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Living in a Material World: Reflecting on Some Assumptions of Health Psychology

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AS WE ENTER the 21st century a major challenge for health psychologists is to reflect on the adequacy of our theories and methods for improving the health of the world's masses. While many of us may think that our theories developed in the quiet of the academic seminar room are at least benign, the evidence suggests that this may not be the case. For example, in a recent review Waldo and Coates (2000) considered the role of behavioural science, and implicitly of health psychology, in the worldwide programme to develop a strategy to halt the spread of AIDS, the most relentless infectious disease that has led to the deaths of millions in the developing world. They argued that the very theoretical assumptions of health psychology have actually hindered attempts to control this epidemic. Through persistently directing attention towards the individual level of analysis in explaining health-related behaviours, health psychology has contributed to masking the role of economic, political and symbolic social inequalities in patterns of ill-health, both globally and within particular

countries. Thus, while some health psychologists may laud the innovativeness of subtle changes to the basic social cognition models of health behaviour it can be argued that these very models may actually be hindering attempts at improving health.

Prilleltensky and Prilleltensky (this issue) raise the seriousness of the need for considered reflection by health psychologists and begin to develop an alternative strategy based upon exploring opportunities for critical practice at different levels of intervention. They distinguish between individual, group and organizational and community and societal levels of analysis and intervention. In this short commentary piece we wish to extend this reflection to highlight the broader political forces within which health psychology is shaped and is practised. In particular, we focus our attention on the material dimensions of health and illness and the issues of social inequality and poverty. This critique is discussed more extensively elsewhere (Murray & Campbell, 2003). In addition, other challenges to mainstream health psychology have been developed previously (e.g. Campbell & Jovchelovitch, 2000; Murray & Chamberlain, 1999).

World of poverty and suffering

Those of us who have the good fortune to live and work in western academic institutions often forget the misery and sorrow experienced by countless millions throughout the world and upon whose very deprivation western wealth is built. While there have been dramatic improvements in the health of the world's population during the past century many millions still lead a life condemned to poverty, war and disease.

According to the World Health Organization (WHO) around 20 per cent of the total world's population (1300 million people) live in absolute poverty with an income of less that US$1 per day. Further, as many as half of the world's population lives on US$2 per day and this figure is rising (WHO, 1999). While this horrendous level of poverty is largely confined to Africa and Asia the

development of these countries is intimately linked to political and economic developments in western society.

Currently the popular ideology of the West is neoliberalism that is espoused by politicians of the liberal left and right. Its so-called middle or third way conceals its desire to further advance the interests of large corporations. As McLaren and Farahmandpur make clear:

> [It] refers to a corporate domination of society that supports state enforcement of the unregulated market, engages in the oppression of nonmarket forces and antimarket policies, guts free public services, eliminates social subsidies, offers limitless concessions to transnational corporations, enthrones a neomercantilist public policy agenda, establishes the market as the patron of educational reform, and permits private interests to control most of social life in the pursuit of profits for the few. (2000, p. 25)

With the collapse of totalitarian regimes in Russia and Eastern Europe it has seemed that the ideological debates of the past were over and that capitalism in its new reformed guise had emerged triumphant (Fukuyama, 1993). But what has this meant to the masses throughout the world. In the western world we have a steady increase in social inequality and poverty and in the developing world we have seen increasing levels of poverty.

A sustained research effort over the past two decades has documented the clear relationship between poverty, social inequality and poor health. The WHO (1999) statement summarized a selection of the findings:

> 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. Differences in maternal mortality are even more dramatic: the lifetime risk of dying in pregnancy in parts f sub-Saharan Africa, where almost 50% of the population live in absolute poverty, is one in 12, compared to one in 400 in Europe.

However, these linkages between poverty and ill-health are not confined to the developing world. Neither is it simply absolute poverty but the unequal distribution of wealth in society that is linked with measures of ill-health. Reports from advanced industrialized nations have shown that as the inequalities in wealth increased in the 1980s and 1990s so too did measures of ill-health (see Denny, 2001).

In a recent review of the debate between those who focus on poverty and those who focus on inequalities Gwatkin (2000) has argued that important though this debate may be it is vitally urgent that we link further analysis with action to reduce poverty and inequalities and to improve health. He concluded that it is time for 'health professionals [to be] prepared to enter the political forum on behalf of social and economic equity, rather than limiting themselves simply to work within the health sector' (2000, p. 6). But what does this mean for health psychologists?

Some assumptions of psychology

Psychology is a creature born of 19th-century individualism and positivism. It is also a discipline that historically has allied itself frequently with those who favoured sexism, racism and other forms of social oppression (Louw, 1997). Health, illness and suffering have been defined as something that belongs to the individual. Our theories are designed to define our very subjectivity as an asocial experience. The extraction of suffering from the social context within which it develops pits the researcher as separate from the sufferer.

The study of language and discourse has attracted substantial recent interest among some health psychologists looking for a way out of the blind alley of measurement and objectivity. However, there is a danger that this sustained concern with language can divert attention from the broader material issues. To quote McLaren and Farahmandpur again:

> Like graffiti sprayed across the tropes and conceits of modernist narratives, postmodern theory remains a soft form of revolt. It constitutes a transgression

> of the 'already said' in the name of the 'unsaid'. Slouching under the Promethean hubris of the metropolitan cognoscenti, postmodern theorists privilege the poetics of the sublime over the drab flux of quotidian existence; evanescent immateriality over the materiality of lived experience; the imponderability of representations over the historically palpable concreteness of oppression; the autonomy of cultural and political practices over the political and economic determinations of capitalism; fashionable apostasy over the collective ideals of revolutionary struggle from below (*'bas materialisme'*); the salubriousness of aesthetic subversion over revolution; the bewitchment and exorcism of signs over the class struggle that shapes their epistemological character; transgressive pedagogy over the pedagogy of revolution. (2000, p. 31)

Of course, not all those concerned with language can be tarred with this dismissive brush and many of them (e.g. Parker, 1992; Willig, 1999) have been actively engaged in attempts to define a critical agenda for psychology. For example, their work has played an important role in exposing the individualistic roots of mainstream psychology and in highlighting many of the ways in which various discourses have served to legitimize oppressive and unjust social relationships. However, more work needs to be done to connect this focus on language with the possibility of concrete social action in the interests of reducing poverty and health inequalities, and increasing social justice. Or as Hook (2001: 542) concludes 'without reference to materiality (as evidenced in the work of Parker [1992] and Potter and Wetherell [1987]), discourse analysis remains largely condemned to the "markings of textuality", a play of semantics, a decontextualized set of hermeneutic interpretations that can all too easily be dismissed'. While not ignoring the importance of language in constituting health and illness (e.g. Murray & Flick, 2002) we would seek to place the material world more squarely at the centre of the debate about the future of health psychology.

Re-orienting health psychology

Health psychology needs to be a call to action. Through the very process of understanding social suffering it must provide a means to alleviate such suffering (Kleinman, Das, & Lock, 1997). Thus we move from the standpoint of the detached observer to that of the socially committed. This means that the debate about methodology becomes subservient to the broader concern about the potential impact our research can have in improving the quality of life of the many. As Eliot Mishler (Mishler & Steinitz, 2001) emphasized in a recent conference presentation:

> The basic issue in regard to whether or not our studies can be useful in the struggle for social justice does not have to do with reliability or validity of our methods—nor . . . with whether we do qualitative or quantitative research. Rather it has to do with the form of relationship we establish with the groups and movements with whom we ally ourselves, the nature of our collaboration with them in carrying out our studies, and how we negotiate ways to combine our different interests to make our findings useful and relevant to our shared political aims.

Our argument is that health psychology needs to re-position itself as a discipline that sides clearly with the interests of the oppressed and disenfranchised masses, whether that be the residents of inner city Chicago or the millions currently facing famine in sub-Saharan Africa.

The role of critique and action can take many forms from active engagement in movements for social change through to theoretical exposure of the assumptions underlying much contemporary psychological practice. It is respect for this diversity of strategies that is important and the desire to contribute to the broader movement for social justice and health on this planet. It is important to challenge the dominant ideas of the discipline and to expose how not only do

they individualize and reductify health and illness and ignore social deprivation but that they also position health psychology on the sidelines of the movement to improve health.

Defining strategies for health

The WHO (1999) has identified four broad strategies for combating poverty and promoting health. They provide a starting point for developing a more politically engaged health psychology. We briefly consider the potential role of health psychology within each of these broad strategies.

Act on the determinants of health by influencing development policy

The WHO has emphasized that a key component of this strategy is to promote a more equitable distribution of economic wealth. In their research role health psychologists can contribute to exposing the negative impact of widening social inequalities on health throughout the world. For example, they can contribute through tracing the psychosocial processes whereby adverse social circumstances undermine the very possibility of health, both through reducing the likelihood of health-enhancing behaviours as well as impacting more directly on the body. In their advocacy role they can seek to translate these insights into action through participating in social movements to promote a more socially equitable society. As David Werner stressed at the Global Assembly on 'Advancing the Human Right to Health':

> In [the] last analysis, to ensure health as a human right, the whole globalized market system—with its by-product of increased poverty and ill-health—needs to be reexamined, regulated and eventually transformed so that [the] well-being of the people and the planet becomes a top priority. (2001, p. 7)

Reduce risks through a broader approach to public health

This includes not only improving access to basic public health services, safe and adequate food and water but also release from the many forms of social conflict and the consequences of natural disasters. The WHO also calls for the promotion of healthy cities, workplaces, homes and schools. Health psychologists can participate in both research and action in all of these arenas. They can work with communities to expose the current inadequate living conditions and services and campaign with them for improvements.

Focus on the health problems of the poor

Rather than ignoring the social inequalities in health there should be a deliberate focus on the health problems of the politically and economically oppressed. Martín-Baró (1994) in his articulation of a liberation psychology defined this as adopting a 'preferential option for the poor'. By this he meant that psychologists need to begin to develop theories and methods that can enhance the capacity of oppressed and marginalized groups to change their living and working conditions and so their health and that of their families and communities. However, this does not mean restricting ourselves to concern for the interests of the poor as a group separate from society but rather health psychologists need to consider themselves as participants in a broader movement for social change and the eradication of poverty. As Kenneth Anderson asserted in a recent review of the limited role of non-governmental organizations in resisting the rampage of globalization throughout the developing world: 'The history of modern Europe is littered with local peasant risings, guild revolts and religious movements that took the side of the poor. They all failed' (2002, p. 8). The challenge for health psychologists is to explore how to connect local and community efforts to mobilize resistance to social oppression to broader national and international movements.

Ensure that health systems serve the poor more effectively

By this the WHO meant that healthcare should be designed to ensure access irrespective

of income and that it treats clients with dignity and respect. In the public arena this means that health psychologists have the social responsibility to resist attempts to dismantle universally accessible healthcare systems and instead to participate in campaigns to ensure that health facilities and professionals are widely available and accessible especially in those communities where there is greatest need. Health psychologists also have a key role to play in exposing the way in which people's access to healthcare is undermined by socially or culturally incompetent services characterized by various forms of differential access, cultural differences, racism or communication barriers.

Not a conclusion

The fact that we are actually writing this commentary is a clear indication that health psychologists are seriously reflecting on their discipline and attempting to articulate theories and methods so that they can participate in the broader movement for social justice and health. Different psychologists will develop different strategies. As Martín-Baró emphasized:

> If it is not in the calling of the psychologist to intervene in the socio-economic mechanisms that cement the structures of injustice, it is within the psychologist's purview to intervene in the subjective processes that sustain those structures of injustice and make them viable. (1994, p. 45)

Martín-Baró's challenge for critical health psychologists is a strong one. Much work remains to be done in developing *actionable* understandings of the complex individual–society dialectic underlying social inequalities. Such understandings should aim to do more than theorize the way in which subjectivities are implicated in broader structures of injustice. These theorizations need to be developed in ways that point towards the possibility of challenging and reshaping these mutually reinforcing subjectivities and structures that are damaging to the health and well-being of people. Each of us has a role to play.

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