PART I

THE BACKGROUND TO COMMUNITY PSYCHOLOGY AND WHAT IT STANDS FOR

Chapter 1
CHALLENGING PSYCHOLOGY OVER ITS NEGLECT OF THE SOCIAL

THE INDIVIDUALISM OF PSYCHOLOGY

Community psychology is about the social context of people's lives. The word 'context' in that statement is used in its broadest possible sense. In the pages of this book we shall touch on topics such as income distribution, social class, work conditions, and people's sense of community. Each of those is deeply psychological. All the time we shall be thinking of people in collectives, and the ways in which those collectives are disempowered and how they can become empowered. That ought, or so it seems to the present author, to be at the very heart of psychology. Yet nothing could in fact be further from the case. Psychology, at least in the form taken in those countries – the richer ones – that have led the discipline, has taken a very individualistic route. Psychology has laid itself open to the challenge that it has neglected whole domains of its legitimate subject matter. There have been many critics of that position from within psychology itself, and their voices have been growing louder and more numerous. Let us hear what some of them have said.

Among the critics is Bruner (1990) who wanted to see the development of a new, "meaning-centered, culturally oriented psychology" (p. 15). He pointed to the disappointing way in which the cognitive revolution in psychology – a reaction to the dominance of purely behavioural explanations grounded in animal models of learning, experimental methods, and a distrust of what people *say* as opposed to what they *do* – had in the event been routed towards an emphasis on individual information processing, with computation as the ruling metaphor. Bruner argued that a human psychology based on the individual alone was impossible, and that studying *shared* meanings and concepts and modes of discourse was essential for understanding our culturally adapted way of life. He accused much of psychology of displaying an anti-historical, anti-cultural, and even anti-intellectual bias. He saw psychology as having remained isolated from recent currents of thought in neighbouring disciplines, attributable in part to psychology's stubborn

anti-philosophical position. Glenwick *et al.* (1990) also viewed much academic psychology as being intellectually out of date:

> . . . in the academic psychology department, current research practice appears grounded in a way of thinking – logical positivism – that antedates postmodernism. Its dominant attributes are familiar: (a) the experimental method as the only way of knowing; (b) an experimenter who studies 'subjects'; (c) an environment that is typically controlled and artificially manipulated; (d) a process that is 'objective' and seemingly value-free; and (e) a focus that is short-term and interested in a single, or very few, points in time (p. 86).

One effect had been that psychology had not played the role that it might have done in commenting critically on the way society is organised.

> Intellectuals in a democratic society constitute a community of cultural critics. Psychologists, alas, have rarely seen themselves that way, largely because they are so caught up in the self-image generated by positivist science. Psychology, on this view, deals only in objective truths and eschews cultural criticism (Bruner, 1990, p. 32).

Rapley *et al.* (2003) put that point even more pungently:

> . . . psychology has largely abandoned any pretence it might once have had to stand for social justice or the rights of the poor, the miserable and the dispossessed (p. 17).

Even social psychology, which might have been expected to have taken a lead in moving beyond an exclusive focus on the personal, has often been surprisingly individual-centered. Hepburn (2003) has described how social psychological studies in the USA in the years after the Second World War, carried out by people such as Allport, Sherif, Asch, and Milgram, who had lived through the depression of the 1930s and the war, and who were often refugees from Nazi persecution, had been motivated by concern with oppression and exploitation (carrying out studies of prejudice, conformity, and obedience, for example), but had later lost track of those big themes, moving away from the 'social' towards the 'individual', and producing what came to be known as the 'crisis in social psychology'. The area of social cognition, for example, has used experimental methods to understand how individuals make social judgements, for example about members of different ethnic groups. The focus has been on establishing general principles about social perception irrespective of the specific context (Marková, 2003).

Himmelweit (1990) and Bar-Tal (2000) are among other European social psychologists who have been critical of the cognitive and individualistic bias of social psychology, particularly in the USA. In Bar-Tal's view, European social psychology, notably Moscovici's (1972, 1984) influential notion of social representations, and Tajfel's (e.g. 1981) social identity theory, had restored to the discipline an interest in macro-social or societal questions that had been promised by the founders of the discipline decades earlier: for example by Wundt (1916), Durkheim (1933) and McDougall (1939), with their notions, respectively, of folksoul, collective representations, and group mind (as Jahoda, 1982, pointed out, psychology was in its earliest days much more closely connected with anthropology that it was later on). Bar-Tal's (2000) interest was in what he called 'societal beliefs', which serve the functions

of providing members with knowledge about the society, maintaining social and individual identity, preserving the existing societal system and structure, and motivating and guiding societal action. Consequences might be positive or negative. Among the latter were: the maintenance of a very unequal societal power structure; and the preservation of negative stereotypes about other groups and their members. Himmelweit (1990) proposed a whole new sub-discipline that she referred to as 'societal psychology', which would emphasise the, "... all-embracing force of the social, institutional, and cultural environments, and with it the study of social phenomena in their own right as they affect and are affected by the members of the particular society" (p. 17). Such a psychology would study the socio-cultural context in which people live and act, would draw on a variety of disciplines and theories, would involve taking a historical perspective that is so often lacking in psychology, and would use a multi-level systems approach, combining micro and macro levels of study.

The French psychologist Doise (1986) is among others who have drawn attention to the surprisingly asocial nature of much social psychology. He distinguished the four levels of analysis shown in Figure 1.1: the *intra-personal*; *inter-personal/situational*; *positional*; and *ideological* levels. He believed that Lewin (e.g. 1951) – regarded by some as the originator of community psychology – had been at pains to develop a social psychology that studied the articulation of the individual and the collective, or what Durkheim called the socio-psychical, but that those who followed him had retreated to the first two levels. Much of social psychology had remained at those levels. Another critic, Burkitt (1991), wrote:

> The view of human beings as self-contained unitary individuals who carry their uniqueness deep inside themselves, like pearls hidden in their shells, is one that is ingrained in the Western tradition of thought ... [this] image of humans ... is totally inappropriate for the study of personality. In order to truly understand the human self, [this] vision of humans ... must be dispensed with (pp. 1, 189).

In an attempt to build a better vision of the human self, Burkitt drew heavily upon the writings of George Herbert Mead, whom he described as a philosopher and social psychologist. Mead's theory was that human nature was social, conditioned by the social group from the earliest moments of life and developing in transaction with it throughout life. Individual personality had no meaning taken out of the context of one's social group. It is interesting to note that Mead is often thought of within psychology as a sociologist – a good measure of the extent to which psychology has become over-focused on the decontexualised individual and how social views of human nature have become marginalised within psychology.

Burkitt criticised Mead, however, for saying nothing about society and about social divisions and inequalities within it. As a corrective he drew equally heavily on the writings of the French Marxist psychologist, Lucien Sève. Like Mead, Sève saw personality as constantly shaped by, although never totally constrained by, the present-day system of social relations which have developed in the past up to the present day – a form of historical structuralism. Most of us were unaware, most of the time, how our actions and ways of thinking are shaped by social circumstances: we assume we are free agents – rugged individualists. In particular we are unconscious of the power relations that constrain us and shape our personalities and the ways we interpret and cope with adversity. Some have posited a 'structural

The Intra-Personal Level

Theories at this level, "describe how individuals organise their perception, their evaluation of their social milieu and their behaviour within this environment. In such theories, the interaction between individual and social environment is not dealt with directly, and only the mechanisms by which the individual organises her/his experience are analysed" (Doise, 1986, p.11).

The Inter-Personal and Situational Level

This level is, "concerned with inter-personal processes as they occur within a given situation. The different social positions occupied by individuals outside this particular situation are not taken into account… The object of study is the dynamics of the relations established at a given moment by given individuals in a given situation" (p. 12).

The Positional Level

"Differences in social position which exist prior to the interaction between different categories of subject" (p. 13) are brought into the picture at this level. For example pre-existing differences in socioeconomic status, gender differences, or ethnic group membership, might be taken into account in trying to understand people's subjective experience or ways of interacting.

The Ideological Level

At the fourth level, analysis goes further to take into account the "systems of beliefs and representations, values and norms, which validate and maintain the established social order" (p. 15), which are widely shared within a given culture or society, and which powerfully influence a society's institutions.

Figure 1.1 The four levels of analysis in social psychology according to Doise (1986)
Source: Doise W. (1986, originally in French, 1982). *Levels of Explanation in Social Psychology*. Cambridge, UK: Cambridge University Press

unconscious' (Lichtman, 1982, cited by Birkett) paralleling the psychic unconscious. Indeed one might say that psychology as a subject was structurally unconscious, showing little awareness of the, "…social contexts in which people learn and in which they act, nor about the effect that social structure may have on the shaping of predispositions of the personality" (Burkitt, 1991, p. 19). Hence, according to Mead, Sève, Burkitt, and others, "Socio- and psycho-genesis are…two processes which are inextricably linked…" (Burkitt, p. 180). Yet so unconscious are we of the social part of the equation that we are ever ready to individualise or psychologise problems that are, in the true sense of the expression, psychosocial. The theme of consciousness about social conditions that affect us is one that will recur many times later in this book.

A strong voice, raised in support of the same position, has been that of Prilleltensky. In his book, *The Morals and Politics of Psychology* (1994), he had a chapter entitled Abnormal Psychology in which he traced the development of the field over the previous 40 years. He saw a progression having taken place from an *asocial* approach, through an enhanced awareness of *micro-social* elements, to an increased alertness to the *macro-social*. In the asocial approach problems are formulated in terms of individual defects:

> The medical model, in either its organic or psychodynamic version, captures the essence of the asocial stage . . . Environmental factors are not entirely disregarded, but they are given only secondary priority and remain largely in the background . . . the individual is too frequently dissociated from the wider systems of society that shape her or his behaviour extensively, thus creating an ahistorical and asocial image of individuals (pp. 99, 100, 102).

Discussing the micro-social stage in the development of abnormal psychology, Prilleltensky referred to the systemic model of psychological problems as one that had raised expectations that it would address social systems on a number of levels, from the micro-system of family to macro-social and macro-social–political levels. In fact, after radical beginnings in the 1950s and 60s, when it challenged a uniform benign view of the family, it had become entrenched in forms of family therapy that at best were ambiguous about the social structural influences on family life, and at worst perpetuated a psychopathological model, appearing to blame the family unit rather than just individuals. Family therapy, in Prilleltensky's opinion:

> . . . portray[s] the family as the main generator of certain kinds of dysfunctions and omits the fact that the family is very much a product of social forces. Family therapy's analysis is reductionistic . . . By depicting the family as a central perpetrator in the infliction of psychological distress, attention is deflected from macrosocial conflicts that may actively shape and perpetuate the mental health of the population as well as that of the individual and his or her family (Prilleltensky, 1994, p. 112).

Prilleltensky went on to consider whether community psychology had been successful in addressing macro-social and macro-social–political levels, concluding that although steps had been taken in that direction, it was, ". . . still too attached to the comforts of the academic world to venture into the uncertainties of the political arena" (p. 115). In part that was attributable to community psychologists using in their studies variables such as social class or ethnic group, without taking their analyses further. The same criticism was made by Bronfenbrenner (e.g. 1988) who referred to that kind of analysis as using a 'social address model', that is assigning people a social 'address' but without paying attention to what the environment was like at that address – what people's experiences were there and what activities were taking place. Whether community psychology has advanced since then may perhaps be judged by the contents of the remainder of the present book. Certainly Prilleltensky (1994) was of the view that we needed to look to such movements as feminist psychology and the politics of psychiatric consumers and survivors in order to see how the macro-social–political level could be addressed.

Self-Efficacy and Other Individualised Concepts

Nothing illustrates better the individualistic bias of psychology than its preoccupation with individual personalities abstracted from the settings and collectives of which people are a part. From a community psychology viewpoint, the disappointing thing is that concepts are often treated in psychology as if they were solely to do with individual personality, when they might, with a bit of development, serve well as useful concepts for understanding the psychological contexts of people's lives. Examples we shall briefly consider include locus of control, social support, stress, and vulnerability. Paramount in the legion of personalised concepts has, of course, been the 'self', and the many related ideas – self-esteem and self-confidence for example – all treated, in the hands of psychologists, as personal, decontextualised concepts (Bruner, 1990; McKenna, 2002).

A form of the 'self' idea that has been hugely popular in psychology is that of 'self-efficacy' (Bandura, 1977). Franzblau and Moore (2001) analysed the concept from a community psychology perspective. They argued that the concept was derived from a view of the self that stressed autonomy, self-reliance and independence. Change was a question of modifying one's personal beliefs so that one could attain a particular outcome. Both successes and failures were self-made according to that formulation. It derived, according to Franzblau and Moore, from a western view of individual responsibility that supposes that adversities can always be overcome by correcting dysfunctional individual ways of thinking or behaving. That ignores, they argued, the systems of social support that may or may not exist to help an individual action including: economic support for completion of the task; social/emotional and institutional support for engaging in the task and feeling confident about it; whether or not the person has the education and training to do the task; and ideological support embedded in cultural and political expectations of success for someone of his or her sex, ethnic group, or socioeconomic status. It assumes that action is individual in the face of adversity, rather than collective. These social resources remain hidden in self-efficacy studies which only measure the confidence of individuals. When self-efficacy fails, there is every likelihood of 'blaming the victim' (Ryan, 1971). It, "... leaves the ideological, economic, political, institutional, and legal structures of control intact, while the blame for continuing oppression is placed on dysfunctional thinking of the oppressed" (Franzblau & Moore, 2001, p. 94). In later chapters (particularly in Parts III and IV) we shall meet several examples of people blaming themselves for circumstances that are not of their own making (e.g. Bond *et al.*, 2000).

In fact, Bandura (1995) refuted the charge that self-efficacy theory ignored social structural factors, or – another criticism levelled at self-efficacy – that it was of little relevance in less individualistic societies. But, however much he insisted otherwise, the emphasis remained on individual personal beliefs, the exercise of individual agency, personal mastery, and experiences of personal change. Although he introduced the concept of 'collective efficacy', his discussion of that concept actually focused on the many ways in which it could be undermined. He was also suspicious of the idea that how families felt about their communities reflected objective economic conditions rather than their personal sense of efficacy. Nevertheless, the

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idea of collective efficacy (or what Hobfoll *et al.*, 2002, termed 'collective-mastery') could be considered close to the concept of collective empowerment (to be discussed in Chapter 2), suggesting that efficacy need not remain a purely individualistic concept.

Another popular construct in psychology, also treated as a personal trait, has been 'locus of control' (LOC: Rotter, 1966). It has been treated that way despite its roots in social learning theory, and some developments of the idea that suggest it might have something important to offer community psychology. One of those developments was the recognition that LOC was a multi-dimensional concept and that one dimension was a greater or lesser belief that the world was controlled by 'powerful others'. Some people held views about control suggesting that they were structuralists, believing that societal determinants of behaviour were paramount, while others, who stressed external control, were fatalists, seeing outcomes as dependent mainly on luck, fate or chance (Furnham & Steele, 1993). Another development was the recognition that a person's beliefs in control might depend upon the context, leading to domain-specific measures of LOC (Furnham & Steele, 1993). Others have shown that control beliefs are related to social class and to income (Lachman & Weaver, 1998; Wardle & Steptoe, 2003). Challenging collective beliefs in fate is an important idea in liberation psychology (Martín-Baró, 1994), as we shall see in Chapter 2. Despite those intriguing possibilities, LOC has remained essentially a personal trait concept.

Social support is another such idea. It has been very popular in the field of social psychology and health (Cobb, 1976; Sarason *et al.*, 1990) but, once again, in psychology we have tended to individualise it. We have been inclined to see it in terms of the network of individual supportive people surrounding an individual focal person (Orford, 1992). We have not found it so easy to handle the idea that a person might get support from groups or from settings (Felton & Shinn, 1992), and we have been slow to take advantage of developments in network analysis (Scott, 2000) that treat individuals or groups as parts of interacting networks rather than as foci of individual network diagrams. Arguably the greatest failing of the way in which social support has been used in psychology has been the failure to consider the way in which it relates to questions of influence and power, and empowerment. Social support has been treated as if it were power-neutral. Perhaps because its use has been limited in that way, it can be argued that it has now been somewhat superseded by the more embracing concept of 'social capital'. The latter idea, which will be dealt with at some length in Chapter 6, is better able to deal with the 'vertical' (more powerful–less powerful) as well as the 'horizontal' (between equals) aspects of social relationships.

Another concept that has been ubiquitous in modern psychology is 'stress'. The way in which it has been dealt with has been roundly criticised by Hobfoll (1998). His argument was that we had individualised the idea of stress by the emphasis in stress theory on the way in which an individual appraises his or her circumstances (as in Lazarus & Folkman's, 1984, influential theory). It is as if there is no objective reality out there in the world, only each separate individual's perception, appraisal, or understanding of it. We had lost sight, he argued, of the social context of stress. Particularly if we share a set of social and cultural norms, we know what is stressful

and what is not, and we do not need to resort to perception at the individual level in order to know it. He shared the view of Brown and Harris (1989) that, provided enough detail was obtained about stressful events or circumstances and about the context in which they took place, then another person who shared the same culture (a trained research interviewer in the case of Brown and Harris's research on women and depression – see Chapters 4 and 8), could objectively rate the degree of stress, independently of the person's emotional response and the ease and difficulty of coping.

Hobfoll's own theory of stress, which is of considerable relevance to community psychology and bears some similarity to notions of power and empowerment that we shall meet in the next chapter, was that stress occurred when people's resources, necessary for survival and achievement of goals, were lost or threatened. By resources he had in mind a wide range of things, some of them familiar topics of study in psychology, others neglected. As well as *personal resources* such as occupational skills, leadership ability, self-esteem, and self-efficacy, they included what Hobfoll called *object resources*, such as home, household possessions, and transportation; *condition resources*, such as health, employment, seniority, and marriage; and *energy resources* such as money, credit, and knowledge. Hence, unlike much of psychology, Hobfoll's conservation of resources theory gives material resources and social roles a prominent place. The central tenet of the theory is that, "... people work to obtain resources they do not have, retain those resources they possess, protect resources when threatened, and foster resources by positioning themselves so that their resources can be put to best use" (Hobfoll, 1998, p. 55). Because resources are widely valued but often finite, social conflict over resources is a principal source of stress. Individuals and groups with fewer resources are, according to the theory, more vulnerable to further resource loss or threat of loss. Hobfoll emphasised that the notion of possession of resources, motivation to conserve them, and stress occasioned by their loss or threat of loss, could be applied to groups, organisations and communities as well as to individuals. Indeed the need to gain and preserve resources tied individuals into their social groups (although much of the time Hobfoll described the theory as if it were a theory of individual stress).

The tendency to psychologise is not limited to trait terms popular in psychology. Boyle (2003) considered the way in which the term 'vulnerability', popular in political and policy-making circles, was used as an expression, not wholly complimentary, to focus attention on vulnerable individuals, hence diverting attention away from, "... the potentially damaging activities of relatively more powerful social groups" (p. 29). She provided a telling list of pairs of statements, including most of those shown in Table 1.1 (I have added some with which I am familiar from my own work): statements on the left are about the vulnerability of groups of individuals, the paired statements on the right being translations into relational statements focusing on the perpetration of abuse towards those groups.

This proneness to individualise – we might call it psychology's 'default option' – is ever-present and we need to be always on guard against it. Many examples will crop up in later chapters. In the following chapter we shall see that even 'empowerment', which has been a key concept in community psychology, is itself not immune from the individualising tendency.

Table 1.1 How the language of vulnerability diverts attention from oppression

Statements of vulnerability	Statements of oppression
Old people are vulnerable to hypothermia	The government doesn't pay a high enough state pension for old people to pay their heating bills
People from ethnic minorities are vulnerable to racial discrimination	White people discriminate against black people
Lone women drivers are vulnerable at night	Men attack women when they are less likely to be seen
Unassertive people are vulnerable to being bullied at work	Managers in some workplaces pick on weaker employees
School dropouts are vulnerable to developing problem gambling	Gambling operators make money out of the socially excluded

Source: based on Boyle, M. (2003). The dangers of vulnerability. *Clinical Psychology*, **24**, 27–30, Table 1

The Individualism–Collectivism Dimension

Individualised concepts may be the result, as Burkitt (1991) supposed, of the dominance of psychology by western nations, particularly the USA. Hobfoll (1998) made the point that most psychological studies have been carried out in cultures that value individualism, and many with middle-class, youngish adults as participants. Hence the danger is that much of psychology has focused on the very people who might be least dependent on collective resources and action. While concepts such as self-efficacy had been popular, those such as honour and self-sacrifice – more important in collective cultures – had been much less often studied. Indeed a leading idea in cross-cultural psychology has been the concept of *individualism* versus *collectivism* (Hofstede, 1994; Triandis, 1994; Kemmelmeier *et al.*, 2003). Some cultures – the more individualistic ones – are ones in which the self is defined more individually, where personal goals are a priority, where there is a relative emphasis on contractual relationships, and individual attitudes are important. In others – the more collectivistic – the self is defined more collectively, group goals have greater priority, the emphasis is on communal relationships, and social norms are more important (see Table 1.2).

In fact the matter is rather more complicated than that. For one thing it has been a repeated finding that there is a strong association between the relative affluence of a country – as indexed by, for example, GNP, calorie supply per capita, or per capita energy consumption – and the value placed on individualism (Schwartz, 1994; Georgas *et al.*, 2004). Furthermore, different forms of collectivism have been identified, depending on the nature of the collective that is most salient in a particular culture. In some cultures, *mestizo* Mexico for example, the family is all-important and the culture is often said to be one characterised by familial collectivism. In eastern European countries that until l989 were part of the Soviet bloc, the term 'collective' has a different meaning; for many it has negative associations left over from the era in which individuality is seen as having been subordinated to the goals

Table 1.2 Some of the main distinctions between individualistic and collectivist cultures

Individualistic	Collectivist
Self is defined as an independent entity	Self is defined in terms of in-groups, relationships
Change the situation to fit the self	Change the self to fit the situation
Emotions tend to be self-focused (e.g. anger)	Emotions tend to be other focused (e.g. empathy)
Focus on own needs, rights, capacity (contracts)	Focus on the needs of the in-group (obligations)
Favour beliefs reflecting independence, emotional detachment	Favour beliefs reflecting interdependence
Value pleasure, achievement, competition, freedom, autonomy, fair exchange	Value security, obedience, duty, in-group harmony, personalised relationships
Less willingness to self-sacrifice for the group	Self-sacrifice for the group is natural

Source: adapted from Triandis, H.C. (1994). Theoretical and methodological approaches to the study of collectivism and individualism. In U. Kim *et al.* (eds), *Individualism and Collectivisim: Theory, Method, and Applications* (pp. 41–51). Thousand Oaks, CA: Sage

of a political collective (Marková, 1997; Moodie *et al.*, 1997). Marková contrasted that type of 'collectivism' with a longer central European tradition emphasising a strong historical heritage of democratic communities, a sense of responsibility for self and others, and a stress on the agency and identity of individuals. A special issue of the *Journal of Community and Applied Social Psychology* on 'The Individual and the Community: a Post-Communist Perspective', edited by Marková (1997), focused on the dramatic changes that had occurred in eastern Europe after the break-up of the Soviet bloc. In one contribution, Topalova (1997) reported results from three representative national surveys carried out in Bulgaria in the early 1990s. Results showed that, in that country, traditionally collectivist in its values, values were gradually moving in an individualistic direction. Those who endorsed the more individualistic values tended to be younger, particularly students, more often male, and non-religious. Collectivists tended to identify (referring to 'we' rather than 'they') with social groups with interests in maintaining the status quo and traditional social values (e.g. the Socialist Party, monarchy, religious leaders, and rich people in powerful positions), whereas individualists identified themselves more strongly with social groups who were declaring themselves in support of the new ideology (e.g. opposition political parties, republicans, the non-religious, and individuals whose standing in the social hierarchy was lower).

The Individualism of Psychotherapy

Treatment for an ill-health condition, whether the treatment be medical or psychological, rests on the idea that the individual is suffering from some disorder or defect that lends itself to individual cure or correction. The limitations of that

individualistic conception of ill-health have often been pointed out. Porter (1997, reviewed by Mitchell, 1998), for example, developed at length the argument that the technical success of scientific medicine has led to a neglect of the less glamorous preventive health care. He was convinced that the historical evidence showed that the largest improvements in health had been due, not to cures for individuals, but due to the public health movement. He also pointed out that most traditional approaches to life and healing, unlike modern scientific medicine, placed individuals in a wider social context.

Using the often cited analogy of jumping into a river to rescue a succession of people who might otherwise drown, with no time to consider why they are all falling (or being pushed) into the water upstream, Alonzo (1993) was another who eloquently made the point that medicine is largely committed to 'downstream' healthcare while paying only lip service to 'upstream' prevention. He took the reader of his article carefully through the positions for and against different forms of prevention, detection, protection, and health promotion, extending the analogy of drowning in the river to consider the different ways in which people might be deceived into jumping into dangerous waters apparently of their own volition. Much of prevention, he argued, was based on the idea that individuals are responsible for their own ill-health through acts of omission or commission:

> In the Reagan Era of excessive individualism, it was the individual who needed to come into line regarding preservation and promotion of health. This ideological position . . . makes it easier for our society, or those charged with providing resources for prevention, to consistently avoid examining the socio-structural impediments to maintaining and protecting one's health (p. 1020).

Psychotherapy is especially vulnerable to the charge that it individualises personal distress, failing to take account of the real world in which people live (Smail, 1987, 1991; Masson, 1989; Pilgrim, 1991). Critics have argued that the promise of psychotherapy, that it would stand for progressive humanism and would therefore be open to consideration of the social determinants of mental distress, has not been fulfilled (e.g. Pilgrim, 1991). It can be said (e.g. Smail, 1987) that psychology and the other 'psy professions' have led us in the direction of strengthening the concentration on the individual in trying to understand the reasons for human difficulty and distress. They have been blinkered when it comes to identifying the social origins of distress, particularly the more 'distal' sources of power or powerlessness in people's lives. For example, Smail (1991) believed that much of his patients' insecurity could be traced to the disruption and confusion caused by mergers and takeovers of international capital. People were often left in despair and their inclination to blame themselves for their circumstances was reinforced, he argued, by the use of concepts such as 'stress management' or 'coping skills'. He particularly noted the neglect of social class:

> While it is considered quite in order to focus on, for example, the 'irrationality' of the patient's 'cognitions' and to imply thereby a voluntaristic psychology of 'change' contingent upon professional criticism, it might seem almost indecent to explicate his or her predicament in terms of class disadvantage . . . And yet

> there can be little doubt that, particularly perhaps in English society, occupancy of a negatively valued class position entails much more than mere economic deprivation: it establishes within the individual a (realistic) sense of inferiority which . . . colours almost every aspect of his or her social conduct and awareness. How can any psychology purporting to confront personal distress fail to address this issue? (Smail, 1991, p. 63).

Much of the blame is laid at Freud's door for having abandoned his seduction theory, which threatened to expose the prevalence of sexual abuse perpetrated by adult males, in favour of a theory that focused instead on individual mental mechanisms (Masson, 1989; Pilgrim, 1991; Smail, 1991). In fact, the mental health field might have been much more socially oriented if the views of Adler had not been eclipsed relative to those of Freud and other post-Freudian psychoanalysts (Ansbacher, 1979). Adler was much more interested than Freud in the relationship between the individual and the environment, in issues of power and equality, in style of life and positive mental health. In particular he wrote about the values of democracy and cooperation, and about a concept – that has been translated into English as 'social interest' – which he considered to be a fundamental human motive. Some of his writings, however, betray what might be thought of as an over-optimistic, almost metaphysical belief in the human striving for cooperation and perfection, and a corresponding neglect of conflict (Adler, 1933/1979; Ansbacher, 1979).

Later varieties of constructivism and subjectivism, such as Kelly's (1955) personal construct theory, may have compounded the encouragement of therapists in their neglect of the significance of real-world material constraints (we consider the disputed role of social constructionism in community psychology in Chapter 2). The result is what Smail (1987, p. 67) called 'the individualisation of fault':

> . . . our beliefs about our reasons for our conduct, and our official psychologies, are above all designed to repress: we come to feel personally to blame for social injustices which are in fact perpetrated far beyond the reach of our awareness (Smail, 1987, p. 69).

Masson's (1989) critique of psychotherapy rested, in addition, on the power differential between therapist and client, and the way in which it served to maintain relationships of power in society, including the powerful position of psychotherapists themselves. As Smail (1987, p. 47) put it:

> . . . it [psychology] serves the interest not only of its practitioners, but more importantly of those who have actually achieved power within society and constructed an apparatus to maintain it (. . . not *necessarily* with any consciously evil intent).

Health psychology – a relatively new branch of psychology, promising a refreshingly new approach – has also been criticised for taking a non-critical and non-reflective stance towards health and illness, failing to address the social causes of distress and focusing all its efforts on individual assessment and individual change (Osterkamp, 1999; Fox, 2003; Fryer *et al.*, 2003; Murray & Campbell, 2003; Prilleltensky & Prilleltensky, 2003a). Murray and Campbell (2003, p. 231) put it thus:

> 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.

Nor has humanistic psychology escaped criticism for its concentration on self-actualisation, with its assumption that individual emancipation is possible, irrespective of social restraints. In Osterkamp's (1999) view this has turned responsibility on to those suffering misfortunes, hence serving the interests of those with greater power who need to feel no guilt at others' misfortunes.

How Most Prevention has Remained Person Centred

As a corrective to the dominance of individual therapy, in the early days of community psychology prevention appeared to offer the promising way forward (Bloom, 1968; Heller *et al.*, 1984; Orford, 1992). Blair (1992), for example, writing from Britain in the early 1990s, was hopeful about the prospects for primary prevention in the area of mental health, although he recognised that it was, "... still in its infancy relative to other levels of prevention and is, as yet, built upon shaky research foundations" (p. 88). Both in Western Europe and North America he saw preventive work as neglected and marginal within mental health services. Writing from the USA nearly a decade later, Cowen (2000) similarly concluded that although the evidence was by then strong for the efficacy of mental health primary prevention (Durlak, 1995, 1997; Durlak & Wells, 1997; Albee & Gullotta, 1997), the mental health system as a whole remained dominated by an after-the-event, repair-oriented model with relative neglect of before-the-fact, 'upstream' prevention. Albee (interviewed by Guernina, 1995) was equally critical. Although individual therapy could do little to alter the main social sources of people's problems – unemployment for example – the demand for clinical psychology in the USA had greatly expanded from the time of the Second World War, when large numbers of servicemen and women developed mental and emotional problems, to the time when he was being interviewed about his career as a psychologist. By then many US clinical psychologists were in private practice and moves were afoot, encouraged by the pharmaceutical industry, to obtain drug prescription privileges for clinical psychologists.

Even when prevention rather than treatment has been attempted – such a central theme in the history of community psychology – the form it has taken has sometimes been criticised as well. An important distinction that is often pointed out is that between the specific prevention of a particular problem or disease, and the more general enhancement or promotion of health or well-being. Blair (1992) referred approvingly to a shift that had occurred in the 1970s away from an exclusive focus on the specific towards considering the general role of stress, differing ways of managing stress or responding to crises, and the generally protective effects of social support. He referred, as illustrations, to British work by Brown and Harris (1978, and see later chapters) on the importance of support from a confiding partner in protecting against depression, and by Quinton *et al.* (1984) on the prevention of adult difficulties in women brought up in institutions. Durlak and Wells (1997), in

the USA, also referred to many researchers having widened their goals beyond the prevention of specific disorders, and a trend towards including the enhancement of protective factors (Hawkins *et al.*, 1992), as well as a move towards aiming for the development of positive 'competencies' as well as preventing problems.

Such trends may not have been maintained, however. Rappaport (1992) described what he saw as a dramatic reversion in the USA from 1980 onwards (with a US administration that did not share its predecessor's commitment to community mental health), towards a narrowing of the concept of prevention, now largely being interpreted as the prevention of specific disorders. Writing nearly a decade later, Cowen (2000) was still of the view that the dominant prevention model was that of forestalling serious psychological disorder, requiring that the disorder to be prevented be specified and prevention programmes be designed, tested and evaluated in the light of knowledge about risk and protective factors relating to the specific disorder. Difficulties for that model, according to Cowen, were that paths linking psychosocial risks and a specific disorder were often complex and individual, with both multi-causality and multi-finality being features (i.e. that any particular disorder may come about for very different reasons and via different routes, and that any given risk factor can lead to diverse negative outcomes). Such difficulties had reactivated interest in more general, positive health-building or wellness-enhancing alternatives. Although the two strategies – disorder prevention and wellness enhancement – were not antagonistic, they were distinct conceptually, tactically, and practically, as summarised in Table 1.3.

Wellness enhancement Cowen saw as: more oriented towards whole populations; driven more by protective, health-building factors than by risk factors; aiming to promote wellness from early in life and to maintain and foster it across the lifespan; likely to target broader, ongoing challenges rather than circumscribed, time-limited risks; using tactics maintained over lengthy periods of time, at different levels and in different settings; and calling on the expertise of diverse specialists ranging from teachers to urban planners. Unlike disorder prevention, which has the immediate appeal of promising the prevention of troubling problems – such as substance misuse or major mental disorder, with associated cost savings – wellness enhancement offered fewer immediate, tangible payoffs, was likely to involve long gestation periods and an absence of obvious links to the prevention of specific disorders. It was therefore vulnerable to being seen as dispensable.

Rappaport (1992) suggested that the narrowing down on a disease prevention model in the 1980s was more political than scientific, reflecting a preference for individual over social explanations for deviance during politically conservative times – although he added that in western societies there is a tendency always to blame the individual whatever the government in power. The broader approach to prevention was likely to ally itself with those wishing to redefine social problems and take part in social action research, such as feminists, former patients of mental health services, participants in the self-help and mutual aid movements, and neighbourhood organisation and ethnic minority group leaders. Scientists and practitioners always needed patrons for their research and services, and in modern times the patron was likely to be government in one form or another. Hence the broader view was unlikely ever to be popular with government since it questions the way things are and threatens to undermine those in power.

Table 1.3 Two models for prevention

Model	Risk Detection-Disorder Prevention	Wellness Enhancement
CONCEPTUAL		
Overarching Goal	Prevent serious psychological disorder	Maximise psychological wellness
Guiding Strategy	Identify and neutralise negative effects of specific risk factors for targeted, maladaptive 'end-states'	Identify conditions that promote wellness both as an immediate resource and a protective force that can help to short-circuit major negative outcomes
Proximal and Distal Objectives	*Short-term*: Prevent serious psychological disorder; *Long-term*: Prevent serious psychological disorder	*Short-term*: Enhance wellness and skills; augment life satisfaction; *Long-term*: Build efficacy, and prevent serious disorders
TACTICAL		
Prime Targets	People evidencing risk-signs for specific disorders	All people
Programme Timing	Harness 'windows of opportunity' (i.e. detection of risk-signs) as basis for launching programmes	Utilise diverse levels and types of approaches across the life-span
Programme Scope	Relatively narrow, based on specific steps that seek to neutralise likely negative sequelae of risk factors	Relatively broad, including strengthening: ways of parenting and family operation; influential social settings and institutions; and society's overt (e.g. laws, policies) and hidden 'regularities'
Programme Duration	Relatively brief, to address the perceived needs of a specific disorder-prevention targeted programme	Varies with specific sub-goals and life stages but, in the aggregate, may extend across the entire life span
PRACTICAL		
Hoped for Payoff	Early reduction of frequency of occurrence of targeted psychological disorders, with associated human and financial savings	Relatively long term, with the immediate, way-station goal of promoting wellness indicators (e.g. efficacy, happiness) as well as the ultimate goal of reducing major psychological disorder
Current Interest and Support	Substantial, because of potential for short-term reduction of specific dysfunctions, and financial savings; attracts vocal advocates for preventing particular disorders	Relatively low; has limited constituencies because potential for success in reducing major disorders is non-specific and futuristic

Source: Cowen, E.L. (2000). Now that we all know that primary prevention in mental health is great, what is it? *Journal of Community Psychology*, **28**, 5–16, Table 1

A similar shift in Britain towards a focus on individual responsibility was noted by Blair (1992). The bulk of prevention work, he noted, had been person-centred in orientation. This could be seen as a failure of primary prevention specifically, and in community mental health more generally, to escape a medical model of emotional distress, and a lack of commitment of community mental health towards the more community-oriented, positive health-enhancing concept envisaged by many of its founders. Issues requiring a political frame of reference thereby became depoliticised, and prevention became adaptive rather than transformative. This perpetuated the tendency of the psy professions to focus on adjusting the 'under-privileged' and to avoid attacking the 'over-privileged' (Kolstad, 1987, cited by Blair, 1992), hence helping to maintain those aspects of the existing social order which might be contributing to the distress of individuals.

Levine (1998) gave two specific US examples. One was the lobbying of the US Congress by the National Rifle Association in order to limit research exploring the link between handgun registration and health. The second was the example of sexual abstinence programmes in the USA, such as Best Friends, supported by prominent political figures and rapidly becoming adopted nationally in the USA despite absence of evidence of its effectiveness and some evidence of its *lack* of effectiveness. The need to accept that prevention is political was underlined by Albee (interviewed by Guernina, 1995) when he suggested that, "... prevention efforts almost always mean changes in the social structure, doing something about injustice and about unemployment and poverty" (p. 208).

Much of existing prevention work, despite the enormous gains in the theory and practice made by 'prevention science', had, in Tseng *et al.*'s (2002) view, targeted person-centred deficits among high-risk populations, risking victim blaming and disempowerment through labelling and reduced expectations. Even an emphasis on positive outcomes, as in wellness enhancement and competence promotion, might carry the same risks and serve to maintain the status quo: parenting classes for low-income mothers, for example, were unlikely to alter the dynamics of privilege and oppression and would run the risk of reinforcing assumptions that such mothers are deficient in parenting skills. Despite much of the rhetoric of community psychology regarding prevention, there had been comparatively little psychological prevention that adopted a social change orientation. They believed there were four ways in which their own conception of the promotion of social change could be distinguished from previous concepts of promotion. First, it aimed to promote positive processes rather than particular end-states or outcomes. Secondly, it targeted social systems rather than individuals, hence allowing for alternative individual pathways for diverse individuals. Third, it showed an appreciation of variations by context, including time, culture, and power structures. Fourth, and most importantly, their framework paid careful attention to values, language, and critical systems analysis. Emphasised was the need to continually examine and re-examine the values of various stakeholders, to generate dialogue, and to ask for whom and in which context a process might be adaptive. Central to their framework was the need to begin with a critical analysis of the system: "... the need to critically view the current, existing system of assumptions and rules in which social *problems* and their *solutions* have been defined and understood " (p. 409). Social

change involved more than targeting individuals or small groups for change; it necessitated changing the relationships or rules that operate within the system to maintain the status quo, including existing relationships of power. That is what some systems theorists have called 'second-order change' (Watzlawick *et al.*, 1974) in distinction to 'first-order' individual or small group change. As examples of work that was moving in the right direction Tseng *et al.* cited Fairweather and colleagues' Lodge programme and the work of the Pacific Institute of Community Organizing (PICO) – both described in Part IV.

Also critical of much prevention work was Potts (2003), who focused his critique on prevention programmes in schools (many included in a large meta-analytic review by Durlak & Wells, 1997), from the perspective of emancipatory education in African American communities in the USA. Schools, he argued, were by no means politically neutral, tending to inculcate pupils into the dominant system, and perpetuating oppression and the status quo, "... by marginalizing voices, histories, values, and experiences of oppressed groups; emphasizing the 'classics' and canons of the hegemonic culture; instilling values consistent with the status quo (e.g. individualism, competition, etc.); and ignoring issues such as colonialism and racism" (p. 174). Furthermore, Potts drew attention to inequities in school funding and the fact that African USAmerican students were disproportionately to be found among the expelled, suspended, and those in special programmes for the disturbed, disabled or retarded. In that context, primary prevention programmes that targeted the substance abuse, school maladjustment, teen pregnancy, delinquency and violence of individual students, without paying attention to the historical and socio-political forces that were in operation, ran the risk of protecting and maintaining the status quo, and sending a message that achievement was based strictly upon individual ability and merit and that individuals had only themselves to blame.

Emancipatory models of African USAmerican education, on the other hand, located problems such as substance abuse and violence within a context of the history of violence and abuse experienced by people of African descent. Such African-centred schools in the USA, of which Potts stated there were over 400, were far more than multi-cultural education programmes with additive content. Rather, they aimed at something fundamentally different that 'reclaimed historical memory' (Martín-Baró, 1994 – see Chapter 2), reconnecting students with African and African USAmerican history, traditions, values and principles. The approach to violence, for example, "... is one in which the student is not singled out and castigated as the primary source of violence, yet is challenged to not contribute to a process that continues to harm the community" (p. 181).

Like Tseng *et al.* (2002), Potts (2003) had challenging words for community psychology. The latter was at risk, he thought, of being part of what West (1982, p. 120, cited by Potts, 2003, p. 176) called a "neo-hegemonic ... [culture that] ... postures as an oppositional force, but, in substance, is a manifestation of people's allegiance and loyalty to the status quo". The kind of interventions that Potts described might not, he thought, be the kinds that many community psychologists would feel comfortable with, but would require a willingness to be involved in 'horizontal' as opposed to 'vertical' collaborations and a commitment to a liberation psychology.

Blair (1992), Albee (1995) and Levine (1998) were among those advocating a broader role for community psychology, involving efforts to change the structures and practices of organisations and institutions, and engaging with public policy, which might include advocating for changes in the law. Objections to moving more into the sphere of political activity, "... ignores the fact that current practice, to the extent that it serves to maintain existing power structures and social inequalities, is also political" (Blair, 1992, p. 87).

THE NEW PUBLIC HEALTH PSYCHOLOGY

In Britain public health psychology is being suggested as a new sub-discipline of psychology, emerging from behavioural medicine, public health, health psychology, and health promotion (Hepworth, 2004). Critical voices are being raised in that context which are encouraging because they hit some of the same notes being struck by critics in community psychology. The idea of a public health psychology has attractions since at least some of the matters that have been of concern to the public health movement are the very ones that are of most interest to community psychology.

The history of public health in Britain (Lewis, 1991), as in the USA (Fee & Porter, 1991), is a long one, certainly going back as far as Chadwick's 1842 report on the health of the working classes that recommended such measures as the provision of clean water supplies, effective sewerage and drainage, and removal of refuse from the streets, as the means of preventing disease, and which established the basis for the sanitary engineering approach to health that, in one form or another, was one of the major approaches to public health in Britain for the following 100 years.

The unequivocally environmental approach of Chadwick and mid-nineteenth-century medical reformers such as Simon in Britain and Virchow in Germany, who believed in medicine as politics (Fee & Porter, 1991), had given way by the time of the First World War to a more personal approach that emphasised what individuals could do to ensure personal hygiene (Lewis, 1991). Maternal and child health, for example, was seen in terms of discrete personal health problems, requiring the attention of health visitors, infant welfare centres, and better maternity services. Mothers were being encouraged, for example, to breast feed and to strive for higher standards of domestic hygiene. Socialist campaigners Sidney and Beatrice Webb were strong supporters of public health, encouraging local authority public health departments to create, "in the recipient an increased feeling of personal obligation and even a new sense of social responsibility ... the very aim of the sanitarians is to train the people to better habits of life" (Webb, Sidney & Beatrice, 1901, p. 206, cited by Lewis, 1991, p. 201). In Lewis's (1991) view the British public health movement had not recovered, by the time she was writing, a thorough-going environmental–political model, and it had certainly not, as some had hoped it would, occupied a central role in medicine. The National Health Service was open to criticism that it was rather more a national sickness service. The following, from a report on training of medical students in preventive medicine in 1930, might well have been true 50 years later and, with a few changes of wording, could be said to be true of psychology still:

> The medical student lives in the atmosphere of the dissecting room, the laboratory, the operating theatre and the hospital ward. His [sic] whole attention is directed to what is abnormal and he is taught to think almost entirely in terms of individual sick persons and never at all to regard himself as a member of a profession with great communal responsibilities (Archives of the Society of Medical Officers of Health, 1930, cited by Lewis, 1991, p. 208).

Hepworth (2004) was positive about the revitalisation of public health in Britain at the turn of the millennium, with increasing recognition of inequalities in health and the need to overcome them (e.g. the British government's policy paper on a new health strategy for England, *Saving Lives: Our Healthier Nation*, Department of Health, 1999), and the development of new infrastructure including the establishment of Public Health Observatories in England and Wales and the Public Health Institute in Scotland. She saw a number of elements as necessary for an adequate public health psychology theory. One was epistemological: a realisation that for a *public* health psychology it was imperative to move away from a view of health as being essentially an individual phenomenon, focused on modifying risk factors such as behaviours related to diet and exercise. A second was a multi-level approach, recognising that improvement in health required strategies at individual, social-relational, and structural levels – all the way from individuals' health knowledge to promoting new legislation such as banning smoking in public places. That would require drawing on other sub-disciplines in psychology, including social and community psychology, and other social sciences such as cultural and communication studies. Third, health behaviour needed to be understood within its social and cultural context. Fourth, public health psychologists should be part of a critical move away from an essentialist, individual focus on health that had dominated health psychology and health education and promotion without much criticism in the 1980s:

> The conceptualization and design of contemporary health interventions need to fully embrace public health practice that eschews individual blame and responsibility as a means to solving problems that are structural, gendered, cultural, social, economic, political and environmental in nature (p. 47).

Hepworth saw psychology, historically practised as a mono-discipline, as lagging behind the more multi-disciplinary and inter-disciplinary field of public health in Britain, and as marginal to public health training programmes. Psychology needed to catch up by focusing on, "... public rather than individual health, inequalities in health, multi-method design and multidisciplinary and interdisciplinary practice" (p. 52), and by sharing with public health increasing recognition of the global nature of public health and the issues it faces. Murray *et al.* (2004) also recommended that, instead of maintaining psychology's carefully nurtured boundaries, community health psychologists should welcome the blurring of traditional boundaries between disciplines, and seek alliances with other health and social sciences that are further ahead in developing a critical perspective and recognising the centrality of power.

There are many indications that writers on health psychology have begun to appreciate the importance of social context. In a review by Taylor and Repetti (1997) that appeared in the *Annual Review of Psychology*, the authors asked a central

question for health psychology: What is an unhealthy environment and how does it get under the skin? Among the conclusions of their lengthy review were the following:

> Individual experiences and behaviors predictive of health outcomes are nested within geographic, social, developmental, and economic environments . . . Psychosocial predictors of health outcomes do not occur and should not be studied in an economic, racial, developmental, and social vacuum . . . What is an unhealthy environment and how does it get under the skin? . . . the beginning of an answer is emerging. Consistently across the environments examined – community, family, work, and peers – those that threaten personal safety; that limit the ability to develop social ties; or that are characterized by conflictual, violent, or abusive interpersonal relationships are related to a broad array of adverse health outcomes. These effects appear to occur across the lifespan . . . (pp. 438–9).

Introducing a special issue of the *Journal of Health Psychology*, Vinck *et al.* (2004) stated their view that mainstream health psychology, traditionally restricted to individual- or group-focused methods, was thereby hindered in making the contribution to public health that it should be making. However uneasy it might make health psychologists feel to work at unaccustomed levels, they needed to work with systems and with those with control over environmental determinants, such as politicians, the food industry, and local communities. The prevention and minimisation of harm associated with alcohol consumption is an example, where interventions can range from: alcohol education/health promotion; to specific environmental initiatives such as advocating for toughened drinking glasses to minimise alcohol-related violent harm, and labelling of drinks containers; to forms of community action and attempts to influence alcohol control policies (Plant & Harrison, 2001). In similar vein, Murphy and Bennett (2004) argued for a psychological approach to public health that encouraged the development of social, organisational, and economic networks, with a long-term goal of increasing social cohesion and social capital (see Chapter 6 for a discussion of social capital). They cited examples of: the influence of gender–power relations on the different positions of men and women in the negotiation of safer sexual practices; and the low power position of young injecting drug users as a factor accounting for the sharing of injecting equipment. More generally they advocated that health psychology might move, ". . . from a predominantly social regulationist model of prevention to one that is more radical structuralist in nature" (p. 14).

The problem of how to conceptualise the relationship between macro-level, sociopolitical, economic and cultural factors and individual health – a constant theme throughout the present book – was addressed by Cornish (2004). The 'biopsychosocial model', she argued, had failed to challenge the dominance of the biomedical model, and had not proposed theoretical relationships between biological, psychological, and social levels. For example, Bronfenbrenner's (1979) influential ecological model (summarised in Figure 1.2) had the advantage of defining meso- and exo-levels in such a way that it could be seen how they affected concrete experience in a person's micro-systems. The way in which the macro-system affected the micro-system was not clearly specified, however. Without that relationship being satisfactorily theorised, there was the constant danger of slipping back into

Micro-level

Systems of which the individual person has direct experience on a regular basis, e.g. home, school, work group, club

Meso-level

System consisting of two or more of a person's micro-level systems and the links between them, e.g. home–school, hospital–patient's family, mother's family–father's family after separation

Exo-level

Systems that influence the person and the person's micro- and meso-level systems, but which the person has no direct experience of him/herself, e.g. a school governing body, a parent's place of work, the county transport department

Macro-level

Systems on a larger scale which determine the prevailing ideology and social structure within which the individual person and his/her micro-, meso- and exo-level systems operate, e.g. current rate of unemployment, other conditions of the labour market, gender roles in society

Figure 1.2 Bronfenbrenner's ecological model of systems at four levels
Source: Bronfenbrenner, U. (1979). *The Ecology of Human Development: Experiments by Nature and Design*. London: Harvard University Press

reductive or individualistic language and theorising and person-blaming problem definitions.

The solution to this problem proposed by Cornish was to put at the centre of her approach, "... relationships rather than elements, change processes rather than stable states, and processes of mutual constitution rather than one-way, cause-effect determinism" (p. 284). The basic unit of analysis would be the 'activity system' – a culturally mediated collective activity centred around some particular object or aim – such as the joint activity of a teacher and pupils studying a particular topic. Although such an activity system is concrete and localised, it is at the same time historically and culturally produced, and language and ideology are vital and ever-present (hence going beyond Barker's, 1968, 1978, idea of a 'behaviour setting' – a highly influential idea in an earlier era of community psychology – see Orford, 1992, for a summary, and Chapter 3 of the present book). Within the operation of such activity settings it was possible to identify 'reflected mediating moments' when the influence of macro-level factors could particularly be seen (Seidman's, 1988, 'social regularities' and Tseng *et al.*'s, 2002, 'recurring transactions' are similar ideas). Cornish provided an example from a study, involving semi-structured interviews and group discussions with sex workers and other

local people (HIV prevention and community development project staff, clients of sex workers, brothel managers) in the largest red light district in Kolkata, India. In this context a mediating moment that helps show up the link between a sex worker's health risk and her economic and social disadvantage is the moment at which the sex worker feels that she cannot take time to convince a client to use a condom. The 'madam' system, in which a brothel manager employs one or more sex workers, discourages safe sexual practices because the madam's economic interest is tied to the sex worker's earnings, so the latter cannot afford the time to negotiate with a client, or to run the risk of losing the client to another sex worker who may be more accommodating (part of the work of the local prevention project was to disrupt this effect of poverty on health, by encouraging unity among sex workers and commitment to universal condom use, comparing the situation to that of other workers who have trade unions).

Albee and Fryer (2003) have advocated the development of a critical public health psychology, "... which could be as effective in preventing mental ill health and promoting positive mental health in the future as public health medicine has been in preventing physical ill health and promoting positive physical health in the past" (p. 74). Their challenge was a radical one, namely to find ways of preventing and overcoming the noxious effects of racism, sexism and classism, of the stigmatising and disabling stereotypes of mental illness portrayed by the mass media and popular culture, of unemployment and the so-called flexible labour market, of tobacco companies, the pharmaceutical industry that has such a stake in individual treatment, and of corporations generally with their drive for profits and limited capacity for empathy with those harmed in the process, and a patriarchy that all the world's major religions supported. That would require a shift away from the widespread preference that existed for individual treatment, towards prevention at the collective, public level. The latter would not only be difficult to evaluate, less visible, and perhaps conferring lower status to those employed in it, but also, because it would be likely to require organisational, institutional, and social change, and the conceding of power and control, it would be challenging to the status quo and resisted by those who have a stake in it.

Marks (1996, 2002) has provided a useful summary of the options for health psychology. He described the development of health psychology from the 1970s onwards, outlining four alternative approaches to the subject, summarised in Table 1.4. The first and most dominant approach he termed 'clinical health psychology'. Partly overlapping with clinical psychology, that approach was located within the healthcare system and had adopted the, in his view rather nebulous and insubstantial, biopsychosocial model as an attempt to challenge the more limited biomedical model. Although 'public health psychology' – the second approach – placed greater emphasis on health promotion and prevention, on multi-disciplinary activity and on public health interventions and evaluation, it could be criticised for stressing individual responsibility for health and hence risking a victim-blaming stance. Marks' (2002) third approach, 'community health psychology', was situated mainly outside of the healthcare system, in coalition with members of vulnerable groups and communities, targeting conditions such as social exclusion and poverty that render them vulnerable, and aiming for empowerment as a main outcome.

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Table 1.4 The characteristics of clinical, public, community and critical health psychology

Characteristic	Clinical health psychology	Public health psychology	Community health psychology	Critical health psychology
Theory/ philosophy	Biopsychosocial model: health is the product of a combination of factors including biological, behavioural and social	No single theory and philosophy; supportive role in public health promotion which uses legal and fiscal instruments combined with preventive measures to bring about health improvements	Social and economic model: changes are needed at both individual and systems levels	Critical psychology: analysis of society and the values, assumptions and practices of psychologists, health care professionals, and of all those whom they aim to serve
Values	Increasing or maintaining the autonomy of the individual through ethical intervention	Mapping accurately the health of the public as a basis for policy and health promotion, communication and interventions	Creating or increasing autonomy of disadvantaged and oppressed people through social action	Understanding the political nature of all human existence; freedom of thought; compassion for others
Context	Patients in the health care system, i.e. hospitals, clinics, health centres	Schools, work sites, the media	Families, communities and populations within their social, cultural and historical context	Social structures, economics, government and commerce
Focus	Physical illness and dysfunction	Health promotion and disease prevention	Physical and mental health promotion	Power
Target groups	Patients with specific disorders	Population groups who are most vulnerable to health problems	Healthy but vulnerable or exploited persons and groups	Varies according to the context: from the entire global population to the health of an individual

(*cont.*)

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Table 1.4 (*cont.*)

Characteristic	Clinical health psychology	Public health psychology	Community health psychology	Critical health psychology
Objective	To enhance the effectiveness of treatments	To improve the health of the entire population: reducing morbidity, disability, and avoidable mortality	Empowerment and social change	Equality of opportunities and resources for health
Orientation	Health service delivery	Communication and intervention	Bottom-up, working with or alongside	Analysis, argument, critique
Skills	Assessment, therapy, consultancy and research	Statistical evaluation; knowledge of health policy; epidemiological methods	Participatory and facilitative; working with communities; community development	Theoretical analysis; critical thinking; social and political action; advocacy; leadership
Discourse and buzz words	'Evidence-based practice'; 'Effectiveness'; 'Outcomes'; 'Randomised controlled trials'	'Responsibility'; 'Behaviour change'; 'Risk'; 'Outcomes'; 'Randomised controlled trials'	'Freedom'; 'Empowering'; 'Giving voice to'; 'Diversity'; 'Community development'; 'Capacity building'; 'Sense of community'; 'Inequalities'; 'Coalitions'	'Power'; 'Rights'; 'Exploitation'; 'Oppression'; 'Neo-Liberalsm'; 'Justice'; 'Dignity'; 'Respect'
Research methodology	Efficacy and effectiveness trials; quantitative and quasi-experimental methods	Epidemiological methods; large-scale trials; multivariate statistics; evaluation	Participant action research; coalitions between researchers, practitioners and communities; multiple methodologies	Critical analysis combined with any of the methods used in the other three approaches

Source: reproduced with permission from Marks, D.F. (2002). Editorial essay. Freedom, responsibility and power: contrasting approaches to health psychology. *Journal of Health Psychology*, **7**, 5–19, Table 1

Finally, 'critical health psychology' used, "... theoretical analysis, critical thinking, social and political action, advocacy, and leadership skills ... to analyse how power, economics and macro-social processes influence and/or structure health, health care, health psychology, and society at large" (p. 15).

Marks recognised that many health psychologists used more than one of those four approaches, some using three or even all four. He believed them to be complementary and looked forward to greater integration. By the time of his later, 2002, article, he believed things had moved on from 1996 when he had seen health psychology as still heavily dominated by individualistic approaches, concepts, and models such as 'locus of control', self-efficacy, hardiness, Type A behaviour, and the 'theory of reasoned action', derived solely from psychology, lacking in ecological validity and indifferent to culture. There had been neglect of key variables such as social support resources, social class, and material circumstances. Health psychology at that time remained detached from policy matters, and had taking little account of health inequalities (Marks, 1996).

Murray *et al.* (2004) have also contrasted clinical health psychology with community health psychology, the contrasts being summarised in Table 1.5. Their view of community health psychology was that of a psychology which, "... emphasizes a critical examination of professional and social power and social change as a necessary strategy for the promotion of health" (p. 328). A similar contrast was drawn by Campbell and Murray (2004) between what they called 'accommodationist' and 'critical' community psychology (terms used by Seedat *et al.*, 2001, cited by Campbell & Murray, 2004). Clinical, accommodationist or mainstream health psychology had focused on individual and micro-social factors, had focused analysis on the impact on health of family, neighbour, peer or sexual relationships, had developed interventions either of a clinical kind in medical settings, or health promotion programmes in the community emphasising lifestyle change, and had followed general psychology's fascination with method. Despite the rapid growth in numbers of health psychologists, their voices had been relatively absent from debates about health inequalities and social injustices, and health psychology had not focused on the larger macro-social determinants of health and illness which lie beyond the boundaries of the families and local communities which had been the focus of most attention. As Campbell and Murray (2004, pp. 191, 192) put it:

> ... if community psychologists ignore how people are limited by wider structural and institutional structures, they become part of a victim-blaming enterprise. Such analyses implicitly blame local community members for problems whose origins lie outside of their power and control ... it is vitally important that conceptualizations of participation and community development are located against the backdrop of wider conceptualizations of politics and power.

Critical community health psychology, on the other hand, did not ignore the broader social and political context: it developed a critical consciousness of oppressive relationships and the operation of power, including gross inequalities in material wealth and gender relations. Campbell and Murray (2004) drew here on the work of Freire (1973, and see Chapter 2) including the concept of *conscientisation* and the notion of *praxis* – "... action informed by critical social analysis, springing from

Table 1.5 Assumptions and practices of clinical and community health psychology

Assumptions and practices	Clinical health psychology	Community health psychology
Levels of analysis	Intrapersonal or micro-systems	Ecological (micro, meso, macro)
Problem definition	Based on individualistic philosophies that blame the victim	Problems are reframed in terms of social context and cultural diversity
Timing of intervention	Remedial (late)	Prevention (early)
Focus of intervention	Deficits/problems	Competence/strengths
Goals of intervention	Reduction of 'maladaptive' behaviours	Promotion of competence and well-being
Type of intervention	Treatment/rehabilitation	Self-help/community development/social action
Role of 'client'	Compliance with professional treatment regimes	Active participant who exercises choice and self-direction
Role of professional	Expert (scientist-practitioner)	Resource collaborator (scholar-activist)
Type of research	Applied research based on positivistic assumptions	Participatory action research based on critical and constructivist assumptions
Ethics	Emphasis on individual ethics, value neutrality and tacit acceptance of status quo	Emphasis on social ethics, emancipatory values and social change
Interdisciplinary ties	Psychiatry, clinical social work	Critical sociology, health sciences, philosophy, social work, political science, planning and geography

Source: adapted from Prilleltensky, I. & Nelson, G. (1997) and reproduced with permission from Murray, M., Nelson, G., Poland, B., Maticka-Tyndale, E. & Ferris, L. (2004). Assumptions and values of community health psychology. *Journal of Health Psychology*, **9**, 323–33, Table 1

engagement in the real world" (Campbell & Murray, 2004, p. 189). Their concluding recommendation was that,

> . . . as health psychologists we transform ourselves from scientist-practitioners to scholar-activists. Through linking analysis and action our research should not simply be a thing in itself but a means of helping to create health through the broader struggle for social justice (p. 194).

CRITICAL PSYCHOLOGY

Much of this first chapter has taken a critical stance towards the way in which psychology as a discipline has neglected the very aspects of the subject that are

of most interest to community psychology. Not only that, but it has also come to be realised that this neglect often has the malign effect of diverting focus from attention on the way in which the status quo may be serving to perpetuate injustice and inequality; hence psychology fails to address major sources of difficulty and distress. Community psychology therefore needs not only to claim part of the discipline of psychology for itself, but also needs to maintain its critical stance towards the parent discipline – and related disciplines too. The rise of a branch of the subject referring to itself as 'critical psychology' has therefore been very welcome.

Critical psychology is important for community psychology because it provides the latter with a core part of its necessary framework of philosophy and values. Critical psychology is about identifying, reflecting critically on, and bringing out into the open the ways in which the dominant, prevailing, or 'ruling' ways of understanding and doing things support the interests of some people and groups and not those of others. It is therefore about ideology and power (Osterkamp, 1999; Fryer *et al.*, 2003). Hepburn (2003, p. 34) suggested that ideology could be treated as a, "... system of concepts or ideas that hides oppression or prevents radical action".

Critical psychology often turns its attention on psychology itself. Indeed the practice of psychology has been a particular object of its critical reflections. Psychology has been criticised for failing to engage with psychological aspects of socially caused problems, and colluding with dominant forces in society, even allying itself frequently with those who favour sexism, racism, and other forms of social oppression, rather than being in the vanguard of promoting social justice and human liberation (Austin & Prilleltensky, 2001; Fryer *et al.*, 2003; Murray & Campbell, 2003). According to Austin and Prilleltensky (2001, p. 1), "Critical psychology focuses on reshaping the discipline of psychology in order to promote emancipation in society". Fryer *et al.* (2003, p. 1) wrote that a critical community psychology should be, "... problem driven, value committed, politically positioned ... [and] ideologically progressive".

Hepburn (2003) suggested that feminism had been the paradigm of how a critical approach can be effective in psychology and more generally. Following Wilkinson (1997, cited by Hepburn, 2003), she summarised the ways in which psychology had tended to work in an opposite direction by asserting women's inferiority, hence supporting the status quo: for example measures had repeatedly taken the male as the norm; the huge body of work on sex differences had uncritically assumed that such differences were 'essential'; and work had focused on internalised attributes such as 'fear of success', thus shifting the focus on to the individual and away from the social origins of inequality. Psychology can be criticised also for its dominant methods of research; for example, its preference for experimental methods that extract people from their social environments and bring them into the laboratory in order to be able to study them more 'objectively', and for its preoccupation with classifying, measuring, regulating and shaping individuals (Osterkamp, 1999; Austin & Prilleltensky, 2001).

The origins of critical psychology are traced by some (e.g. Hepburn, 2003) to the pre-Second World War Frankfurt school in Germany (including Fromm, Adorno and others, most of whom were Jewish Marxist radicals, forced to flee from fascism) and by others (e.g. Austin & Prilleltensky, 2001) to post-war German

critical psychology (associated with the Free University of Berlin and particularly associated with the name of Klaus Holzkamp – Tolman, 1994; Osterkamp, 1999). Particularly influential on modern critical psychology have been the writings of the French social theorist Michel Foucault (e.g. 1977, 1979). The importance of Foucault for critical psychology, according to Hepburn (2003), lies in his elaboration of the Marxist notion of power, and the way he saw power, knowledge and subjectivity as linked. Unlike Marx's monolithic concept of the power exerted by one social class upon another, Foucault had seen power relations running through all the social settings and social relations that people are part of, and through all the everyday routines, rituals and disciplines that a person engages in.

A principle in critical psychology is that critical psychologists should be among their own strongest critics, and indeed there are many lively controversies within critical psychology. Among those described by Hepburn (2003) are those surrounding sexuality, feminism, and psychoanalysis. For example, writers such as Kitzinger (1987, cited by Hepburn, 2003) and Butler (1990, cited by Hepburn, 2003) have been critical of the way in which the gay and lesbian and feminist movements, despite their successful social action orientations, had accepted uncritically traditional categories such as 'homosexual' and 'woman', the very categories that have supported oppressive ideologies and practices in the past. What is needed, such writers argued, is a more thorough going post-modernist approach that critically deconstructs those categories and questions whether they are as natural or 'essential' as they have been made out to be.

A different kind of controversy has surrounded the value of the psychoanalytic tradition in critical psychology. Perhaps strangely, a number of prominent critical psychologists have been attracted to psychoanalytic ideas (e.g. Hollway, 2006; Billig, 2006; Parker, 1997). According to Hepburn (2003), the attraction has been that psychoanalysis appears to offer a 'theory of the subject' that fills the gap left by the materialist, anti-individualist orientation of Marxism. Furthermore it offers to correct the assumptions in traditional psychology that we are rational subjects, that cognition can be separated from emotion, and that the individual and the social can be separated. Psychoanalysis may appear attractive because it recognises people's fundamental irrationality, has a life history orientation that challenges the traditional individual/social split, and recognises the inter-dependence of cognition and affect. Others, such as Osterkamp (1999) and Hepburn (2003), have remained sceptical, however, on the grounds that psychoanalysis is basically an individualistic model, that its notions of subjectivity are made to seem fixed and natural, and that, at least in its classic form, it is misogynist and dangerous, as evidenced by Freud's own abandonment of the theory of children's sexual abuse by adults (the seduction theory) in favour of a theory that totally inverted the relationship between victims and perpetrators (children's alleged sexual desires for their parents, as in the Oedipus theory).

Whatever the answers to those and other dilemmas about critical psychology, there is general agreement about the values espoused by critical psychologists and about the need to engage in social action. Exposing and working to eliminate oppression, promoting social justice, freedom and emancipation, and siding clearly with the interests of the poor, oppressed and disenfranchised, are values widely

1. Social interventions and changes in public policy; for example by developing critical work, a contribution can be made to public information campaigns, changes in policy etc.
2. Rhetorical interventions, for example using discursive research to expose the ways in which ideology is used to support current practices, hence encouraging social change.
3. Intervening in psychology, for example by challenging its individualistic and cognitivist bias and identifying the ways in which it is complicit with oppressive values and practices.
4. Practical interventions, for example alongside oppressed and marginalised groups or relatively powerless users of services.
5. Postmodern interventions, examining common sense understandings, how 'truth' is constructed and claims made about 'reality'.

Figure 1.3 Five ways in which critical psychology can address social problems and oppression according to Hepburn
Source: Hepburn, A. (2003) *An Introduction to Critical Social Psychology*. London: Sage

shared (e.g. Austin & Prilleltensky, 2001; Fryer *et al.*, 2003; Murray & Campbell, 2003). An element frequently stressed is the requirement to 'give voice' to those who have been denied a voice either because accounts of their experiences have not been heard and/or because their input to social policies that affect them has not been sought (Sampson, 2000; Ussher, 2000; Austin & Prilleltensky, 2001). Critical psychologists want to enable the voices of the powerless to be heard more and the voices of the hitherto powerful – specifically the interests of large corporations and the voices of noxious consumerism, as represented for example in the media – rather less (Fox, 2003; Lyons, 2000; Murray & Campbell, 2003; Prilleltensky & Prilleltensky, 2003a).

But, as Austin & Prilleltensky (2001, p. 6) put it:

> . . . this work needs to be translated into social actions that have a direct impact on the life circumstances of people who suffer because of globalization, unemployment and discrimination. Powerful ideas need to be matched by powerful actions.

Hepburn (2003) saw five major ways, shown in Figure 1.3, in which critical psychologists could go about actively addressing social problems and oppression. Prilleltensky and Prilleltensky (2003a) have also outlined an agenda for a critical health psychology practice. They argued that health psychology has largely adopted practices of reacting to illness rather than proactively promoting wellness, and has largely addressed problems at the individual level, rather than at the level of social systems that maintain power imbalances and therefore the conditions for ill-health. Hence they proposed a set of values for a critical health psychology, with examples of actions that can be undertaken in health settings to promote personal, relational, and collective wellness (see Table 1.6). They recognised the difficulties:

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Table 1.6 Ecological levels, values and potential critical psychology interventions in health settings

Timing and population of intervention	Values and ecological levels		
	Values for Personal Wellness *self-determination, protection of health, caring and compassion* Individual Wellness	Values for Relational Wellness *Collaboration, democratic participation and respect for diversity* Group and Organisational Wellness	Values for Collective Wellness *Support for community structures, social justice* Community and Societal Wellness
Reactive to existing illness or disability	• Self-determination in rehabilitation • Power sharing in treatment plans for coping with illness and chronic pain	• Assertiveness training for hospital patients dealing with professionals • Communication training for professionals dealing with vulnerable patients	• Securing access of minorities, refugees and the poor to all health services • Lobbying for funding of health services in deprived areas
Proactive high risk	• Smoking cessation with emphasis on exploitation of community by tobacco companies • Diet and exercise programme for overweight people with emphasis on ill-effects of consumerism	• Exercise programme for disadvantaged populations at high risk for heart disease • Organisational interventions to reduce stress in patients and staff	• Self-help/mutual aid and support groups for people caring for disabled family members • Community-wide programmes to improve diet, lower alcohol consumption and increase exercise
Proactive universal	• Self-instruction guide on breast examination • Self-instruction guide on HIV prevention	• Organisational development to improve working atmosphere • Bill of rights and responsibilities for patients and staff in hospitals	• Critique and boycotts of media and corporations making profits at expense of population health • Promote social cohesion and egalitarian social policies

Source: reproduced with permission from Prilleltensky, I. & Prilleltensky O. (2003a). Towards a critical health psychology practice. *Journal of Health Psychology*, **8**, 197–210, Table 2

> Re-inventing ourselves as advocates, social critics, community leaders and psychologists at the same time is a necessity that may not sit well with health psychologists. However, to remain at the level of reactive or person-centred interventions is to deny a massive body of evidence linking social and economic structures to physical and psychological health (p. 208).

They also recognised the contrasting sets of values, assumptions, and practices associated with the roles of professional helper on the one hand, trying to bring about amelioration at the individual level, and critical agents of social change, trying to bring about transformation at the systems level. From the perspective of the former, a critical health psychologist should be asking: "How does our special knowledge of wellness inform our social justice work? How does our ameliorative practice inform our transformative practice? How does our insider role of wellness promoter in the health system inform our outsider role as social critic?" (Prilleltensky & Prilleltensky, 2003b, p. 243). From the latter perspective, the questions for the critical health psychologist are: "How does our knowledge of inequality and injustice inform our health psychology work? How does our transformative practice in society inform our ameliorative work in the health system? How does our outsider role as social critic inform or relate to our insider role?" (2003b, p. 243).

Since critical psychologists have been so critical of mainstream or traditional psychology – Sampson (2000) put it pithily when he wrote, "Critical psychology believes that psychology has adopted a paradigm of inquiry that is ill-suited to understanding human behaviour and experience" (p. 1) – it is not surprising that they have often felt uncomfortable working in academic psychology departments where their work may be misunderstood, discouraged, undermined, or openly attacked (Sloan, 2000; Ussher, 2000; Fox, 2003; Fryer *et al.*, 2003). There has been lively disagreement about whether or not to stay in psychology in order to change it from inside and to introduce students to critical psychology ideas. A number of psychologists have found more productive niches, for example in departments of cultural studies, women's studies, social policy and social work, organisational and management theory, or 'third world' development (Hollway, 2000; Ussher, 2000). O'Sullivan (2000) is one who argued that, although it was important to have a critical presence within the discipline of psychology, the primary loyalty of a critical psychologist should be with progressive social movements such as the feminist, gay-lesbian, human rights, anti-racism and equity movements.

One of the implications for community psychology is clearly a need for continual self-criticism since there is always a danger that by, "... collaborating with the establishment in launching and evaluating programs that divert attention from injustice and structural oppression" (Austin & Prilleltensky, 2001, p. 5), community psychology might be practised in a way which goes against the interests of those whose emancipation and health we are trying to promote (Fryer *et al.*, 2003).

In this chapter psychology has been challenged over the way in which it has repeatedly taken individual people out of their social contexts in order to study them more closely, in the process neglecting the very parts of psychology that are of most interest to community psychologists. Even social psychology can be charged with the same crime. Some of psychology's concepts that sound most promising

from a community psychology perspective – self-efficacy and social support are examples – have largely remained at an individual level. Individual psychotherapy has been a heavy influence in psychology, with its assumption that the most important site of change is the individual person. Even prevention, which held such promise for community psychology, has not always escaped the individualism which is perhaps the cultural norm in those western nations that have led in psychology. The new public health psychology, and the relatively new critical psychology, are both promising signs that times are changing. The following chapter begins to look at some of the ideas that are near to the heart of community psychology. They include power, empowerment and liberation, and social justice.