Towards a Global Health Contribution for Critical Health Psychology : Some Comments on Hepworth

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Abstract

The ability of critical health psychology to deliver on its implicit promise to link social and biological processes is compromised by: (1) a morally superior stance of being *critical of* rather than being *critical for* other disciplines; (2) insufficient pluralism in its concepts and methods; and (3) unwillingness to engage with more 'distant' disciplines that are salient to its goals; particularly economics, management and law. The global health movement offers critical health psychology an avenue to develop its project, especially in low-income countries, where a pragmatic approach to the interconnectedness of poor health and inequality is needed.

Keywords

- *critical health psychology*
- *culture*
- *developing countries*
- *economics*
- *global health*
- *law*
- *management*
- *pluralism*

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AS BOTH AN enthusiast for, and an apologist for, critical health psychology (CHP), I welcome Hepworth's reflections on its development. However, I am also rather embarrassed at the precocity of such a young discipline: a tweenager rushing to the mirror to pop their first spots! Although Hepworth (this issue) touches on a broad range of issues that are important, I briefly want to note four issues that I feel she has not sufficiently considered. First is that although CHP has been *critical of much*, its moral presumptions have alienated many, and it has failed to demonstrate that it is *critical for much*. Second, I want to question the idea that CHP is integrative, pluralistic or some 'meta-commentary' on more narrowly culturally constructed views. Third, I want to argue that to contribute to global health, justice and equity, CHP can only do this by engaging with disciplines that it has previously eschewed; in particular those disciplines that it sees as 'the suits'—economics, management and law. Finally, I want to argue that the global health call for health to be recognized as a human right needs the conduit of CHP to rivet ultimate social processes into the proximate biology of health and illness. An implicit question I raise throughout is whether CHP is prepared to reach beyond the 'feel good' in order to 'do good'?

Being *critical for* rather than *critical of*

While disciplines demarcate themselves by distinguishing their point of view, few do so on the 'explicit presumption that everyone else is wrong and stupid'. While I am clearly overstating the case here, based on a quote from a colleague, that is none the less the sense that many outside CHP have of the perspective. It is, for instance, humbling to hear neuroscientists working with great passion, intellectual and personal conviction, on immunological processes and acknowledging that they have a 'very small, but important' contribution to make to improving human health. Contrast this with the morally superior elitist arrogance of some espousing a CHP perspective, happily informing such boffins that they are operating in the 'wrong paradigm'. While there is justification for being critical of oppressive practices wherever they arise (Prilleltensky, 2001) what CHP has failed at—spectacularly—is promoting a critical perspective through *persuasion* rather than *condemnation* (spotty precocious kids again!). Such a socially embedded perspective as CHP should surely recognize and value the importance of social persuasion. But it does not. So for instance, it is incumbent upon us to illustrate that CHP is *critical for* psychoneuroimmunology in order for psychoneuroimmunology to realize its full value, by appreciating how economic inequalities, cultural oppression or social marginalization are the ultimate drivers of the biological processes that psychoneuroimmunologists see as being vital for health. As a potential bridge between the biological and social health sciences CHP needs to address other health science perspectives much more positively and constructively, by demonstrating how rather abstract critical constructs, such as embodiment, might do this (MacLachlan, 2004). Being *critical for others*, is like 'being there' for others, it is about genuine personal assistance, reducing intellectual distance and banishing moral superiority.

Whatever happened to pluralism?

I must disagree with Hepworth who believes that there is 'clear evidence of the centrality of pluralism' in CHP. IN my view it is neither pluralistic in its concepts, nor its methods. There is a suggestion that the CHP project is a reaction to a monolithic biologically reductionist paradigm which is the product of a peculiarly western Cartesian paradigm. However, like many cultural constructions, CHP creates a sense of coherence and safety though simplistic and extreme presumptions: 'we good–they bad', 'we right–they wrong'. One aspect of this folklore has already been noted earlier. However, to suggest that a reaction to biological reductionism is somehow 'a-cultural', or some meta-cultural-commentary is, as Hepworth notes, daft. This is particularly so, once again, for a perspective that sees itself as being rooted in social constructionism and motivated by re-constructionism. CHP does of course reflect a western cultural perspective—in response to another western cultural perspective—and neither of them illegitimate because of that. All ideas 'come from' somewhere, both within

'disciplinary cultures' and within the broader society in which they arise. The obvious predominance of western psychologists within the CHP perspective makes it clear where it comes from. And even though its purview admirably seeks to reach beyond that perspective, the viewer remains a 'part of the view'.

At the first CHP conference in Newfoundland I presented a paper on 'Cultivating pluralism in health psychology', in which I discussed different cultural perspectives as well as presenting different research methodologies. After the talk someone asked me 'Why do you bother with that quantitative stuff, if you can do the qualitative stuff?' While this was a refreshing reversal of the form of question I was more familiar with, it was of course equally misguided, failing to understand that different methodologies answer different types of questions. CHP is clearly not pluralistic in its methods; often preferring qualitative over quantitative methods and, except in a few notable cases (e.g. Lyons, Spicer, Tuffin, & Chamberlain, 2000), fails to attempt to integrate the qualitative with more quantitative, or the more biologically focused, in a way that might contribute to a genuinely more holistic understanding of people's health. While espousing the idea of being 'holistic', CHP prefers a partial view and rarely even attempts the (woefully inadequate) parallelism that is found in mainstream health psychology's biopsychosocial perspective.

Towards a global health psychology

Global health seeks to address health problems that transcend national boundaries, that may be influenced by circumstances and experiences in other countries and that require co-operative actions and solutions. The age of globalization determines that the world's health problems are shared problems and are therefore best tackled by shared solutions, but that these solutions should be available to all as a fundamental human right.

The broadness and contextuality of global health appeals to CHP's concern to move 'upstream' in considering health. As part of this CHP has snuggled up to anthropological and sociological perspectives somewhat, dare I say, uncritically. I say this as someone who has for many years valued many aspects of these disciplines. They certainly are complementary to CHP, yet they are not without their limitations. Most obvious are the roots of anthropology as the hand-maiden of colonialism and the loss of individual agency in much of sociology (MacLachlan, 2006).

Particularly in developing countries (of course we are all, hopefully, in 'developing countries', but this term is widely taken to signify those in the poorest countries, including what the UN system refers to as 'least developed countries') the potential drivers of economic development are also the potential facilitators of better health; whether this comes from greater financial freedom from commercial exploitation, improved water supply or access to available healthcare (Sachs, 2005). This is increasingly recognized at the highest political levels as well as within the multilateral aid system (Commission on Macroeconomics and Health, 2003; World Bank, 2004). CHP, in its concern with 'upstream' and contextual determinants of health, cannot escape a concern with factors that promote economic development and social development, and as such it should not eschew an explicit interaction with the discipline of economics.

The same is true for the discipline of management. There is no great puzzle about *what* needs to be done to protect the health of people in 'developing countries' from some of the major killer diseases. For instance, insecticide impregnated bed nets can be used to protect against malaria; safe sex practices, including condoms, can be used to protect against HIV/AIDS; simple and inexpensive water sterilization can be used to protect against diarrhoea. Furthermore, if these diseases are contracted there is no great mystery regarding what treatment to use: Malarone for malaria (for example); ARVs (antiretrovirals) for HIV/AIDS; oral rehydration salts for diarrhoea. By and large, we know *what to* do; but not *how to* do it. People die, many people, because we do not know how to provide the health services which we know would work.

The lack of ability to provide healthcare through an effective health system is the reason that our own Centre for Global Health focuses on 'using social science to strengthen health systems'. While this can be done in many ways,

our own efforts include an ongoing project with UNESCO addressing knowledge outflows from developing countries (see also Carr & MacLachlan, 2005), recognizing the centrality of culture as a primary medium of healthcare (MacLachlan, 2006; UNESCO, 2001), exploring alternative cadres of health workers to the highly professionalized and protective health professions of the 'West' (McAuliffe & MacLachlan, 2005) and trying to understand donor–recipient human dynamics in the realm of international aid (MacLachlan & Carr, 2005). These issues are all concerned with *how* health is delivered; that is, with the improvement of health delivery *systems*; and consequently with their management. While the G8 nations increasingly emphasize the need for 'good governance' (Commission on Macroeconomics and Health, 2003) there is an equal need for 'good governance' among donors, where NGO, unilateral and multilateral aid is sometimes shambolic. Obviously strengthening health systems is only one way in which CHP can contribute to improving health in developing countries, and there are many others that might fit more conventionally into a 'traditional' CHP ethos.

The right to health

The unifying axis of the global health movement is the insistence on a human right to health, or more precisely, a right to access services that provide for heath. This applies in 'rich' and 'poor' countries and is not just about an absolute level of resources, but also about equality of access to them. Unashamedly idealistic, the global health movement seeks to make the global right to health as 'obvious' as the (as yet unachieved) global right to education. If CHP is to see economic and social 'development as freedom' (Sen, 1999) and health as a human right, we must also interact with the discipline of law; which can provide international instruments that create the necessary legal means for promoting health (witness the work of Amnesty International in both 'rich' and 'poor' countries). As noted earlier, is any other discipline as well placed as CHP to trace the complex braded pathways from injustice, oppression and exploitation through the social matrix and into mental disharmony, immunosupression and physical disease? CHP must not forget its implicit promise—to place physical and psychological processes in a broader social and political context.

Returning to developing countries, the discipline of psychology has contributed relatively little to addressing problems in poorer countries (Carr & MacLachlan, 1998). However, there are signs of this changing, most particularly in the realm of CHP (see, Aikins, 2004; Campbell, 2003; Cornish, 2004; Marks, 2004 to note but a few excellent recent contributions). For CHP to realize Hepworth's wish that it contribute to global health, it is going to have to get 'into bed' with the much maligned 'grey suited' and perhaps more 'masculine' disciplines of economics, management and law—disciplines that CHP should be *critical for*. Unlike Hepworth, I see the championing of good ideas from other disciplines as unproblematic, especially if their methods help us reach beyond polemical assaults on injustice and renew our resolve on 'how to' do what would work. While some find 'mainstream' health psychology objectionable, few acknowledge that it is so because of the failing of CHP to engage constructively our mainstream colleagues. Sadly, some will also feel that the 'suits' of economics, management and law are the 'enemies' of CHP, instruments of oppression etc. For those who think like this, it is time to stop making peace with your friends and try making peace with your enemies!

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