socially defined, but what it means to be treated and, make a good recovery' (2000, p. 302).

The chosen method of helping is not only determined by the best available scientific evidence; but it is also mediated by the meaning of the condition negotiated among patient and multiple professionals. Thus, for example, a

patient's complaint of physical pain may not conform to known anatomical structures. This may lead to some scepticism regarding the legitimacy of the complaint, and to a hypothesis of a possible underlying psychological mechanism. An inability to find a clear organic basis for a patient's complaint often results in various such hypotheses being generated and perpetuated by different professionals. If a law suit is pending against an employer or the state, diagnosis becomes even more complicated.

The point of this hypothetical situation is to show how complicated assessment and choice of treatment can become. When we combine all of the contextual factors implicated in diagnosis and treatment, a fairly complicated picture emerges. A critical appraisal of the situation would take into account power differentials in problem formulation, risk of diminished self-determination of patients, potential labelling of patients and access by patients to needed resources. In synthesis, critical psychology adds another dimension to helping. Selection of best cognitive or behavioural strategies is not enough (Crossley, 2001a, 2001b). Patient participation and empowerment in method of help are also crucial.

However helpful clinical interventions might be, health psychology has been criticized for concentrating too much on individuals and for preferring a reactive mode of intervention. According to Winett, 'to be effective health psychologists need to adopt an intervention orientation more diverse in terms of timing and level than their apparent preference for tertiary prevention with clinical, individual-level interventions' (1995, p. 344). Studies show that remedial interventions for high risk conditions such as obesity, high cholesterol and smoking, are not very effective (Smedley & Syme, 2000; Wilkinson, 1996). Once entrenched, these patterns of behaviour are hard to change. In any case, even when they are effective, they do not address the constant flow of new cases with such adverse conditions.

The critique levelled against health psychology is not only that it responds late to conditions, but also that it addresses individuals and not societal structures. The proactive approach that centres on individuals at risk is incapable of reducing incidence, or the number of new cases of a problem. As Wilkinson noted:



Sometimes it is a matter of providing screening and early treatment, other times of trying to change some aspect of lifestyle, but always it is a matter of providing some service or intervention. This applies not just to health, but also to studies of a wide range of social, psychological, developmental and educational problems. What happens is that the original source of the problem in society is left unchanged (and probably unknown) while expensive new services are proposed to cater for the individuals most affected. Each new problem leads to a demand for additional resources for services to try to put right the damage which continues to be done. Because the underlying flaw in the system is not put right, it gives rise to a continuous flow, both of people who have suffered as a result, and of demands for special services to meet their needs. (1996: p. 21)

*Critical practice* Opportunities for helping are present at the individual, group/organization and community/societal levels. At each level, we propose to use a partnership model. A partnership ensures that clients and all other professionals are heard. Furthermore, it implies that decision-making power will be shared, and that the wishes of medical patients will be given proper priority.

We consider here the case of patients in a rehabilitation hospital, following serious accidents, strokes or exacerbation of pre-existing conditions such as Multiple Sclerosis. Following the initial phase when one is simply grateful to be alive, the reality of decreased mobility and difficulties with various aspects of daily living, often sets in. Sometimes it is a temporary condition that is expected to improve with time and physical therapy, other cases may require adjustment to a permanent change in status, whereas in some situations, further decline in health and physical functioning is to be expected. Notwithstanding these important differences, affected individuals often become psychologically vulnerable.

The overarching goal of rehabilitation settings is to enable individuals to return to previous levels of functioning, resume roles and re-integrate into society with as little disruption as possible. Undoubtedly, this is a desired outcome for most patients, and serves as a major

motivating factor for the hard work they invest in their various therapies. Notwithstanding the commitment and dedication of most rehabilitation professionals and the vital work that they do with patients, the elevated value attributed to physical independence in such settings should be questioned. Occupational and physical therapists work with their patients towards enhancing the latter's ability to carry out independently activities of daily living. Whereas most people would prefer to be as independent as they can in self-care, needing assistance, even with the most intimate tasks of daily living, is not tantamount to losing autonomy and control. Deconstructing such words as independence and autonomy from a disability rights-perspective, can have a profoundly empowering effect on the lives of individuals with severe physical impairments. This is exemplified by the following quotation by a disability rights activist:

We believe fundamentally that all individuals have the right to live independently in the community regardless of their disability. But it is important to note the sense in which we use the term 'independence', because it is crucial to everything we are saying. We do not use the term 'independent' to mean someone who can do everything for themselves, (*sic*) but to indicate someone who has taken control of their life and is choosing how that life is led . . . it can be applied to the most severely disabled person who lives in the community and organizes all the help or 'care' they need as part of a freely chosen lifestyle. The most important factor is not the amount of physical tasks a person can perform, but the amount of control they have over their everyday routine. The degree of disability does not determine the amount of independence achieved. (Brisenden, 1998, pp. 26-27)

We are not suggesting here that occupational and physical therapists should cease to help people restore physical abilities and promote unaided functioning. Rather, it is the unquestioned assumption that physical independence should be attained at all costs, with which we take issue.

If a person does not find meaning in preparing breakfast for herself, a task that may take her 45 minutes and drain her of energy that may already be in short supply, perhaps another

person could do it for her in five minutes. A rehabilitation patient in a setting we worked in jokingly spoke of the routines he goes through in order to appease his treating therapists who decided that he should participate in 'breakfast group'. A stroke had left this man with significant physical impairments, while his cognitive functioning remained relatively intact. While it was very clear to him that he would not be attending to his own breakfast at home given the time and energy that this required of him, he felt it necessary to be a 'good patient', thereby avoiding conflict, which may be more trouble than it is worth. This man was willing to play the game and had maintained his sense of humour in the process. However, making such decisions on behalf of patients is what truly robs people of dignity and control over their lives.

Proactive interventions with individuals have to address the societal sources of smoking, drinking, bingeing and sitting for too long. To begin addressing the societal causes of disease it is important to politicize community members. It can be empowering for a young woman with an eating disorder to understand and take action against the media. Lyons (2000) asserts that media representations of health and illness have been surprisingly overlooked by health psychologists. She makes a cogent argument for a critical analysis of media images. In addition to affecting people's beliefs and understanding of health and illness, media images can influence people's attitudes towards certain sub-groups of the population, as well as mediating individuals' own lived experience of illness. She further reminds us that 'examinations of what is not represented in the media are also extremely beneficial' (2000, p. 356), referring to the preponderance of images of young female bodies versus the invisibility of disabled bodies, aging bodies, etc.

Feminists use anger towards societal oppression in empowering ways (Riger, 2000). So do narrative therapists and advocates of just therapy (Community Mental Health Project, 1998). There is a need to connect corporate agendas with personal suffering. In a smoking prevention programme with children and young people we discussed at length the commercial roots of addictions. Children in the programme protested in shopping malls against tobacco companies and made a presentation to city

council on the subject (Prilleltensky, Nelson, & Sanchez Valdes, 2000). These are examples of linkages between personal risk factors and their societal origins. We have to make these connections for the benefit of people who are at risk today and for the benefit of those who will be at risk tomorrow if corporations continue to infect the public with toxic products. As critical health psychologists we have to ask ourselves whether we want to support the status quo by treating its victims, or whether we want to join with them to challenge noxious consumerism.

### *Interventions for group and organizational wellness*

*Typical expectations* Work with groups and organizations can also be reactive or proactive. Health psychologists can work with patients in support groups or exercise programmes, and they can assist worksites to improve the social climate and reduce stress and conflict. Many health psychologists assist organizations to improve the health of their employees through lifestyle changes and exercise.

*Critical formulation* In the meso context of hospitals, clinics and work settings, power and control affect health in significant ways as well. In the Whitehall studies, Marmot and his colleagues followed the health of thousands of British civil servants for three decades (Marmot, 1999; Marmot, Siegrist, Theorell, & Feeney, 1999). The participants were all middle class people who enjoyed relative affluence. Although all of them could be considered middle class, the 25-year follow-up study showed that those in lower positions had a four times higher mortality rate than those in administrative positions. There was a clear correlation between level of control over the work environment and several measures of disease, with those lower on the scale of control experiencing poorer health. When participants were divided into four employment grades, there was a distinct and gradual escalation in health from the lower grade to the higher grade. As Marmot noted:

There are abundant data showing a link between poverty and ill health. These results from Whitehall have influenced us in coming to the view that inequality is also important.

The problem of inequality in health is not confined to the poorest members of society but runs right across the social spectrum. In Whitehall the social gradient was seen not only for total mortality, but for all the major causes of death, including coronary heart disease and stroke. (1999, p. 12)

Studies conducted by Marmot and others suggest that the work environment affects health through three psychological mechanisms. The first relates to levels of demand and control, whereby higher demands and lower levels of control affect health negatively. The second mechanism refers to the effort–reward imbalance and the third to the level of social support (Marmot et al., 1999).

From a critical psychology perspective, we see that the amount of power experienced by workers is directly related to health and mortality. How this power is attained, and how it may be challenged and redistributed is a key concern for critical psychologists. The struggle to distribute power and control equitably within hospitals and work settings defines a key job for the critical health psychologist.

Hospitals and work settings are laden with power conflicts. It would be a mistake to intervene in these types of organizations without considering the effects of the political environment. Unless the health psychologist recognizes the political role that he or she might be fulfilling, undesirable consequences may ensue. Interventions to improve the working climate may mask underlying conflict, to the direct benefit of management. Surely reducing stress is a meritorious cause, but diverting attention away from the root causes of that stress hinders the cause of health. As we can see, the health psychologist is caught in a bind, much like the organizational psychologist who is asked to improve working conditions. On one hand, research clearly suggests that reduced stress is good for health. But on the other hand, superficial attempts to alleviate conflict may divert attention from more fundamental roots of discomfort.

Marmot and colleagues (1999) clearly showed that lack of control at work is related to increased levels of illness. Launching initiatives that restore employee control across the board is a good health intervention for as long as it is not temporary or superficial. The health

psychologist has the difficult job of discerning whether an intervention will benefit workers unequivocally or only temporarily, and whether the net effect of the programme is not worker appeasement.

*Critical practice* We consider possible interventions in hospital and work settings in turn. Because of the prescribed scripts that patients and doctors are expected to follow in a total institution like a hospital, we regard both of these groups as sites for action. Of course not all patients and professionals engage in stereotypical roles of sick and helper, but the evidence is such that people in hospitals often behave in hierarchical and constraining ways. Hence, at the group/organizational level we recommend interventions to improve communication between professionals and patients. Research suggests that communication between practitioners and patients is often faulty. A study by Beckman and Frankel (1983) confirms this claim. In a sample of 74 office visits, only 23 per cent of the patients had a chance to finish their explanations of concerns. Doctors were found to interrupt patients in 69 per cent of the visits. On average, doctors interrupted patients after they had spoken for only 18 seconds. In another study, West (1983) reported that patient-initiated questions were discouraged. Out of a total of 773 questions asked in 21 medical encounters, only 9 per cent of the questions were initiated by patients. The use of jargon, patronizing attitudes and patient anxiety contribute to miscommunication between doctors and patients.

While we advocate for assertiveness and communication training, we should remain sceptical of the potential for such interventions to make lasting changes. The origins of patriarchal mentality in medical settings are profound and may not be undone by workshops on communication. Lupton cautions that:

To assume that the majority of patients, given appropriate training in communication competencies, will have equal authority in the doctor–patient relationship is to ignore the structural and symbolic dimensions of this relationship. Although there is limited opportunity for patients to assert their agency, the whole nature of the doctor–patient relationship and the healing process rests on the

unequal power balance and asymmetry of knowledge between patient and doctor. (1994, p. 59)

It is clear that more fundamental changes in the medical establishment will have to occur to democratize the patient–doctor relationship. Work towards that goal, however, does not invalidate the need to empower patients while they are the subject of medical investigations and interventions.

The health psychologist can also intervene in work settings. Solidarity among workers is very important. It is a source of social support and even empowerment. Not all aggression in the workplace comes from above. Horizontal violence is quite prevalent (Keashley, 1998). Programmes that address workplace bullying and that build cohesion among workers can have substantial health benefits. By linking health with solidarity we are politicizing wellness and supporting cohesion among workers.

We touched here on hospital and workplace actions. Table 2 mentions other possible interventions with groups and organizations. We move now to consider tasks at the community and societal levels.

### *Interventions for community and societal wellness*

*Typical expectations* Psychologists participate in health promotion campaigns through research, education and intervention. They may facilitate the dissemination of information through regional health authorities or contribute to the development of public policy.

*Critical formulations* The macro economic and psychosocial environment where we live have direct repercussions for health and quality of life. Consider the following examples provided by Wilkinson (1996). A child born and raised in Harlem has less chances of living to 65 years old than a baby born in Bangladesh. Also in the USA, life expectancy is seven years longer for whites (76 years) than for African Americans (69 years). In lower social classes, infant mortality in Sweden (500 per 100,000) is less than half the rate in England (1250 per 100,000). Because of more egalitarian income distribution, the life expectancy of Japanese people increased by 7.5 years for men and eight years

for women in 21 years. This dramatic increase took place between the years 1965 and 1986. Japanese people experience the highest life expectancy in the world, near 80 years, in large part because in that period of time they became the advanced society with the narrowest income differences. Communities with higher levels of social cohesion and narrow gaps between rich and poor produce better health outcomes than wealthier societies with higher levels of social disintegration.

When probability of death between ages 15 and 60 is compared between richer and poorer countries, the former have outcomes that are about three times better than the latter. Reasons for death include infections, perinatal, nutritional, maternal, cardiovascular, cancer, respiratory disease and other external causes (see Marmot, 1999, p. 6). Lack of shelter and sanitation are major causes of killing disease around the world. Feuerstein (1997) reports that between 1988 and 1991, in 34 of the 47 least developed countries, only 46 per cent of the population had access to safe water. The atrocious effects of poverty on health have been documented extensively. They remind us that health is not only the effect of health care but of living conditions.

Within countries, the poor, the unemployed, refugees, single parents, ethnic minorities and the homeless have much lower rates of health than more advantaged groups. This applies not only to poor countries, but to rich countries as well. Homeless people in western countries, for example, are 34 times more likely to kill themselves than the general population, 150 times more likely to be fatally assaulted and 25 times more likely to die in any period of time than the people who ignore them on the streets (Shaw, Dorling, & Smith, 1999). There is no question that the macro environment influences health in potent ways.

But the body of knowledge compiled by Marmot and Wilkinson (1999) clearly indicates that, in addition to economic prosperity, equality and social cohesion are also powerful determinants of health. Indeed:

In the developed world, it is not the richest countries which have the best health, but the most egalitarian . . . Looking at a number of different examples of health egalitarian

societies, an important characteristic they all seem to share is their social cohesion . . . The epidemiological evidence which most clearly suggests the health benefits of social cohesion comes from studies of the beneficial effects of social networks on health. (Wilkinson, 1996, pp. 3–5)

As Wilkinson observed, social cohesion is mediated by commitment to positive social structures, which, in turn, is related to social justice. Individuals contribute to collective well-being when they feel that the collective works for them as well. Social cohesion and coherence are 'closely related to social justice' (Wilkinson, 1996, p. 221). The critical psychologist faces a serious challenge in trying to incorporate these lessons into his or her practice. We distill below some of the implications for action.

*Critical practice* Within the reactive and indicated framework, there is much that needs to be done to ensure that minorities have adequate access to health care. 'A lack of access can have deadly consequences' (Weitz, 1996, p. 61). Advocacy, lobbying and solidarity partnerships are vehicles to pressure governments to act on behalf of vulnerable populations. Although the formal medical system is not the only means to health, it is a social resource that needs to be distributed equally among all. We see this type of political work as integral to the work of critical health and community psychologists. Feuerstein (1997) outlines several strategies for collaborating with the poor for improved health, including financial services and credit for the poor.

The practice of health promotion at the social and community levels is appealing, but only insofar as it includes a critique of capitalist market rules. We link health promotion to a critique of corporate ruling because, otherwise, we focus on individuals and neglect the societal and market origins of illness (Kawachi et al., 1999; Kim et al., 2000; Korten, 1995). As Lupton noted, 'although the health promotion perspective relies heavily on a critique of the biomedical model, it fails to challenge the hegemony of ideologies that deflect the responsibility of health maintenance from the state to the individual' (1994, p. 57). Therefore, we advocate a combined approach that couples

health promotion to activities designed to challenge corporate ruling of health and illness (Crossley, 2001a, 2001b). What we watch, eat, drink and breathe have a lot to do with global capitalism, an economic structure that has proven detrimental to global health (Feuerstein, 1997; Korten, 1995; Marmot & Wilkinson, 1999).

Re-inventing ourselves as advocates, social critics, community leaders and psychologists at the same time is a necessity that may not sit well with health psychologists. However, to remain at the level of reactive or person-centred interventions is to deny a massive body of evidence linking social and economic structures to physical and psychological health. Critical health psychology is well positioned to break interdisciplinary barriers and address wellness in a truly ecological way.

## Conclusion

What health psychologists do mostly is not necessarily what helps the most. Whereas most health psychologists work with individuals already affected or at risk for health problems, evidence suggests that the most promising ways to promote overall health is to work with entire communities in a proactive fashion (Kaplan, 2000; Smedley & Syme, 2000). Critical and community psychologists used to argue that the focus on the individual is not enough. New information indicates that working with groups at risk is not good enough either. By the time groups of people develop symptoms, it is extremely difficult to revert unhealthy behavioural patterns. Furthermore, most risk conditions do not reside within the individual but within the social and physical environments. As a result, preventive efforts for people at risk have proven only minimally effective (Kaplan, 2000; Wilkinson, 1996). This was the rather disappointing result of the largest trial of behavioural change ever conducted. The Multiple Risk Factor Intervention Trial (MRFIT) 'attempted to change diet, smoking and exercise among white men identified as being in the highest 10 per cent of risk for coronary heart disease. Despite concentrated efforts over six years they only succeeded in making minimal changes' (Wilkinson, 1996, p. 64). The implication of these findings is that risk factors are in themselves symptoms of more profound causes

of disease that most behavioural interventions fail to address. In other words, these interventions do not address the causes of the causes, but only some outcomes of deeper causes.

Evidence from social determinants of health indicates that overall wellness is predicated on sufficient material resources, equality in distribution of resources and social cohesion. These three factors are the domain of proactive universal interventions for community and societal wellness. Large international epidemiological studies demonstrate that each of these factors is a necessary but not a sufficient precursor of overall health. For optimal health to occur, they have to operate simultaneously. For critical health psychologists the implication is clear: we cannot fragment wellness into economic, social and psychosocial health; they work in synchronicity, and so should we.

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