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The Emergence of Critical Health Psychology

Can It Contribute to Promoting Public Health?

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Abstract

The purpose of this article is twofold: first to provide an overview of the emergence of critical health psychology for those working in the related social and health sciences and as a review of its major developments for health psychology; and second to discuss critically the potential for critical health psychology to contribute to promoting public health with specific reference to the directives espoused by Prilleltensky (2003) and Murray and Campbell (2003). The identification of three philosophical phases of the emergence of critical health psychology is used to examine the directions of the field and the challenges facing critical health psychology in order to contribute to public and global health.

Keywords

- *critical health psychology*
- *health promotion*
- *public health*
- *public health psychology*
- *social action*

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Introduction: what is critical health psychology?

THE EMERGENCE of critical health psychology (CHP) during the 1990s developed alongside a number of other emerging strands of health psychology. As a general overview of health psychology Marks (2002a) identifies four contrasting approaches, namely: clinical health psychology,[1] public health psychology,[2] community health psychology[3] and critical health psychology.[4] Health psychologists use one or more of these complementary approaches. When integrated, Marks (2002a) maintains that these four approaches will be a powerful set of tools for the health care system. While CHP is defined as a distinct approach to health psychology it is also fundamentally different from other approaches in so far as its critical orientation is both acutely discerning about the theory, methods and practice of mainstream health psychology (hereafter MHP) and is able to be particularly drawn upon as a standpoint, perspective or approach in some clinical psychology, public health psychology and community health psychology.

To be sure, CHP developed in direct contrast to and is specifically critical of MHP (see Marks, 1996). In particular, CHP disagrees with MHP in relation to at least the following: (1) the alignment with traditional scientific thought; (2) reproduction of the historical roots of psychology whereby disciplines are bounded and made impermeable through institutional processes such as professionalization; (3) separation between the justice orientation of certain psychology special group activities and the individualist, reductionist foci of mainstream health psychology practice; and (4) the acontextual approach to some explanations of individual health behaviours.

So what is CHP? Undoubtedly, the founding work on CHP (see Marks, 1996, 2002a, 2004; Murray, 2000, 2004; Murray & Chamberlain, 1999) represents the clearest descriptions of what CHP comprises. As Marks (2002a) maintains, in relation to health psychology; 'Diverse and conflicting views are expressed about the direction and shape of the field.' Critical of MHP, CHP proposes some radically different approaches, arguing for new agendas, theories and methods. Examples of this radical agenda include criticism by Stainton Rogers (2002) that both biomedicine and health psychology are ideological and ethnocentric in nature. Further to this, Radley (2002) is critical of the mind–body dualism of biomedicine and health psychology arguing for a radical re-reading of what it means to evaluate a patient in diagnosis or treatment taking into account fragility and vulnerability. Stam (2002) makes a plea for theory not as something we do after collecting data, but as one of the most crucial steps in entering the world of health and illness because it establishes our political, epistemological and moral grounding. Lastly, the contribution of a psychology of liberation for health psychology is introduced by Brinton Lykes (2002) in a critical examination of the application of the work of Martin-Baro (1994) in the context of her own participatory action research with Mayan women of rural Guatemala.

For Murray (2004) CHP is organized into four interconnected areas: (1) *theory* that is typically reflexive, relational, moral and experiential; (2) a focus on *contexts* that take into account social justice and activism, feminist approaches and an appreciation of the meanings of culture as transitional; (3) *research methods* that are critical, qualitative and ethical; and (4) *practice* that is enabling, community-based and empowering for participants. Further to this, there is an emerging debate within CHP about the way in which it contributes to social action and developing forms of community/public health action. Certainly, there are at least two strands of work: language/discourse work that may well be argued by some of its authors that it contributes to social action, and more explicitly community/public health approaches that draw on CHP theories and methods (see Hepworth, 2004; Murray & Campbell, 2004). CHP is in a position whereby it is simultaneously aware of the ongoing critique about the nature of the discipline of psychology within critical psychology/social science, and also trying to participate in movement for change (Murray, personal communication, 2005).

What (critical) health psychology is not

Turning to consider what CHP is not, and thereby further defining its constitution, it is

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useful to initially consider what current arguments have been put forward more generally about what health psychology is not. As a subdiscipline of psychology, health psychology developed in the late 1970s and in mapping out its territory kept open as many routes to future development as possible for survival and growth (McDermott, 2002). The initial definition of health psychology by Matarazzo (1980)[5] is over-inclusive because it encompasses any topic connected with health, and has contributed to the risk of health psychology being in danger of fragmentation and collapse (McDermott, 2002). Holding Matarazzo (1980) responsible for this confusion McDermott continues: 'Indeed, it is this lack of a distinct self-identity that has led to confusion amongst non-health psychologists as to what health psychology is and is not' (2002, p. 44). Preferring instead Matarazzo's definition of behavioural health as a '. . . new interdisciplinary subspecialty . . . specifically concerned with the maintenance of health and the prevention of illness and dysfunction in currently healthy persons' (1980, p. 807), McDermott (2002) argues this definition is more fitting for health psychology because of its emphasis on health, the psychology of health promotion, the maintenance of health and upon psychological processes involved in risk reduction. In this recent attempt to refine what constitutes health psychology what is crucial is the emphasis placed on the primary prevention of illness rather than upon treatment of or recovery from illness. This emphasis is also consistent with other work that is critical of the 'clinical' and 'illness' foci of health psychology (see Marks, 1996). The emphasis on health has real implications for both health psychology and clinical psychology because, at least on paper, it clearly sets out health and clinical as distinctive realms of psychology. There are also material reasons for addressing these realms as separate. Seeing health psychology as a 'potential invader' some UK clinical psychology departments 'reinvented and re-branded themselves as "Departments of Clinical Health Psychology"' (McDermott, 2002, p. 41). The territorial war over these realms is evident in psychology university and hospital departments in several countries. In terms of addressing this dispute McDermott's (2002) work is at least a beginning, if not an unproblematic one.

The relevance of the definition of health psychology here is twofold; first, what constitutes the major field from which CHP emerged has implications for deciding upon both teaching and practice areas of which CHP is a part. Second, it behoves critical health psychologists to engage with these questions and distinctions especially at a time such as this when the constitution and future of CHP is of particular interest within the health psychology field. Therefore, is it the case that CHP is over-inclusive and should have an exclusively health focus? In attempting to answer this question a more substantive question emerges which addresses the epistemological basis of CHP. While CHP has previously espoused a more 'radical', 'critical' and 'participatory' agenda, what it has not done is describe and explain the epistemological and philosophical assumptions underlying its emergence and development. As far as asking the same questions of CHP about its focus as have been asked of MHP, this actually becomes an endeavour that is simultaneously problematic and potentially illuminating. Asking these questions of CHP forces a conversation about not only the constitution of CHP but also differences between the epistemological bases of MHP and CHP. It is argued here that the form and content of MHP and CHP are fundamentally different. The form includes realist v. interpretive/critical approaches to health psychology and the content includes an applied v. theoretical focus to the mainstay of their respective works. Being founded upon philosophical and critical bases CHP necessarily includes the possibility of a broad application through a predominantly theoretical interpretive lens. Thus, its foundation renders the potential criticism of CHP being over-inclusive redundant.

As a corollary of this, the distinction between health and illness is made impossible as well as undesirable. For example, for those living with type 2 diabetes there is neither a distinct recovery period nor an absence from illness. Yet, simultaneous with the presentation of this chronic illness are explorations and implementations of health-promoting interventions applied to daily living (see Hepworth, 1999). Therein, understanding and explaining the psychological aspects of health becomes inseparable from aspects of illness. In terms of

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planning diabetes programs, counseling services or policy advice the theoretical and methodological breadth and pluralism of CHP becomes one of its major strengths. In order to more fully address what CHP is and is not it is important to examine more closely the various philosophical phases that its work directly engages.

Three philosophical phases of critical health psychology

Since the key beginning of its emergence 10 years ago the goals of CHP have become increasingly ambitious and visionary, involving a greater consideration of ethics as the field has evolved. It is argued here that CHP has engaged with three main philosophical phases.

The rejection of reification

Critical of MHP health psychologists organized a wholesale rejection of the idea that data are isolated objects to be reified, the independent existence of scientific 'facts' and notions of self-containment. The First International Conference on Critical and Qualitative Approaches to Health Psychology, held in St John's, Newfoundland, 1999 hosted the initial public organization of critical health psychologists. This first phase transformed what was, as Murray calls it, 'an increasing disillusion with the whole enlightenment project of the discipline [psychology]' (2004: 3) through an engagement and direct contribution to critical debates within the broader social and health sciences.

Consensuality and subjectivism

The second phase of CHP is typified by an expansion and pluralism in relation to the inclusion of theories and methods. On the one hand, this phase privileged the notion of a 'community of meanings' (see Moscovici, 1981; Parker, 1989), relational theories of self and systems and highlighted the significance of the context of health and illness. On the other hand, CHP also includes clear statements about what is right and wrong concerning health-related topics and, in some instances, basing these arguments on individual views and moral decisions that are conscience based. The growing number and breadth of contributions to CHP over the last six years includes clear evidence of the centrality of pluralism to the field. Such breadth does involve risks to CHP, not in terms of becoming over-inclusive, as in the case of McDermott's (2002) criticism of MHP, but in terms of espousing simplistic moral rights in isolation from theory and/or practice-based analyses.

Justice and fairness

The third phase of CHP is one that is most recently emerging in calls for a greater practice and action orientation. The initial visionary goals that CHP set itself are increasingly becoming situated within broader discussions of justice and fairness. To take as an example the work of John Rawls (1999) justice and fairness is conceived of as being the fair allocation of benefits and burdens at a societal level. CHP emphasizes the structural determinants of health, the impact of poverty on human health and ethics in the context of a just society. Rawls and others' work may well be a useful additional set of frameworks for a CHP whose enduring vision of health is one intrinsically linked with equality. Moreover, the challenge for CHP is a pragmatic one that has been set by members themselves in that the worth of the ideas espoused thus far will be measured much more in the future by their practical applications.

These three phases (see Fig. 1) clearly demonstrate the pluralism of CHP. In their co-existence these phases also provide sets of common aims, goals and shared understandings for those working in the field. However, let us now examine more closely where CHP is at the present and what specific directives mean for its future.

Where CHP is now

To date, two of the most prominent directives for CHP are found in the concept of 'psychopolitical validity' (Prilleltensky, 2003) and the 'call to action' (Murray & Campbell, 2003). Psychopolitical validity is a concept that 'derives from the consideration of power dynamics in psychological and political domains of health, at various levels of analysis' (Prilleltensky, 2003, p. 2), and involves two types: (1) epistemic, when this analysis is applied to research; and (2) transformational, when it is applied to health and social interventions. According to Prilleltensky:

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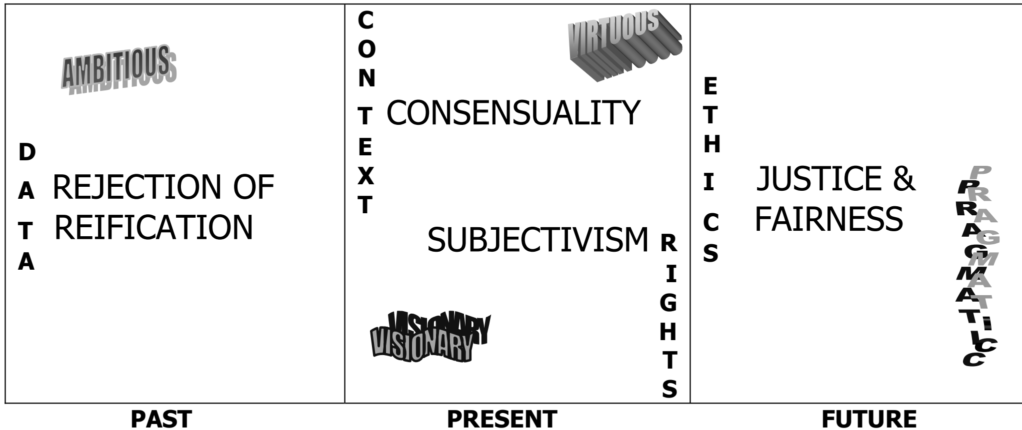

Figure 1. Diagram of the three philosophical phrases underpinning critical health psychology.

> The challenge for critical health psychologists is to offer alternative practices that go beyond the status quo and its critique . . . this is the most pressing challenge for the emerging critical approaches within psychology and the health and social sciences. Unless we translate our tenets into concrete practices, professionals and the public at large will grow impatient with critical approaches to health and wellness. (2003, p. 2)

While it's difficult to find a clear definition of psychopolitical validity, Prilleltensky goes on to say that its main objective is to:

> . . . infuse in critical community and health psychology an awareness of the role of power in wellness, oppression, and liberation at the personal, relational, and collective domains. In order to attain psychopolitical validity, investigations and interventions would have to meet certain criteria. (2003, p. 3)

Two tables (Tables 1 and 2) with nine cells each itemize these criteria.

There are a number of criticisms that can be made of this position. Here, the rejection of the concept of psychopolitical validity is based on three reasons. First, Prilleltensky's (2003) definition of psychology and politics are represented as separable domains, although the historico-political construction of psychology is already widely employed in the health and social sciences, and specifically CHP as a founding principle, rendering the concept outdated. Second, the concept of psychopolitical validity and the criteria proposed with which to evaluate it are overly proscriptive and relatively impractical. Similar types of criteria were previously proposed as part of the 1970's and 1980's health promotion agendas, especially in Australia and Canada, and such an approach seems unlikely to be adopted as a step forward. Finally, the concept's objective, to work towards a reflexive, politically aware practice focused on wellness, oppression and liberation is and has already been for at least three decades a cornerstone of critical approaches in the social and health sciences (see, for example, the journal entitled *Critical Public Health*).

The second example of defining the way forward for CHP is the 'call to action' made by Murray and Campbell (2003). Simply put, Murray and Campbell argue for a health psychology that is more politically engaged; one that is focused: 'on the material dimensions of health and illness and the issues of social inequality and poverty' (2003, p. 12). The authors continue: 'While not ignoring the importance of language in constituting health and illness . . . we would seek to place the material world more squarely at the centre of the debate about the future of health psychology' (Murray & Campbell, 2003, p. 14). Indeed, these authors continue that 'Health psychology needs to be a

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Table 1. Guidelines for epistemic psychopolitical validity in critical health psychology

	Domains		
Concerns	*Collective*	*Relational*	*Personal*
Wellness	Accounts for role of political and economic power in economic prosperity and in creation of institutions that promote equality and public health	Studies the role of power in creating and sustaining egalitarian relationships, social cohesion, social support, respect for diversity and democratic participation in communities, groups and families	Studies role of psychological and political power in achieving self-determination, empowerment, health, personal growth, meaning and spirituality
Oppression	Explores role of globalization, colonization and exploitation in illness and suffering of nations and communities	Examines the role of political and psychological power in exclusion and discrimination based on class, gender, age, race, education and ability. Studies conditions leading to lack of support, horizontal violence and fragmentation within oppressed groups	Studies role of powerlessness in learned helplessness, hopelessness, self-depreciation, internalized oppression, shame, physical and mental health problems and addictions
Liberation	Deconstructs ideological norms that lead to acquiescence and studies effective psychopolitical factors in resistance to norms that cause illness	Studies acts of solidarity and compassion with others who suffer from oppression and illness	Examines sources of health, strength, resilience, solidarity and development of activism and leadership

call to action' re-positioning itself as a discipline that 'sides with the interests of the oppressed'.

Both Murray and Campbell's (2003) and Prilleltensky's (2003) directions clearly call for significantly greater political engagement, and specific attention paid to groups who are oppressed. There is much in common between these directions and existing public health and health promotion work. However, in determining the relative contributions of each direction CHP needs to be reminded, like some areas of health psychology, that it does not need to 'reinvent the wheel' by creating another slew of criteria, models or theories about public health practice (Hepworth, 2004) or arguments about the greater impact of working with 'upstream' determinants of health. It is precisely through this explicit political agenda CHP has now come to share with public health and health promotion common theoretical, methodological and practice areas. Interestingly, the political agenda of CHP makes it also much closer to some MHP practice that already uses public health and health promotion frameworks for health psychology practice (see Vinck, Oldenburg, & von Lengerke, 2001). However, CHP does remain distinctly different from public health and health promotion in so far as we are not social epidemiologists, and we are not specialist public health policy experts, so why try to imitate these? Also critical of Prilleltensky and Prilleltensky's (2003) argument for CHP to focus on more 'upstream' determinants of health, Adler writes:

> Most of the research cited by Prilleltensky & Prilleltensky has been done by social epidemiologists. One way to characterize their critique of health psychology is that it is not social epidemiology. Yet each field has its own role and its contribution. We need to understand both the upstream social factors and downstream psychological and biological processes that influence health, and we may

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Table 2. Guidelines for transformational psychopolitical validity

	Domains		
Concerns	*Collective*	*Relational*	*Personal*
Wellbeing	Contributes to institutions that support health, emancipation, human development, peace, protection of environment and social justice	Contributes to power equalization in relationships and communities. Enriches awareness of subjective and psychological forces preventing solidarity. Builds trust, connection and participation in groups that support social cohesion, health and social justice	Supports personal empowerment, health, sociopolitical development, leadership training and solidarity. Contributes to personal and social responsibility and awareness of subjective forces preventing commitment to justice and personal depowerment when in position of privilege
Oppression	Opposes economic colonialism and denial of cultural rights. Decries and resists role of own reference group or nation in oppression of others and deterioration of health in other groups	Contributes to struggle against in-group and out-group domination and discrimination, sexism and norms of violence. Builds awareness of own prejudice and participation in horizontal violence	Helps to prevent acting out of own oppression on others. Builds awareness of internalized oppression and role of dominant ideology in victim-blaming. Contributes to personal depowerment of people in position of privilege
Liberation	Supports networks of resistance and social change movements that pursue health and wellness. Contributes to structural depowerment of privileged people	Supports resistance against objectification of others. Develops processes of mutual accountability	Helps to resist complacency and collusion with exploitative and illness-producing system. Contributes to struggle to recover personal health and political identity

learn more by encouraging respect and collaboration across the fields rather than by having each one encompass all levels of analysis. (2003, p. 211)

Rather, a more pertinent question regarding the relative merits of the future direction of CHP is to determine how to most effectively work across related disciplinary fields. Consistent with this approach, it is Murray and Campbell's (2003) consideration of the potential role of health psychology within the WHO's (1999) four broad strategies for combating poverty and promoting health that is one of the most useful directions for CHP.

The WHO's four strategies are:

1. Act on the determinants of health by influencing development policy.
2. Reduce risks through a broader approach to public health.
3. Focus on the health problems of the poor.
4. Ensure that health systems serve the poor more effectively.

Thus, 'the call to action' approach demonstrates a practical integration and application of how health psychology can be more effectively linked to problems of public health. An approach such as Murray and Campbell's (2003) that aims to more effectively integrate health fields precisely addresses a major obstacle to the future development of CHP; that of translating existing knowledge into more applied strategies. There are, however, a number of remaining issues that impact on the future of CHP and its capacity to contribute to promoting public health. In order to address some of the key issues the following questions are asked. First, what problems are there with the vision of CHP? Second, what challenges does CHP need

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to address to contribute to the promotion of public or population health?

Current problems or facing dilemmas?

The problems are not ones that are easily resolved, and to some extent, may be better thought of as a series of dilemmas involving both internal contradictions and external structural and social conditions. Three areas of CHP require development: (1) professionalization; (2) clarity and purpose; and (3) research. First, concerns about the professionalization of critical health psychology are well summarized by Bolam and Chamberlain (2003) and centre on the 'scientist-practitioner model' in health psychology (see Marks et al., 1998) that 'assumes a strongly positivist tradition within which the psychologist is positioned as expert using scientifically proven and quality approved technical solutions to social and individual problems' (Bolam & Chamberlain, 2003). In contrast, the reflexive practice of CHP involving recognizing 'the situatedness of knowledge and practice, and works to redefine the detached, objective technician of the scientist-practitioner model into a reflexive, engaged and invested social actor' (Bolam & Chamberlain, 2003, p. 216).

The dilemma here is one whereby CHP rejects much of the professional definition of the content and practice of health psychology versus the need to have innovative, critical theory, research and practice options included within the mainstream health psychology curriculum. This inclusion is especially important at the level of the Masters in Health Psychology; the cornerstone of most professional routes to health psychology. Being part of the main curriculum, in certain countries such as the UK, means inevitably having to engage with professional psychology boards and committees (see Hepworth, 2004). Yet, the representation of CHP in the mainstream curriculum is itself a form of critical action through more broadly informing new generations of health psychologists and translating concepts and the practice of reflexivity, such as espoused by Bolam and Chamberlain (2003), into a viable option for graduates alongside MHP.

Second, CHP needs greater exposure and greater transparency about what we do. The breadth of innovative, critical approaches to redefining health psychology practice is both inspiring and potentially confusing. The dilemma here centres on pluralism versus the risk of fragmentation. Yet, while pluralism is regarded as a risk to the fragmentation and collapse of health psychology (McDermott, 2002) and CHP (Prilleltensky, 2003) any attempt to streamline the breadth of CHP focus would be stifling.[6] Rather, now that CHP is well beyond its establishment phases it is time to pay less attention to the criticisms and rejection of MHP and put more emphasis on what CHP actually does. In this way, for example, the pluralistic basis of CHP has the chance of becoming consolidated (and clearly represented) around key action areas such as power relations, inequalities, poverty and health and social contexts.

Third, to make real differences in 'upstream' determinants of health, as well as more 'downstream' treatment and preventative levels of practice requires large well-funded research projects. The dilemma here is one of isolation versus integration of critical with MHP research. Multidisciplinary research may well mean working within the mainstream health research arena versus the risk of becoming isolated. However, greater collaborative work and securing large, at least medium-term grants that have real *financial* as well as social capacity to create change are essential. Short-term funding for intervention projects can raise ethical issues unless there is longer-term follow-up (see Hepworth, 1997). In order to make these differences learning to work differently is required whereby critical health researchers have to be willing to build networks, communicate their approaches and use multi-method designs in some instances that will bridge the gap between mainstream and critical work (Hepworth, 2004).

Challenges for a critical health psychology that promotes public health

The challenges facing health research are grim. The most overarching facts to consider are the structural determinants of health in the context of global changes. Both MHP and CHP, while increasingly drawing on the language of health

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promotion and public health, are themselves unprepared for global health challenges. In a rare and refreshing publication the passion of Marks in his description of global health determinants is clearly evident in which he states; 'Social capital must be viewed as a local band-aid, not a structural change that prevents the poverty problem in the first place. The latter needs to be tackled at its root cause, not by band-aids' (2004, pp. 77–78). CHP does not have the developed strategies for the prevention and promotion of health that are able to make a contribution at the level that current arguments, such as Murray and Campbell's (2003) and Marks' (2002a, 2002b, 2004) demand.

Clearly, CHP advocates for more social and political change (Murray & Campbell, 2003) and argues there is an urgent need for psychologists to get involved in the larger political domain (Marks, 1996, 2002a, 2004). However, global politics has entered a period of neo-conservatism that is impacting global health. Western countries, and especially the United States' internal and foreign policies, substantially influence this period. It includes a resurgence of 'moral panics' and a refocus on the need to simply retain hard-won civil rights (non-discrimination legislation, abortion, gay & lesbian, pay) that directly affect health status. There is a retreat to individualism that reinforces a focus on modifiable 'lifestyle' factors rather than structural determinants of health. Funding and research enquiry is dominated by large-scale 'big science' projects such as the human genome project and stem cell research while the social sciences receive conservative funding for what can be considered time-consuming, expensive approaches to health. Moreover, current geopolitical conditions involve selective economic developments; trade-offs between political affiliations and funding for development projects, which are in stark contrast with needs-based health interventions such as required in African countries. Together with these changes are also the changing relationships between global corporations, governments and affected populations through, for example, corporate social responsibility (CSR). As an example, Bill Gates set up the world's largest charity, the 'Bill and Melinda Gates Foundation', which is defined in *The Economist* as being 'dedicated to making the poor world healthier' (2005). With a donation of a $750m grant to the Global Alliance for Vaccines and Immunization in February 2005 it became the impetus for governments to follow suit with a $2 billion pledge by the United Kingdom two days later (*The Economist*, 2005).

For these reasons, it is a major contention of this article that CHP move out of the first phase of its establishment and the binary opposition between itself and the mainstream. The second phase of CHP brought with it a pluralism that includes relational, contextual and rights-based arguments as central tenets of CHP work. However, like CHP, colleagues in critical sociology, critical public health and so on who contribute specifically to the public good face similar dilemmas to critical health psychologists. It is not that CHP could become over-inclusive, rather it may become over-simplistic in its restatement of moral rights without substantial applications of critical research and practice. The immediate problems facing CHP have been deliberately reframed here as dilemmas; these are internal dilemmas that as a critical discipline have to be grappled with to remove obstacles to representing a clear view of what CHP constitutes and the expansion of its application to promoting public health.

Concluding comments

The emergence of CHP was founded on laudable aims. CHP kicked against the mainstream psychology industry, and has brought international scholars together through a common vision: 'The critical approach to health psychology is concerned with the analysis of social structures and of the social, economic and political issues that produce health, illness, and health care' (Marks, 2004, 79–80). This brief overview of the emergence of CHP outlines how well placed CHP is to develop a third phase as long as it also meets the challenges of the impact of structural determinants on global health. This work represents a third phase of the development of CHP; a pragmatic phase defined by a rights- and an ethics-based premise, and one that more fully engages with issues of justice and fairness; a more assertive vision for CHP. It is not expected that a piecemeal approach to the discovery of longstanding concepts and practices in public health, health promotion or social

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epidemiology will create real change. Joining with colleagues in related fields and through interdisciplinary work will. Facing the dilemmas and challenges outlined in this article is suggested as being a useful place to start to consolidate the third phase of CHP: a period of action. The alternative is unacceptable. During the past year approximately 250 million children have worked as child labourers working 12 plus hours every day. During the last month approximately 2800 children were recruited into the sex industry worldwide. And, during the time it took to read this article approximately 400–500 people died of hunger; 75 percent of these were children.[7]

Notes

1. Clinical health psychology is based on the biopsychosocial model; overlaps with clinical psychology; works within health care system.
2. Public health psychology includes psychological aspects of health education and health promotion; individual health is the outcome of social, economic and political determinants.
3. Community health psychology is based on community research and social action; part of community psychology, working on health promotion and illness prevention among healthy people as members of communities and groups.
4. Critical health psychology analyses how power, economics, and macrosocial processes influence health, health care, health psychology and studies their implications for practice.
5. Health psychology is:

   > 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, 1980, p. 815)

6. I disagree with Prilleltensky's (2003) critique of the pluralism of CHP because this critique is based on assumptions that CHP is a realist movement when the breadth (or pluralism) of CHP is based on the philosophical bases of interpretivism and critique.
7. These statistics are approximations only that were derived from estimates provided by various sources including ECPAT International, UNICEF and WHO.

References

Adler, N. E. (2003). Looking upstream and downstream from the middle of the river: A commentary on Prilleltensky and Prilleltensky. *Journal of Health Psychology*, *8*(2), 211–213.

Bolam, B., & Chamberlain, K. (2003). Professionalization and reflexivity in critical health psychology practice. *Journal of Health Psychology*, *8*(2), 215–221.

Brinton Lykes, M. (2002). Possible contributions of a psychology of liberation: Whither health and human rights? In D. F. Marks (Ed.), *The health psychology reader*. London: Sage Publications.

Economist, *The*. (2005). Can Bill Gates cure the world? *The Economist*, 29 January–4 February, pp. 10 & 76.

Hepworth, J. (1997). Evaluation in health outcomes research: Linking theories, methodologies and practice in health promotion. *Health Promotion International*, *12*(3), 233–238.

Hepworth, J. (1999). Gender and the capacity of women with NIDDM to implement medical advice. *Scandinavian Journal of Public Health*, *27*(4), 260–266.

Hepworth, J. (2004). Public health psychology: A conceptual and practical framework. Special Issue of the *Journal of Health Psychology*, *9*(1), 41–54.

Marks, D. F. (1996). Health psychology in context. *Journal of Health Psychology*, *1*, 7–21.

Marks, D. F. (Ed.). (2002a). *The health psychology reader*. London: Sage Publications.

Marks, D. F. (2002b). Freedom, power and responsibility: Contrasting approaches to health psychology. *Journal of Health Psychology*, *7*, 5–19.

Marks, D. F. (2004). Rights to health, freedom from illness: A life and death matter. In M. Murray (Ed.), *Critical health psychology* (pp. 61–82). London: Palgrave.

Marks, D., Brucher-Albers, C., Donker, F. J., Jepsen, Z., Rodriguez-Marin, J., Sidot, S., & Wallin Backman, B. (1998). Health psychology 2000: The development of professional health psychology. *Journal of Health Psychology*, *3*, 149–160.

Martin-Baro, I. (1994). *Writings for a Liberation Psychology*. In A. Aron & S. Corne (Eds.), Cambridge, MA: Harvard University Press.

Matarazzo, J. (1980). Behavioural health and behavioural medicine: Frontiers for a new health psychology. *American Psychologist*, *35*, 807–817.

McDermott, M. (2002). Redefining health psychology. In D. F. Marks (Ed.), *The health psychology reader*. London: Sage Publications.

Moscovici, S. (1981). On social representations. In J. Forgas (Ed.), *Social cognition: Perspectives on everyday understanding*. London: Academic Press.

Murray, M. (Ed.). (2000). Reconstructing health

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psychology. Special Issue of the *Journal of Health Psychology*, *5*(3).
Murray, M. (Ed.). (2004). *Critical health psychology*. London: Palgrave.
Murray, M., & Campbell, C. (2003). Beyond the sidelines: Towards a more politically engaged health psychology. *Health Psychology Update*, *12*(3), 12–17.
Murray, M., & Campbell, C. (Eds.). (2004). Special Issue on Community Health Psychology. *Journal of Health Psychology*, *9*(2).
Murray, M., & Chamberlain, K. (1999). *Qualitative health psychology*. London: Sage Publications.
Parker, I. (1989). *The crisis in modern social psychology and how to end it*. London: Routledge.
Prilleltensky, I. (2003). Critical health psychology needs psychopolitical validity. *Health Psychology Update*, *12*(3), 2–11.
Prilleltensky, I., & Prilleltensky, O. (2003). Towards a critical health psychology practice. *Journal of Health Psychology*, *8*(2), 211–213.
Radley, A. (2002). Health psychology, embodiment and the question of vulnerability. In D. F. Marks (Ed.), *The health psychology reader*. London: Sage Publications.
Rawls, J. (1999). *A theory of justice*. Oxford: Oxford University Press.
Stainton Rogers, W. (2002). Critical approaches to health psychology. In D. F. Marks (Ed.), *The health psychology reader*. London: Sage Publications.
Stam, H. J. (2002). Theorizing health and illness: Functionalism, subjectivity and reflexivity. In D. F. Marks (Ed.), *The health psychology reader*. London: Sage Publications.
Vinck, J., Oldenburg, B., & von Lengerke, T. (2001). Editorial: Health psychology and public health—bridging the gap. *Journal of Health Psychology*, *9*(1), 5–12.
World Health Organization (1999). *Poverty and Health*. Report by the Director-General. Executive Board, RB105/5.

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