

ask the expert

Social Justice: What Has Health Psychology Contributed?**Anthony Montgomery**

University of Macedonia, Greece

The current economic crisis in Europe behoves all organisations to re-examine the contribution that they make to society. Put simply, society wants to know if it is getting value for money from the services and organisations they fund. The EHPS is predominately populated by university employees whose salaries are (typically) funded by taxpayers. Thus, the need for Health Psychology to be relevant has never been more important. The present article was prompted, in some part, by the thought provoking keynote speech by Prof. Michael Murray (EHPS Cluj; 2010), whereby Michael suggested that Health Psychology has a weak ego and challenged us all to ruminate on how our activities impact upon society. This is a good question, and deserves an answer.

With all the aforementioned in mind, I have approached a sample of senior health psychologists to ascertain their personal experiences of how their own careers have contributed to social justice in the world. The following article represents their responses to the following question:

“Looking back on your career, in what way has your own work contributed to social justice in the world?”

**Prof Susan Michie**

University College London

What is social justice? Social justice involves creating a society based on principles of [equality](#) and solidarity, that understands and values [human rights](#), and that recognises the dignity of every human being. At its 2007 World Summit for Social Development, the United Nations proclaimed 20 February as World Day of Social Justice. Governments pledged to promote the equitable distribution of income and greater access to resources through equity and equality and opportunity for all. The day aims to consolidate the efforts of the international community to eradicate poverty, and promote full employment and decent work, gender equity and access to social well-being and justice for all.

Health psychology in relation to social justice: The aims of Health Psychology, according to the British Psychological Society, are:

1. To study scientifically the psychological processes of health, illness and health care
2. To apply psychology to:
 - the promotion and maintenance of health
 - the analysis and improvement of the health care system and health policy formation
 - the prevention of illness and disability and the enhancement of outcomes of those who are ill or disabled
3. To develop professional skills in research, consultancy and teaching/training

How do these aims match the aims of social justice? Psychology is the scientific study of the interaction of behaviour, cognition and emotion with each other, and with the environment. Although environmental context is crucial to psychology, its role is often a secondary rather than primary focus. Applying psychology to the promotion of health and reduction of disability has the capacity to increase social well-being, but this does not automatically translate into increasing equity and equality. Improved health services can lead to increased inequality, due to unequal access to services, with those from low income and ethnic minority groups underserved by services. Population health interventions, such as persuasive mass media marketing, can also increase inequality if not targeted to the more deprived sections of the population.



ask the expert

Social Justice: What has Health Psychology Contributed?

Social justice will not be increased by the application of psychology without a sophisticated analysis and awareness of its political context and consequences. This will require self-conscious policy changes and leadership from our scientific and professional societies. One possibility would be to organise annual Health Psychology events on the World Day of Social Justice.

My work: My first scientific publication (Michie, 1980), 30 years ago, followed a visit to the psychiatric hospital in Cuba, one of the most equal societies in the world. As a newly qualified clinical psychologist, I was inspired to communicate their therapeutic model which embodies the principles of social justice. This experience made me realise the limitations of our own therapeutic approach, which was more individualistic, separated from social values and lacking dignity compared to that in Cuba. It also made me reflect on the role psychologists played in society more generally and our missed opportunities to work towards a more just and equitable society. The following year I wrote an article for Bulletin of the *British Psychological Society*, (Michie, 1981) entitled “The clinical psychologist as agent of social change”.

As a Health Psychology researcher, I am active at a policy level to work to maximise the likelihood that our scientific knowledge is applied in the most effective way to maximise social justice, as well as to increase the general health of the population. I will give two examples of my work aimed at reducing inequalities, one translating scientific research into a health service and one aimed at lobbying politicians to support equality-promoting social interventions.

NHS Health Trainers was a new service set up in the UK in 2004 with the aim of reducing health inequalities by targeting interventions to change behaviours in relation to health. About 1500 Health Trainers, mainly drawn from and based in their local communities, currently provide this service. Along with Policy Leads in Government, I designed the evidence-based intervention and, together with Prof. Nicky Rumsey and a small team of Health Psychologists, have supported its implementation, development and evaluation. It includes behaviour change techniques that are relatively straightforward to train and use, such as goal-setting, action-planning and self-monitoring. To support the health trainers to maintain evidence-based practice as much as possible, we wrote a Behaviour Change Handbook which was distributed to the services and is available on the UK Department of Health website (Michie et al., 2006). The evaluation has demonstrated success, both in engaging low income and ethnic minority groups within the population, and in showing improvement in self-reported health behaviours and Body Mass Index (Smith, Gardner, & Michie, 2010).

The Coalition Government elected in the UK in 2010 has rapidly moved away from the previous Government's health policies of attempting to reduce inequalities. In an effort to preserve as much of the UK's world-leading tobacco control strategy as possible, two Health Psychologists (myself and Prof Robert West) have helped the health charity, Action on Smoking and Health (ASH), to present evidence on effectiveness and public acceptability of components of that strategy and the moral arguments for maintaining it (Featherstone et al., 2010) to the All Party Parliamentary Group on Smoking and Health. This formed a key part of their evidence to the UK Government's 2010 Comprehensive Spending Review.

Future perspectives: The world faces serious threats to social justice in the coming years. There is a global economic crisis, largely created by short-term profiteering by the banking sector. The consequent national debts are overwhelmingly being paid for by the mass of the population, rather than by those who caused the crisis. In the UK, the brunt of the “austerity cuts” to income, jobs and services is being borne by the lowest paid. The financial crisis is being used as an excuse by the UK's government to achieve the Conservative Party's long-standing political goals of minimising the public sector and reducing the constraints on private companies to exploit their markets. Increased inequality within societies has been shown to reduce social cohesion, health and well-being (Wilkinson & Pickett, 2009). Now, more than at any time in my lifetime, it is time for Health Psychology to recognise, and act on, the inter-relationships between social justice and our professional aims.

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ask the expert

Social Justice: What has Health Psychology Contributed?

Before I graduated, I knew that I couldn't practice psychology in the lab or in the office exclusively, as so many acts of injustice were happening all around me, including sufferance, trauma and health disparities. I learned that my way to do psychology is to give voice to vulnerable people who cannot speak for themselves. I also learned that they should not be seen as individuals lacking good resources to cope with adversities, but human beings caught in the middle of unfortunate socio-economic circumstances. Listening and publishing the stories of Romanian women who had to pass through the experience of one of the most draconian pronatalist policy in the world, stories which gave voice also

to more than 10,000 women who died because of a regime which strictly prohibited them access to contraceptives and legal abortion, carried the hope that their traumatic experiences will never again be repeated. The central argument of a study on the psychosocial-health systems dimensions of cervical screening is that the health status of women from countries experiencing tremendous political, economic, social and institutional changes are more vulnerable to different diseases, including cervical cancer. Individual risk factors such as beliefs, attitudes and behaviors should be interpreted through the perspective of the social context. The question of what are the factors which can limit or encourage women to be active agents in health promotion and disease prevention is particularly relevant in the current situation of many countries in Eastern Europe. My research interests also involved psychological consequences of domestic violence and women's ways of coping with it; with a study carried out in Albania I highlighted the fact that the silence around domestic violence makes it the most pervasive, yet least recognized form of human rights abuse. Several other research projects, in which I was involved, have aimed to bring forward the practices that would prevent the social exclusion of young people in residential care, diminish violence in the residential system and facilitate equal opportunities and their social inclusion. The theme of the 24th EHPS Conference in Cluj, Romania, "Health in Context" represented an invitation to participants to become more reflexive researchers, driven by social justice in making decisions that can impact the life of others, in an attempt to validate health psychologists as agents of social change for the benefits of populations, communities and individuals.

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Prof Adriana Baban
Babes-Bolyai University, Romania



Prof Teresa McIntyre
University of Houston, USA

Early on in my education, I became painfully aware of inequalities in wealth, educational opportunities and health. I transitioned to college at the time of the Portuguese Revolution, a peaceful coup d'état that overthrew a 50 year dictatorship which also ended the Portuguese colonial wars and occupation. To fulfil a 1-year community service requirement for college admission, I was placed in a school at a fishing village where children were poor and had alcoholic parents, suffered from poor nutrition, poor hygiene and most of all, were starving for affection. This experience and my personal beliefs in the value of life and solidarity, shaped my career interest in health and psychology, and left a lasting impression that my scientific endeavours should help "solve

real problems" and alleviate suffering among people that needed the most help.

A career in health psychology offers great opportunities to contribute to social justice. My career contribution to social justice has spanned the areas of service provision, education and training, consultancy and professional leadership.

ask the expert

Social Justice: What has Health Psychology Contributed?

As a service provider and clinical supervisor, I had the opportunity to impact diverse underprivileged populations. In the U.S., I developed behavioural medicine services for Portuguese-speaking immigrants who suffered from tremendous victimization, an experience that taught me that contextual factors are key in understanding health behaviour and implementing effective interventions (McIntyre & Augusto, 1999). The health psychologist's role and credibility also relies on expanding beyond the clinical role to the social advocacy arena. In Portugal, I pioneered several theory-based psychosocial interventions in the context of public health services, where more than half of the patient population have less than four years of education (e.g. McIntyre, Fernandes, & Araujo-Soares, 2000). Effective practice requires combining cultural sensitivity with innovation in applying traditional methods of assessment and intervention.

As an educator, I pioneered the development of health psychology in Portugal, training many generations of health psychologists. They have brought the biopsychosocial perspective to an environment where the medical model is still dominant, which empowers patients and fosters more equality in health care delivery (e.g. Sousa & McIntyre, 2008). My teaching often transposed national boundaries. I was privileged to train the first clinical psychologist in Angola, and conduct research on the impact of war trauma on health in young civilian populations (e.g. McIntyre & Ventura, 1996). This work inspired two other important research initiatives. The first one was to co-author the first comprehensive study of PTSD and health consequences of combat stress in Portuguese veterans of the colonial war, a study that became a reference for health policy (Maia, McIntyre, Pereira, & Ribeiro, in press). The second is an outcome study of a psychosocial intervention for women with high HIV-risk, at the province of Beira, in Mozambique, conducted by my PhD student (Patrao, McIntyre, & Veiga-Costa, 2009). All these experiences are examples of how health psychologists can move from local to global focus in unexpected ways as well as to contribute to social justice beyond their immediate milieu.

My role as a consultant produced the most potential for direct impact on policy, fostering social justice by giving voice to different actors in the health care delivery process (patients, professionals, administrators). As a consultant to the northern Regional Health Administration (RHA), I led the first region-wide studies on patient satisfaction, the impact of programs to reduce wait lists for surgery, and professional satisfaction (e.g. McIntyre et al., 2002). I was also a consultant in a matter that is close to my heart, providing a scientific basis for the selection process of adoptive parents and personnel training for the Portuguese National Adoption Agency. The program sought to make the process of adoption more transparent and credible as well as expeditious, thus reducing the social injustice towards the children that await adoption and those that are eager to parent.

Participation in international scientific or professional associations offers great opportunity to contribute to social justice beyond national boundaries. I believe that a scientific society can be a powerful instrument of social justice. Through over 10 years of executive roles at the European Health Psychology Society and with many EHPS Executive Committee colleagues, we worked towards this goal in several ways: (a) by promoting increased equity in health psychology education and training, thus contributing to reduce the great asymmetries in health psychology development that characterize this continent, (b) by promoting local health psychology development through the strategic selection of sites for annual conferences, executive meetings, and other initiatives, (c) by increasing access to conferences, specialty workshops/groups and publications to members from countries that are economically disadvantaged (e.g. reduced fees), (d) by providing leadership opportunities to members from countries that are not mainstream in the EHPS, and (e) by liaison with and representation in regional and world organizations that are advocates for social change.

There is an increasing recognition that health psychology and health psychologists have a social and moral responsibility to contribute to social justice both through the advancement of scientific knowledge and through social action (e.g. Campbell & Murray, 2004). Health psychologists in Europe have the opportunity to demonstrate that health psychology can make a difference to improve equity in health and well-being in Europe and beyond.

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ask the expert

Social Justice: What has Health Psychology Contributed?

Social justice is often seen as an absolute norm: equality (outputs for everyone, independent of inputs). In social psychology, social justice relates not to an absolute norm but a subjective one: people want to be treated in a way they see as representing equity (inputs reflect outcomes). One typical result of equity studies is that people dislike being over-benefitted. Another more negative result of equity studies is blaming of the victim (Jost & Kay, 2010). Equity and equality are not similar.

Social psychologists are merely people. They like to assume that their work contributes to equality. Has our own work contributed to social justice in the world? Social psychologists working in applied research often refer to Kurt Lewin. Mostly because of his remarks on the practicality of theories, but also for this quote:

**Prof Gerjo Kok**

Universiteit Maastricht, The Netherlands

“I am persuaded that scientific sociology and social psychology ... can do as much, or more, for human betterment as the natural sciences have done.” (1948, p. 83).

In that tradition, we have in our research team contributed to a more energy saving driving style of professional drivers, an improved quality of life of patients with diabetes, improved primary prevention of HIV/Aids, less medical consumption in children with asthma; more effective smoking cessation programs; improved environmental conditions for healthy eating; better stress management in children, less stigmatization of people living with HIV/Aids, and etcetera. Some of that work was carried out in developing countries, empowering the target population and training faculty. We also have contributed to the state of the art of understanding and changing behaviour, for example by showing that fear appeals are almost never effective, and that promising alternatives are available. And, finally, we have contributed by diffusing that kind of knowledge (Bartholomew et al., 2011).

Have we done enough? Being familiar with the human tendency for self-justification, we had better not even try to answer that question. Suffice to say that our outcome expectations (as well as our experiential attitude) while doing this work are positive.

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**Dr Wendy Lawrence**

University of Southampton, UK

There is no social justice where health inequalities exist. My work within the Southampton Initiative for Health focuses on improving the health of disadvantaged women. They are more likely to have poor quality diets (Robinson et al., 2004), and we know poor maternal nutritional status leads to poorer growth and development of the fetus and infant, increasing the risk of chronic conditions such as cardiovascular disease and obesity in adulthood (Barker, 1997). My work offers me the opportunity to make a difference by improving the diets of disadvantaged women and their children, thus breaking this cycle of disadvantage and inequality in which generations of UK citizens have been trapped.

I lead the delivery of a training intervention developed from evidence gathered from a programme of research undertaken by myself and colleagues (Lawrence et al., 2009; Lawrence et al., 2011; Lawrence & Barker, 2009). We recognise that the most efficient way of improving disadvantaged women's diets is to support frontline health and social care practitioners who work with them on a daily basis. We are training them to have 'healthy conversations' with the women they meet, modelling what we want to see in their practice post-training (Barker et al., 2011). Practitioners are encouraged to explore their clients' worlds and em-

ask the expert

Social Justice: What has Health Psychology Contributed?

power them to find their own solutions to their problems. As well as empowering the women and increasing their sense of self-efficacy, this approach raises the self-efficacy of practitioners as they see the change in their clients. The training liberates them from feeling they have to find solutions to everyone's problems. Staff working in these settings are frequently drawn from the population with whom they work, further enhancing the ability of the intervention to reduce inequalities.

Supporting change in practitioners will in turn support change in women. A quote from one trainee illustrates the power of the training:

"It's changed my life as well. It made me sit down and think about my life and things I have to change in my life. It certainly has helped me."

From our evaluation work, I know that we have changed the relationship they have with their clients. One trainee reports:

"It got me thinking that people can make up their own minds and have their own ideas; just by asking them open questions, rather than bombarding them with suggestions and ideas yourself, they realise what they can do."

I believe that "a little and often, by many, over time makes a difference". This training is making a difference and in a small way is my contribution to social justice.

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Integrating concern for social justice into research can take place at both the empirical and the conceptual level. A few examples from different stages of my career can illustrate some of this work. In the early 80s I coordinated a large project on smoking among young people. For this I used both qualitative and quantitative methods with the aim of developing an understanding of smoking as being socially and materially located. In articles on this work (e.g., Murray & Jarrett, 1985) I argued against the individualistic victim-blaming approach and for a more social and materialist approach to health promotion to address inequalities in health practices. I referred to Bertolt Brecht's famous poem:

"Too much work and too little food/makes us feeble and thin/Your prescription says/put on more weight/You might as well tell a bullrush/not to get wet."

In a summary volume on this study of smoking (Murray et al., 1988) we further challenged the victim-blaming approach that was commonplace in the newly emerging health psychology. I thought it is useful to quote extensively from this report to give some idea of my thinking at that time:

"In designing our research we criticised the traditional psychological approach adopted by many previous investigators of smoking behaviour. Instead, we preferred a more social psychological approach which concentrated on the character of young people's social interaction and on how they viewed smoking within the context of their own lives. However, in drawing conclusions we cannot ignore the wider societal context within which the young people live and within which smoking occurs. Indeed, as Corrigan (1978) states: *'in so far as we construct our problems apart from society then our conclusions are located outside the political process of change in that society.'*"



Prof Michael Murray
Keele University, UK

ask the expert

Social Justice: What has Health Psychology Contributed?

In the following years I and many others have attempted to different degrees to locate our research on psychological understandings of health and illness within a societal context of increasing social inequalities and also to develop strategies of change within this context (e.g. Murray, 2004). In the early 2000s I helped to convene a working party to develop a more community action approach to health psychology. The basic principles underlying this approach have the desire for social justice as a central theme coupled with a desire to involve health psychologists in various forms of social action (e.g., Murray et al., 2004; Murray & Campbell, 2003). This was taken up further in a recently edited special journal section on poverty and health psychology (e.g., Murray & Marks, 2010). One of our current projects is concerned with promoting greater quality of life among older residents of a disadvantaged urban community through a range of community actions (Murray & Crummett, 2010). While these projects are informed by a desire to promote health and well-being by engaging marginalised groups in a challenge to social exclusion they have illustrated the difficulties of working at a community level and the need to further expand the role of critical health psychology. Elsewhere I discuss this issue further (e.g., Murray, 2011).

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Prof Marie Johnston
University of Aberdeen, UK

Health psychology can contribute to or detract from social justice – we may increase inequalities or fail to benefit the least advantaged by our choices for research and practice. Or we may enhance social justice by developing theory and methods to address behavioural aspects of health and healthcare where there are inequalities of stigma, prejudice and access. I have chosen to focus my applied practice and my research on populations that are relatively neglected by both healthcare and science, especially in the area of disability.

Practice: At an early stage, I chose to deliver psychological services in an area of high deprivation (Johnston, 1978), to people who are dying (Honeyburn, Johnston, & Tookman, 1992; Jones, Johnston & Speck, 1989) and to patients ostracised in the healthcare community (Johnston, 1987). Currently, I supervise two government funded health psychology trainees to develop improved services for behaviour change for people in area of high deprivation; and, for Scottish Government, Diane Dixon and I are developing a framework for defining professional competencies to deliver behaviour change interventions to all populations (Dixon & Johnston, 2010).

Theory: The theories we use can add to social injustice. I have argued that, in health research, explanations for the behaviour of healthcare providers and users differ in a prejudicial way: Healthcare professional behaviour tends to be explained in terms of education and environment whereas patient behaviour attracts deficit and distress theories (Johnston, 2005). In the area of disability, I proposed models of function and activity limitations that could be applied to everyone, elite athletes and people who have severe impairments alike, rather than having stigmatising models of behaviour exclusively for those already disadvantaged by their health condition (Johnston, 1996). Tests of these models demonstrate that the same processes that drive activities in people without impairments are also instrumental in determining activities in people with impairments (Dixon, Johnston, Rowley, & Pollard, 2008). Based on this theoretical approach, we have developed an effective intervention to reduce activity limitations following stroke (Johnston et al., 2007), which has been incorporated into guidelines for the management of stroke (Scottish Intercollegiate Guidelines Network; 2010) and is currently being rolled out throughout the Scottish National Health Service.

While there is ample evidence that gender, social deprivation, age etc. account for variance in health outcomes, the causal processes are poorly theorised. Hannah McGee and I have proposed at least three mechanisms: biological, psychological and environmental and have found evidence for environmental processes associated with social deprivation and gender influencing recovery from activity limitations following MI (Johnston, McGee, Graham, & Macleod, 2002).

Measurement of health outcomes: Assessment of health and healthcare outcomes may introduce inequalities. ►

ask the expert

Social Justice: What has Health Psychology Contributed?

For example, women or people who are socially deprived may appear to have poorer health if the measures assess activities which may depend on access to transport. It is important that the measures do not exaggerate – or obscure – disadvantage. Recent statistical developments allow investigation of differential functioning of items within questionnaires and our work, led by Beth Pollard, demonstrates that even well-accepted measures like the SF-36 may introduce such biases (Pollard & Johnston, 2010).

Intervention: Advances in healthcare interventions frequently result in increased inequalities: Typically the more advantaged are more likely to access the new treatments. Several explanations have been proposed: For example, there is a persuasive case for social identity discouraging access by the more disadvantaged (Oyserman, Fryberg, & Yoder, 2007). Others have argued that health may not take priority in the hierarchy of goals over safety, hunger, social acceptance, etc. Nevertheless, it is possible that some kinds of interventions are more likely to accentuate disadvantage and this remains to be investigated. Dual-processing theories (Strack & Deutsch, 2004) contrast reflective processes with non-reflective, automatic, environmental prompts or cues, methods which are more universally accessible and which have the potential to influence everyone's behaviour. In the context of behaviour change for health, we have identified a wealth of behaviour change techniques which use automatic, prompted or cued methods. However, analysis of methods currently used in health services shows that healthcare staff are trained to deliver many more of the reflective, reasoned behaviour change techniques (Dixon and Johnston, 2010).

Given biases in the delivery of healthcare, enhancing evidence-based practice increases the likelihood that the more disadvantaged will access effective care. Financial incentives used to manage primary care in the UK (Quality Outcomes framework, QOF) have reduced social inequalities in the receipt of healthcare (Ashworth, Medina, & Morgan, 2008). Our recent trial of financial incentives increased the delivery of evidence-based dental practice for children living in deprived areas (Clarkson et al., 2008) and was immediately implemented into policy for the National Health Service in Scotland.

On Reflection: Reducing inequalities has been a major theme for me throughout my career but, like others, I have also had other goals and distractions. In particular I would mention the draw of high tech, innovative medicine. While I have always worked on disability (Williams, Johnston, Willis, & Bennett, 1976), I have also done work in more high tech areas including IVF and surgery, but made a conscious decision to reduce that area of my research to focus more on the less popular, under-researched area of disability. When asked to give keynotes I have always had disability as a major theme, hoping to enhance the status of this area by giving it a prestigious platform. Also, when interviewed by journalists, I have frequently managed to introduce issues of social injustice e.g. the disabling architectural design of homes. There are key points in one's career when choices are made, many at an early stage, but one may also have opportunities to refocus in line with one's values at later stages.

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Some reflections

The contributions reflect a rich diversity of answers. Our "grey beards" have demonstrated that the answer to how we can all contribute to social justice lies in different places; the political, the personal, the economic, the civic and the ability to seize an opportunity when presented with one. The contributions should be mandatory reading for the next generation of health psychologists. "Doing" social justice is not easy, and this is as it should be. Questions of social justice force us to answer questions about values, and it's easy to lose sight of values when we are struggling to be tenured or publish in good journals. That said, social justice will fail to capture the imagination of the next generation of health psychologists unless it is associated with a significant incentive. Personally speaking, I would like to suggest that we need to chain social justice to the bigger question of why we keep failing to show ethical leadership in public about psychology. We either allow psychology to be sold cheaply by non-psychologists or, in extreme cases; we allow psychology to become the tool of governments for interrogation ►



Dr Anthony Montgomery
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ask the expert

Social Justice: What has Health Psychology Contributed?

and torture (Pope and Gutheil, 2009). Maybe this is what Michael Murray meant when he suggested that we have a weak ego?

Let's look forward. At the beginning of the 21st century, social network sites have replaced news and media as the authentic voice of people. Facebook, if it were a country would be the 3rd most populous country on the planet. Increasingly, Facebook and Twitter probably do more for social justice than we can, simply by giving individuals a voice that they control and regulate. Obviously, social justice is not their vision, but they offer people the first steps to feelings of equality and equity. Social network sites are designed so as to maximise the positive projections that individuals can receive from others, which is quite an incentive. Recently published research about Facebook usage showed that doctors, with profiles on Facebook, are being contacted (poked/tweeted) by their patients (Jain, 2009; Moubarak, Guiot, Benhamou, Benhamou, & Hariri, 2011). Such technology changes the doctor-patient relationship beyond recognition. It would be interesting to ask where such behaviour fits in the illness perception continuum or Theory of Planned Behaviour! But seriously, the success of online social networks tells us something very important; people can be highly motivated to disclose, regulate and self-manage information about themselves without significant behavioural interventions. At present, it may be mostly about their cat and their 21st Birthday party, but industry and business has already seen the potential. When will we?

Finally, I haven't answered the question that I posed myself. This reflects my humility. However, rather than wondering what social justice is, I would be very curious to ask our contributors the follow-up question:

"How would the world have to change for your vision of social justice to be realised?"

...but that is probably a question for a sandy beach, good wine and a Greek sunset. ■

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ask the expert

Social Justice: What has Health Psychology Contributed?

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