Keynote article

Health psychology in context

Michael Murray*

School of Psychology, Keele University, Keele, Staffordshire ST5 5BG, UK

Health psychology often traces its origins to developments in the 1970s with the establishment of the Division of Health Psychology within the American Psychological Association and the subsequent development of other national and international associations. This was followed by the publication of journals and textbooks and the delineation of what was meant by health psychology. Since then certain standard practices have evolved within the discipline which define what is acceptable and what is deviant. The purpose of this paper is to reflect on the forms of health psychology and the context within which these forms have become established.

The 1960s and 1970s was a period of great excitement and change in society internationally. The former colonies were asserting their independence and we had the rise of various social movements for change throughout the world. Psychology was not immune from these social movements and there was considerable debate within the discipline about its character and purpose. We had the growth of a range of critical debates within psychology as regards its methods and theories.

At the same time we had the growth of new sub-disciplines within psychology with different applied foci – the most important of which was health psychology. Thus health psychology was established at a time of sustained debate about the nature of the whole discipline of psychology. However, rather than engage in this debate health psychology moved rapidly to establish certain orthodoxies as regards theories and methods. In particular it adopted a limited range of theories (Health Belief Model, Theory of Reasoned Action, etc.) and methods (almost entirely questionnaire). If we look back though the pages of the main journals we will see that this was the case. This narrowing of vision is not unusual in the development of any discipline. There is a desire and an enthusiasm to assert the place of the new discipline in the range of other disciplines. In the case of health psychology this was particularly problematic at that time when other disciplines (e.g. sociology, anthropology) were vying for a place at the big health table traditionally dominated by medicine.

With so much disciplinary demarcation occurring there was little time for critical debate about the nature of health psychology. However, as the discipline has grown so has the space for reflection. Over the past decade this debate is evidenced with the convening of specialist meetings and the publication of special journal issues and textbooks which attempt to develop a more critical approach to the discipline. Unlike much of mainstream psychology this critical approach is not unified but rather promotes a range of methods and theories. Underlying this critique, however, there is a broader concern with values – what is health psychology for and who does it serve.

Michael Murray
Professor of Applied Social and Health Psychology

Recently Michael Burawoy (2005) has developed an assessment of the character of much of contemporary sociology. He starts his analysis with a rather elegant model in which he distinguishes between the audience of our research and the character of our research or knowledge. As regards the audience he distinguishes between academics and non-academics and in terms of knowledge he distinguishes between instrumental and reflexive knowledge. Admittedly these two types of audience and of knowledge should not be considered distinct and it is also important to consider how one informs the other. Despite this caution it still provides a useful framework for considering the different forms of health psychology.

The traditional form of health psychology where it engages with an academic audience is premised upon instrumental knowledge which is especially concerned with the accumulation of facts and ▶

*Corresponding Author: Michael Murray; email: m.murray@psy.keele.ac.uk

Keynote article

Murray (cont'd)

answering clearly defined hypotheses. It frequently uses various quantitative methods to confirm the applicability of certain theories to explain certain health questions. The emphasis remains upon objectivity and distance. This so-called scientific approach can adopt all the trappings of natural science to assert its objectivity. It is particularly concerned with measurement of variables but more recently with describing the character of human experience. While the dominant method still relies upon the use of various standardised measures there has been the growing adoption of a range of qualitative approaches although the emphasis has been on ensuring that these new approaches are carefully proscribed and if possible follow the traditional rules of scientific inquiry. A particular focus has been on the character of the individual whether in terms of individual attitudes and beliefs or of human experience which are often described in terms of deficits. This focus on the individual has tended to separate health psychology from discussion about the importance of the social and political context and to promote a concern with individual change.

The engagement of the discipline with a non-academic audience is the concern of what has been termed applied health psychology. On the one hand there are clinical health psychologists who are concerned with using a variety of methods to enhance the quality of life of people with a range of health problems. On the other hand are those public health psychologists who insert various psychological theories into the broader public health practice. The focus of both is on developing individual change strategies to compensate for certain deficits and to rather ignore issues around the organisation of society and of healthcare. The aim is to apply the findings from scientific investigations conducted by the researcher. Thus rather than developing theory the practitioner is more concerned with refining practices. This form of health psychology follows the guidelines of the scientist – practitioner model defined by clinical psychology. It also presupposes access to specialist knowledge and skills which not only separate the health psychologist from the lay audience but more clearly aligns her/him with other health professionals. This distinction is accentuated by the adoption of various trappings of more established professional groups.

These scientific and scientist-practitioner approaches are the dominant approaches which have led to health psychology establishing itself as influential in a range of healthcare arenas. This preference for a narrow range of standardised approaches which do not challenge the ideas of the dominant discipline (in this case medicine) is not unusual in the early stages of any discipline. It is a means by which a new discipline asserts its identity as distinct and as offering a particular contribution to both knowledge and practice. Part of this process of defining a discipline involves drawing up syllabi and establishing accreditation guidelines such that we can define who is qualified in health psychology. It also means policing the boundaries such that unacceptable theories, methods and practices are sidelined.

Admittedly, within any discipline there are always dissident voices which question the appropriateness of certain theories and methods. This brings us to the second form of knowledge identified by Burawoy – reflexive knowledge. As any discipline/profession grows in size it begins to reflect upon itself and its relationship with the broader society. Within health psychology these critical voices have become more sustained over the past decade and have begun to permeate the broader academic debate in terms particularly of methods. Thus whereas 15 years ago it was difficult to attract contributions to a textbook on qualitative health psychology, today most journals of health psychology contain articles using qualitative methods. Even the APA flagship journal Health Psychology has now published qualitative articles.

Admittedly, this does not mean that critical health psychology is just concerned with qualitative methods. Rather the debate goes beyond research methods to consider the processes of knowledge creation and values underlying the research. In its early days a critical approach is often fuelled by anger and frustration rather than a clearly detailed critique of the orthodoxy. But as it grows it becomes more theoretically informed and can more ably engage in the process of critique. A common aim of critical health psychology has been to reorient the discipline away from a focus on measuring individual characteristics to a concern with more dynamic social psychological, socio-political and socio-cultural processes. It has introduced ideas from discursive psychology on the one hand and other social science disciplines on the other. It has argued that health psychology exists in a certain socio-historical context which raises questions about how research questions are defined and how they are investigated. Of particular interest is the role of power in shaping health and illness and how power permeates our everyday relationships within various healthcare and social arenas. The increasing awareness of these ideas throughout the discipline illustrates how critical ideas can grow in influence as they chime with changing socio-historical circumstances.

A deliberate awareness of a discipline's role in these changing circumstances is the focus of the ▶

Keynote article

Murray (cont'd)

second dimension of reflexive knowledge which is concerned with the character of any discipline's engagement with the public. In the case of sociology, Burawoy articulates the need for a public sociology – one that is involved in an active form of social engagement with the public and not just with the established elites. In the case of health psychology this requires a more active form of public engagement rather than the more common traditional disinterested approach.

Here we can learn some lessons from community psychology which for the past 40 years has been concerned with various forms of emancipatory action with those groups with limited power in society. Admittedly, within community psychology there has been a tendency for some researchers to dispense with discussion about values and to assert a more technical approach. However, more recently there has been increasing challenge to this move towards supposed objectivity and a reassertion of a value informed social critique.

An example of this approach is the attempt to develop a community health psychology. This approach is quite explicit in its values orientation being concerned with social justice, concern for minorities and the excluded, and with challenging various forms of social oppression. There are of course risks involved in promoting this more activist form of health psychology. On the one hand it can be co-opted by mainstream agencies and as such lose its critical edge. Conversely it can become divorced from theoretical and methodological debate and become more self-serving. This tension is longstanding within the larger scholar-activist tradition which articulates the need for self-reflexivity such that the activist researcher brings together ideas from critical theory with involvement in broader movements for social change in an ongoing process of dialogue.

This form of collaborative activist health psychology is underpinned by the principles of participatory action research. It aims to work with collectives to reflect upon their circumstances and to consider strategies of change. Thus rather than imposing a change agenda from the outside the health psychologist as social activist works with the collective to understand their needs and to explore opportunities for change. Here the health psychologist brings together social psychological ideas on the nature of society and of social change together with a commitment to the values of human emancipation.

These different approaches within health psychology have changed over the history of the discipline and reflect the importance of the wider socio-political context within which any discipline works. Back in the 1970s when health psychology was developing there was sustained debate about giving people responsibility for their own health. In the UK there were classic reports about social inequalities in health which identified the importance of structural factors. However, changing the structure of society was not something acceptable to dominant interests who preferred to focus on changing individual behaviour - if people did not change then it was not the government's responsibility.

Forty years later as we enter a much more extensive world economic crisis these debates are coming to the fore again only this time the response of health psychology can be more sophisticated. Within a world of widening social inequalities, war, mass migration, and religious fundamentalism it is increasingly difficult for health psychology to maintain a disinterested stance. At times like this it is increasingly important for any discipline to both engage in critical reflection about our theories, methods and values but also to engage in the broader public debate about the nature of our work.

The use of Burawoy's classification scheme is a means to consider how different forms of health psychology have developed and evolved. This scheme should not be considered exclusive but one within which there is movement as old ideas and methods wane and new ideas are accepted. As such critical health psychology plays an essential role in fostering this debate as does the idea of a more public health psychology. Both can challenge established orthodoxies in the academic and non-academic domains and reassert the importance of emancipatory values underpinning both our research and practice. ■

Reference

Burawoy, M. (2005). For public sociology. *American Sociological Review, 70*, 4-29.