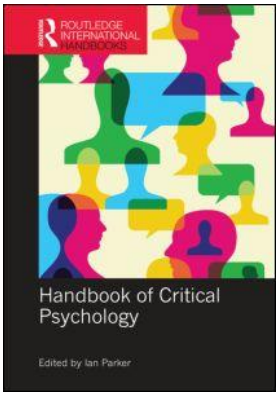

Handbook of Critical Psychology

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Health psychology

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Health psychology

Towards critical psychologies for well-being and social justice

Yasuhiro Igarashi

Health psychology has been often defined as the aggregate of specific educational, scientific, and professional contributions to the discipline of psychology aiming for the promotion and maintenance of health, the prevention and treatment of illness, and the identification of aetiological and diagnostic correlates of health, illness, and related dysfunctions. We can see what the first generation of health psychologists thought to be important from this definition. Intervention targeting those who are identified as risky, and entry to health care services and policies, have been the focus for mainstream health psychology, along with the study of causes of illness.

In 'developed' countries, it has long been pointed out that diseases such as diabetes, cardiac disease, cerebrovascular disease, and cancer are related to the behaviour of patients. It was assumed that if psychologists could change behaviour that 'causes' such illnesses, people could enjoy healthy lives and medical expense could be reduced significantly. Health psychology started to grow rapidly in the late 1970s, mainly in the US, and in Europe shortly after. Health psychology has established its status as a specialized area that treats issues of physical health in the US, the UK, and other English-speaking countries. In other countries, including Japan, it is recognized as a sub-discipline of psychology in psychological circles, but it has not been recognized in medical circles and in society at large (Igarashi 2005).

The development of health psychology

A disciplinary history serves to legitimate the role and authority of health psychology in health care. Although some describe its roots tracing back to the age of ancient Greece (e.g. Belar et al. 2013), the area was formed and termed 'health psychology' in the 1970s when increasing expenditure and change in health care delivery became a major subject of discussion. Behaviour medicine, medical sociology, health economics, medical anthropology, and others had established their interest in health issues in parallel with health psychology. The discipline of health psychology has been constructed in competition with these rivals for the status of expert, showing its usefulness to concerned parties and society at large. Health psychologists needed to position themselves to win the struggle for survival and they succeeded in doing this. Deficiencies of and disenchantment with the biomedical model of illness, escalating costs of health care, the epidemic of HIV, an awareness of the role that behaviour plays in health, and an increasing

ideology of health as the responsibility of the individual facilitated psychology's entry into issues of medical care (Lyons and Chamberlain 2005).

It seems to be relatively clear now that political economy, race, gender, culture, and other external factors significantly affect health and illness, but that research with large-number questionnaires sometimes fails to capture experience concerning health. In the 1990s, some health psychologists started to critique mainstream health psychology and proposed alternative ways of doing health psychology (e.g. Stainton Rogers 1996). Critical psychology informed these approaches, but this 'critical psychology' is so diverse (e.g. Dafermos et al. 2013), it would be better to refer to critical psychologies. Themes, methods, and theoretical resources for research and practice are diverse, depending on what critical psychologists work on (Parker 2011; Teo 2014). However, critical psychologists in different parts of the world broadly share the following two stances towards psychology. On the one hand, critical psychologists try to bring about a psychology that contributes to the happiness and welfare of people, especially those who suffer from abuse of psychology and who are in weak positions in power relations. On the other hand, this psychology yields new theory, research, methodology, therapy, education, and ways of relating to society to resolve problems that spring from existing mainstream approaches to health, including approaches from within mainstream health psychology.

Health is an issue of concern for all of us. It is concerned with our experience of the body and closely relates to our subjectivity. However, health and the regulation of the body for 'health' are the focus of administration by authorities, and this places a series of demands on critical psychologies. Critical health psychology can inform health psychology in many important dimensions, and because it is a newcomer in psychological circles generally, the mainstream has not yet mobilized to exclude emerging critical trends. It has been clear that mainstream health psychology cannot achieve the goal of 'health for all', and critical health psychology has now been recognized as one of four main approaches, alongside clinical health psychology, public health psychology, and community health psychology (Marks 2002a).

The *Journal of Health Psychology* (launched in 1996) committed itself to the promotion of critical health psychology as one of its editorial policies (Marks 1996). Textbooks were published very early on (e.g. Crossley 2000; Lyons and Chamberlain 2005; Marks 2002b; Murray 2004; Murray and Chamberlain 1999) and more have appeared recently (Horrocks and Johnson 2012; Marks et al. 2011; Rohleder 2012). Biennial conferences of the International Society for Critical Health Psychology attract scholars who work in a wide range of health-related areas from multiple cultures to discuss new research.

Critical health psychology and its contributions

Health psychology has developed rapidly in the US and Europe, drawing on existing theories and methods of social, clinical, and cognitive psychology. But in the 1990s, it became clear to some psychologists that it had not achieved the goal of 'health for all' because of the limitations of its cognitive-behaviourist methodology. Critical health psychology started to challenge health psychology's individualism, cognitivism, positivism, reductionism, and other basic tenets. US American psychology achieved its paradigm or dominant methodology based on tenets of neo-behaviourism with the categories of variables (independent, intervening, and dependent variables) and operational definition in the 1930s (Danziger 1997). This became widely accepted in many countries after the Second World War, particularly in places where the United States had a strong influence (Igarashi 2006). At that time, psychology was considered to be a psychology of the organism, and so mental processes of human and animals were treated in the same way. Neo-behaviourism developed into cognitive-behaviourism with the rise of computer

science and cognitive psychology, which became more popular in the 1950s and 1960s. It has become the mainstream in the US and in countries where US American psychology dominates research and application. However, psychology cannot be viewed simply as the psychology of the organism any longer because the difference between human beings and animals, particularly over the use of language, has become a focus of attention in different fields of psychology (including discursive and critical psychology). Psychology has come to be considered as a psychology of person in general, whether it is treated as such explicitly or implicitly. Even here, though, it was for a long time presumed that gender, culture, ethnicity, socioeconomic status, sexuality, and other dimensions of the person do not make a significant difference in an individual's mental process.

A consequence is that this ostensibly 'general' psychology is actually the psychology of male, white, middle-class, heterosexual individuals – those treated as the invisible norm in research – and this is something that is questioned, of course – by different forms of critical psychology. Critical psychology attends to the way that the dominant culture and values in a society enter into psychological approaches, methods, and products in some way or another. Looking back at the history of psychology and the production and application of psychological knowledge, it is clear that psychology has not been merely a pure intellectual pursuit of the mind (e.g. Richards 2009). It has also been a tool for social control and management of individuals' conduct, and has worked as a 'technology of the self' (Foucault 1976). Health psychology, launched as a new branch of this mainstream psychology in the US, disseminated these assumptions about the human being to non-Western countries, including Japan.

Mainstream health psychology devotes itself to research on cognitions and behaviour concerning ill-health, attempting to predict targeted behaviour by adopting quantitative methods in the framework of a so-called bio-psycho-social model (Crossley 2000). This still-dominant form of health psychology tends to reduce questions of health and illness to instrumental, technical problems of management and control. It has not actively grappled with the problems of contemporary society. Rather, it has tended to perpetuate these problems by providing stopgap measures.

Critical health psychology has made efforts to overcome these shortcomings in the following ways.

Beyond individualism

It is natural for cognitive-behaviourism to explain a person's behaviour and mind at the level of the person, and so it is also natural for mainstream health psychology to treat health and illness at the level of a person. Mainstream health psychology has concentrated its practice on the development of individualistic and rationalistic education-type packages, designed by the experts to change individual behaviours (Murray and Chamberlain 2014). But critical health psychologists point out that the behaviour of individuals is not solely determined in their mind but is largely influenced by family, community, institutions, media, and political economy. The 'bio-psycho-social' model (Engel 1977) has been deployed as a slogan to propel health psychology, and this strategy was successful to an extent. But, in fact, health psychology has not actually included the 'social' to any great extent. The relation between the biological and the psychological and the social has not been theorized effectively, and the model has been criticized for its superficial treatment of the three components. We have not been able to understand health and ill-health any more by using that slogan (Stam 2000).

We need to take the social or external factors seriously to understand issues of health, as ecological systems theory does, for example (Bronfenbrenner 1979). Health behaviour is related

to lifestyle, and lifestyle is formed in a personal, familial, social, cultural, political, economic, and global context.

Poverty as the major cause of ill-health and death

Health inequality and poverty are major themes to work on to achieve the goal of 'health for all'. At the end of the twentieth century, the World Health Organization had already reported that those living in absolute poverty are five times more likely to die before reaching the age of five, and two and half times more likely to die between the ages of 15 and 59, than those in higher-income groups (World Health Organization 1999). According to Jha and Mills (2002), one-tenth of the deaths in developing countries (about 1.6 million) are caused by diseases such as measles, diphtheria, and tetanus that are vaccinated for in developed countries. The top causes of death in developing countries, such as diarrhoeal diseases, tuberculosis, neonatal infections, premature birth, and low birth weight, are associated with poverty such as malnutrition and low immunity, and poor health care services (World Health Organization 2002). The major impacts of poverty on health are caused by the absence of safe water, sanitation, adequate diet, secure housing, basic education, income generating opportunities, and access to medication and health care (Lyons and Chamberlain 2005).

The linkages between poverty and ill-health are not confined to developing countries. Health inequalities in 'developed' countries are also significant. It is widely known that socioeconomic status and position in the social hierarchy affect heavily the health of the working class and the marginalized (Marmot et al. 1984). Health inequalities are based on socioeconomic status in all societies; rich people can easily have good health, but poor people are more likely to have poor health. Furthermore, whether a person is wealthy or not is not the only cause of health inequalities. We need to consider inequalities in terms of class, gender, ethnicity, sexuality, and other attributes. These are associated with social and material exploitation that the weak or minorities suffer from. We need to consider the effects of institutional racism, gender discrimination, corporate globalization, degradation of the environment, destruction of the public sector, dangerous workplace conditions, and neighbourhood characteristics (Marks et al. 2011). We should never forget that we live in a world in which poverty and inequalities in wealth and access to resources are the major causes of ill-health (Campbell and Murray 2004). In dealing with these structural issues, we have to squarely address the problems that globalization and the world economy have on health and ill-health.

Beyond cognitivism and positivism

Mainstream health psychology has focused on cognition and its relation to health behaviours of individuals (e.g. smoking, drinking, diet, exercise, unsafe sex), along with positivist measurement, largely with self-report questionnaires and elaborate statistical analyses to validate its findings. Those in the mainstream believe that psychologists can specify cognitive variables and beliefs, which are supposed to cause particular behaviours, as the 'health belief model' and the 'theory of planned behaviour' do. After the mapping and measurement of these illness cognitions, they were reified through the development of standardized questionnaires (Murray and Chamberlain 2014).

Following identification of the psychological causes of unhealthy behaviour, interventions were developed which targeted these variables with the aim of reducing these behaviours, as 'cognitive behavioural therapy' does. As such, mainstream health psychology draws on mainstream social and clinical psychology. In a sense, health psychology has been rather 'ill-health psychology' (Marks 1996). In contrast, critical health psychologists consider that with that

positivist approach we cannot understand the lived experience or subjectivity of being healthy or ill and how these are socially and culturally constructed.

New methodologies and new philosophy of health psychology

The limitations of mainstream health psychology and its methodology have been increasingly evident. Its reliance on self-report measures and their ability to assess the complexity of health behaviour has been critiqued (e.g. Mielewczyk and Willig 2007). Critical health psychology, on the other hand, has been searching for new methodologies to explore the meanings of experiences concerning health. In the 1990s, critical health psychology began to carry out research using qualitative methods such as interviews, focus groups, discourse analysis, and other approaches departing from mainstream health psychology's reliance on quantitative methods, especially questionnaires (e.g. Murray and Chamberlain 1999). Presumptions of cognitivism, reductionism, positivism, and individualism behind the research, intervention, and theory of mainstream health psychology and its 'methodolatry' (Chamberlain 2000) were put under scrutiny. Viewed from the perspective of the history of psychology, this constitutes a part of the qualitative research movement that started in areas of social sciences, including psychology, in 1980s.

Critical health psychology shares an interest in various critical-theoretical ideas, such as post-structuralism, social constructionism, feminism, Marxism, psychoanalysis, and postcolonialism. New research methods that contribute to understanding subjectivities and to social change are being explored. Some psychologists who work in community settings do research with participatory action research, for example.

Beyond the psychology of male, white, middle class, and heterosexual

To achieve the goal of 'health for all', health psychologists need to go beyond ethnocentrism, actually a form of egocentrism that hampers taking the side of those who suffer from ill-health and health inequality. Tracing the history of the discipline of psychology, we can see it has not been 'neutral, objective, pure scientific discipline' (e.g. Richards 2009). In a sense, mainstream psychology can be depicted as the psychology of male, white, middle class, and heterosexual that has been the mainstream of psychological circles and of the society at large, and those who don't belong to such categories can suffer from ill-health and health inequality much more easily than those that belong to the mainstream or majority. This means that we need more diverse psychologies from the perspectives of non-Western cultures, women, poor people, ethnic minorities, sexual minorities, and others.

The challenges for critical health psychology

Critical psychology can inform health psychology in important respects. Doing health psychology critically includes ethical, ideological, methodological, philosophical, and professional engagement with issues related to health (Vinck and Meganck 2006). We can see this in relation to practical examples. On March 11, 2011, a mega-quake and tsunami attacked the east of Japan, and these events caused the accident at the Fukushima No. 1 nuclear power plant. Many people suffered from the tsunami and the nuclear disaster. The accident was rated at level seven, the worst major accident on the International Nuclear and Radiological Event Scale, the same rating as the accident at Chernobyl. Psychologists started to provide psychological services, especially for mental health care, soon after the quake. But those who work on the issue of the

health threat of radiation contamination on the side of the victims of the disaster are still very few, although psychological effects are considered the most important by radiation protection experts, along with physical effects, genetic effects, and others. It is a hot issue in society. Central and local governments, conservative politicians, a large majority of business leaders, and leaders in the circle of nuclear power engineering and related areas play up the safety of nuclear power generation, saying that the level of radiation contamination is low and will not cause substantial health damage. But even radiation protection experts cannot tell us what effects low level radiation contamination will have on long-term health. 'The objective scientific truth' on the effects of low-dose contamination has not been discovered yet. It will be established only after the lifelong health surveys of residents of the contaminated area. What is clear now is that the Fukushima disaster is the test case that the world is watching (*Japan Times* 2012). Viewed from the perspective of discourse analysis, different versions of realities concerning nuclear power generation and the health effects of radiation exposure are now being constructed by those who want to promote nuclear power generation and those who oppose it. It seems difficult for Japanese psychologists to work on the side of those suffering from the disaster. Up to this time, only a few health psychologists have carried out such research or practice. A critical psychological intervention is needed.

Critical health psychologists have been focused on issues of poverty as the most significant cause of ill-health in the world. But up to the present time, we cannot say they have succeeded in making substantial changes either in developed or developing countries. Issues of power disparity in economic, political, and cultural spheres are closely related to poverty. We still need innovative new theories and methodologies for research, practice, and education that can tackle these tough structural problems and the philosophy of psychology that supports them.

Viewed from the perspective of theoretical psychology as a meta-discipline of psychology that includes the history, philosophy, and sociology of psychology (e.g. Stam 2012), health psychology has the potential to make change in North American mainstream psychology beyond its role as a specialized area treating health and illness. To achieve social change for health, health psychologists have to be able to reconcile their roles as health professionals with their roles as critical agents (Prilleltensky 2003). We have to find ways of reconciling the two sets of skills and aims. Prilleltensky (2003), for example, urges critical health psychologists to ask themselves three important questions from the perspective of the health professional: how does our special knowledge of wellness inform our social justice work? How does our ameliorative practice inform our transformative practice? And how does our insider role of wellness promoter in the helping system inform our outsider role as social critic? It is a task for critical health psychologists to think over these questions in their daily activities.

It is a difficult challenge to make social change for health and well-being, but a psychology that has the principal aim of contributing to resolving social problems and increasing social justice would be a revolutionary new discipline in this world. Besides the dichotomy of individual and society that hampers a psychological approach to sociopolitical issues, we can point out other presumed dichotomies in US mainstream psychology, such as division between mind and body, between cognition and emotion, between theory and practice, and between person and environment (Holzman 2012). Critical health psychology focuses on issues of body and embodiment to understand experience and subjectivity concerning health and health behaviour. It does harm to artificially divide mind from body, cognition from emotion, and a person's mind from their society. Today some historians of psychology think that US American mainstream psychology is an example of indigenous psychology that is particular to US American society and culture (e.g. Brock 2006). Findings obtained from research and practice done from an undivided perspective would bring about innovative theory and methodology in the future.

Reflexivity: doing health psychology critically

Reflexivity is a hot topic for critical psychologists, but the term is interpreted in several ways (Finlay and Gough 2003). To think over what health psychology actually is, as this chapter aims to do, is a reflexive endeavour. It is critically important to reflect on characteristics of methodology, theory, and institutions of health psychology to see possibilities and challenges and to propose new ways of doing psychology that will contribute to health for all. We have to reflect on our ethnocentrism, or, rather, egocentrism, that hampers our ability to take the side of those who suffer the effects of powers that operate in this world. Health psychology has been rapidly developing in Japan since the late 1980s. The number of affiliates of the Japanese Association of Health Psychology mounted to over 2000 in 2014. But theories and methods that Japanese health psychologists use are wholly introduced from mainstream health psychology in the US and Europe. Research and practice from an original Japanese perspective or from the perspective of critical health psychology are scarce, although economic and social disparities and poverty among the weak, especially women, single-parent families, and children, have become serious objects of public concern in the last decade. Health psychology research and practice that implements real Japanese culture and values, which can contribute to the health and well-being of people in their actual lives, is seriously needed. In this context of a lack of reflexivity, such tragicomic events can happen as inviting a leading US American health psychologist to deliver lectures in East Asia on his work mainly with US American undergraduate students as subjects, without mentioning any cultural differences in health cognitions and behaviours. When asked about the effects of these cultural differences, he replied that although this is an important theme, it remains for future research.

Reflexivity is indispensable to doing health psychology critically, and there are political implications for this too. For example, it was reported that psychologists, two of them one-time presidents of the American Psychological Association (APA), who played a crucial role in establishing health psychology in its early days and who have contributed to its development through research on 'learned helplessness' and 'positive psychology' were also involved in the implementation of 'enhanced interrogation techniques', psychological torture against 'illegal enemy combatants' in the war on terrorism after 2001 (Democracy Now! 2009; Eban 2007; New York Times 2009). The harsh conditions of the interrogation are visualized in M. Davis' movie *Doctors of the Dark Side* (2011) Psychology has been infamous for its association with torture since the 1950s (McCoy 2012; Roberts 2007). It is also reported that the APA has strong connections with US defence and military sectors (Huffington Post 2009). As the special issue of *American Psychologist* entitled 'Comprehensive Soldier Fitness' (Seligman and Matthews 2011) suggests, psychology is now developing relations with these bodies (Salon.com 2010). Psychology can be used either to promote health or to break it down. Applications of psychology that cause ill-health violate the ethical principles of any health professionals. Critical health psychology needs at least to begin with tackling its own discipline, and the ways that discipline colludes in ill-health, if it is to be able to build genuine alternatives.

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American Psychological Association Division 38: http://www.health-psych.org/index.cfm
International Society of Critical Health Psychology: http://www.ischp.net/
International Society for Theoretical Psychology: http://psychology.ucalgary.ca/istp/

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