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COMMUNITY HEALTH PSYCHOLOGY:

PROMOTING ANALYSIS AND ACTION FOR SOCIAL CHANGE

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Abstract

Community health psychology is concerned with the theory and method of working with communities to combat disease and to promote health. This introductory article outlines key assumptions and debates underlying this area of research and practice – in the interests of framing the papers in this special edition of the *Journal of Health Psychology.* Attention is given to the value of emphasising the community level of analysis and action; the role of collective action in improving health; psycho-social mediators between community participation and health; and the potential role of partnerships in creating 'healthy communities'. A distinction is made between 'accommodationist' and 'critical' perspectives, and the authors debate whether or not significant social change can come from community-level action.

This special edition of the *Journal of Health Psychology* focuses on community health psychology, in the light of the editors' particular interest in global and local health inequalities, and the minimal role that mainstream psychology has played in contributing to debates about the causes of health inequalities and how best to challenge them.

This collection of papers draws on research conducted in a range of settings, including the less affluent countries of Brazil, Ghana, India, South Africa and Tobago, and small and often marginalized communities in the more affluent countries of Canada, England, Scotland and Australia. The focus of the papers ranges widely from abstract theoretical debates, to empirical research findings, to issues relating to the evaluation of community psychology interventions and the training of community psychologists. Research participants include socially excluded youth, sex workers, people battling with diabetes, mental health challenges and eating disorders, school pupils at risk of HIV, and residents of low income formal neighbourhoods as well as informal shanty towns.

However, beneath this diversity, the papers are united by a common commitment to investigating how analysis at the community level can contribute to our understandings of the social context of health, and how action at the community level can contribute to the development of community contexts that are enabling and supportive of health-enhancing behaviours. In this introduction we sketch out what we believe are the key challenges and debates facing community health psychology, and locate this special edition's ten papers within the context of these challenges and debates.

Challenging mainstream health psychology

The poorest people in the world are also the ones with poorest health. Years of concerted action by regional and international agencies have conspicuously failed to achieve the

goals of the WHO-formulated "Health for All by the Year 2000" initiative. At the beginning of the 21st century, poverty and other forms of social exclusion continue to be key determinants of health, resulting in massive health inequalities both between countries and within countries in the north and the south. What role has health psychology played in informing debates, policies and interventions in the field of health inequalities research and practice? Health psychology is one of the most rapidly growing areas within the field of applied psychology, with thousands of psychologists all over the world conducting research into the role of psychological processes in health and illness. Yet their voices are conspicuously absent from debates about health inequalities and the social injustices that underpin them (Marks, 1996).

Within this context, community health psychology is an orientation that has arisen in response to growing concerns about the minimal contribution that mainstream health psychology has made to debates about the causes of health inequalities, and how to address these. Whilst health psychologists have played a key role in exposing the individual determinants of health-related experiences and behaviour, they have too frequently ignored the way in which individual and proximal determinants of health are shaped by wider social context.

Furthermore, whilst health psychologists have produced a bevy of elegant and rigorous explanations of health related behaviour in the context of carefully monitored research studies, these findings often have limited relevance to the challenge of designing and implementing real-world interventions and policies designed to promote health. This is particularly the case amongst the most marginalized social groupings where ill health is most likely to flourish. We argue that the role of academic research should be not only to

understand the world, but also to develop understandings that point towards the possibility of changing it. In other words, researchers should analyse not only the way in which social conditions may be damaging of health, but also point towards the possibility of alternative social relations that are less damaging to health, and map out the processes and mechanisms that would be needed to challenge and alter these. In this regard, the concept of social change is central to both the theory and the practice of community psychology. Community psychologists often align themselves with grassroots social movements working to challenge social inequalities and to promote social justice. Within this context, communities are seen as important social forces in the process of change.

Why the community level of analysis?

Whilst there are many different varieties of community health psychology, its proponents are united by a particular emphasis on the community level of analysis. Communities serve as key mediators between the individual and the social. The definition of 'community' is a controversial area. Within the community health arena, debates often centre on whether it is best to define communities as 'communities of place' (defined in terms of those who live and/or work in geographically bounded spaces) or 'communities of identity' (defined in terms of people who share a common social identity, such as the Christian community or the gay community). Whilst there are equally strong arguments in favour of both approaches, for a range of pragmatic reasons, often related to a combination of resource constraints and convenience, practicing community health workers usually take geographically bounded areas as their focus. Furthermore, given that the most marginalized members of society often lack access to the world beyond

their geographical communities, geographical catchment areas may be their only vehicle for collective struggle and change.

However, residents of place-based communities do not always share common identities or values. On the contrary, local relations may often be characterised by varyingly subtle or obvious differences in access to symbolic or material power. These differences may constitute a microcosm of the wider social inequalities that undermine peoples' health, making local communities particularly useful sites for studying the social processes that undermine health and the possibilities of challenging them. The frequently complex and even conflictual nature of local community relations often forms the contexts within which groups of people (e.g. young men or unemployed people or old people) negotiate the social identities that shape health-related experience and behaviour. They equally often play a key role in enabling or restraining people from taking control over their health. In playing this enabling or restraining role, communities are profoundly structured by the social relations of the wider societies in which they are located, and deeply implicated in the processes whereby factors such as poverty and gender inequalities translate themselves into the most intimate areas of people's lives.

The role of collective action in improving health

Against this background, a key commitment of community psychologists is to understand what constitutes a 'health-enabling community context', and to map out the dialectic of individual and social change involved in promoting such contexts. If many key determinants of individual health are social, the challenges facing health practitioners is that of changing not only individual patterns of health related behaviour, but also the

community and social contexts that sustain ill-health. In this regard, the Brazilian social theorist Paulo Freire (1970, 1973) has been particularly influential through his argument that individuals are most likely to change their own behaviour and improve their own personal circumstances, by simultaneously working to challenge the social structures that disadvantage them. The concept of *conscientisation* is central to Freire's work, which draws heavily on the notion of praxis, understood as action informed by critical social analysis, springing from engagement in the real world.

In relation to health, the first step of this process involves the participation of a group of people in the collective development of critical understandings of how adverse social conditions undermine their health. Ideally, such critical understandings of the social obstacles to health and well-being form a key starting point for this group to mobilise for social change aimed at reducing such obstacles. This emphasis on the dual role of individual and social change in tackling health inequalities goes hand in hand with the belief that a key step in addressing many health issues is the involvement of those affected, facilitating a process whereby they collectively 'take ownership' of the problem. Community health psychologists place strong emphasis on the importance of participation in collective action in increasing the likelihood that people will act in health-enhancing ways, and in lobbying for the creation of community contexts that will enable improved health.

Psycho-social mediators between participation and health

Participation in networks of like-minded people, collaborating to achieve mutually beneficial ends (such as challenging negative social conditions which prejudice their

health) in conditions of solidarity is believed to impact on health in a range of direct and indirect ways. Much work remains to be done in developing theoretical frameworks that conceptualise the psycho-social pathways between participation and health, and in developing appropriate research methodologies for conceptualising these. Elsewhere we have mapped out some of the elements that "a social psychology of participation" would need to take account of (Campbell and Jovchelovitch, 2000). Indirectly, participation in collective action to improve health may result in the development of community networks capable of serving as a potent source of social support, buffering individuals from the health-damaging effects of stress. More directly, participation in such initiatives may increase the likelihood that people will engage in health-enhancing behaviours through a range of processes. The process of *conscientisation* as outlined by Freire constitutes a key psycho-social mediator between participation and health. This involves the raising of a group's critical consciousness of the social roots of their disadvantage, and their understanding of the obstacles they will need to overcome if they are to succeed in creating contexts that are most likely to support and enable them in the struggle for improved health. Ideally, such critical dialogue provides the context for the renegotiation of a group's collective social identity, and the associated social representations that shape the likelihood of health related behaviour change by group members. Ideally, participation in collective action may also increase participants' confidence and empowerment in their ability to take control of their lives in general and their health in particular, increasing the likelihood that they will act in health-enhancing ways.

However, we would argue that a focus on psycho-social processes such as critical thinking, the collective renegotiation of social identities and social representations and

various forms of empowerment is limited and inadequate. Such psycho-social changes need to be accompanied by real changes in a community's access to power and resources. This argument goes hand in hand with a community psychology's on-going debate about the most appropriate level at which to pitch attempts to generate social change in the interests of facilitating health-enhancing community contexts.

Levels of analysis and action: accomodationist vs critical community psychology

The position which particular community psychologists take on what we call the 'levels of analysis and action debate' is often used as the basis for categorising two groups of community psychologists. Seedat *et al*. (2000) distinguish between accomodationist and critical community psychologists. They suggest that, despite notable exceptions, the former often dominate in the northern hemisphere and Australia, and the latter often dominate community psychology in the southern hemisphere (especially in Latin America and South Africa). So-called accomodationist community psychologists are those who take existing economic and political power relations as given, accepting them as legitimate. They seek to promote change at the individual or micro-social levels only, within the framework of the status quo. Those in the more critical camp (with whom the authors of this paper would align themselves) take a more political stance, arguing that many of the social problems which community psychologists seek to address result from wider social inequalities and injustices. They seek to promote analysis and action that challenges the restrictions imposed by exploitative economic and political relationships and dominant systems of knowledge production, often aligning themselves with broad democratic movements to challenge the social inequalities which flourish under global capitalism.

Accomodationist community health psychologists focus their analyses on the impact of face-to-face interpersonal relationships on health. These include relationships between family members, neighbours, peers, or sexual networks. They advocate the need for analysis and action at these levels in the interests of promoting health. Critical community psychologists argue that such small-scale local efforts to bring about change at the level of face-to-face groups of individuals, families or peer groups are deeply conservative (Labonte, 1999). They suggest that 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. By locating the responsibility for health problems within marginalized local communities, such analyses serve as a smokescreen for governments who seek to reduce welfare spending, and development agencies seeking to reduce development aid. Well-meaning community psychologists may inadvertently lend support to unjust social systems through drawing attention away from the impact of social inequalities on health.

We would argue that an effective community psychology is one whose theory and practice draws attention to and challenges the very real power imbalances that generate health inequalities – many of which lie beyond the boundaries of small local communities and beyond the influence of small groups of marginalized community members. For them, the task of community psychology involves not only the psycho-social empowerment of disadvantaged groups but also the transformation of broader processes and structures that perpetuate the social inequalities that so frequently undermine opportunities for health.

Critical community psychologists working with socially excluded communities often align themselves with the concept of people-centred development, placing their emphasis on the development of peoples' skills and capacity to make decisions in ways that strengthen their ability to mobilise for increased control over political power and economic resources (Van Vlaenderen, 2001). They argue that the aim of community psychology should be to investigate and refine our understandings of the ways in which local people can be mobilised to put pressure on those in power to bring about changes necessary to improve their quality of life and health. Success should be evaluated not only in terms of levels of individual and community empowerment, but also in terms of the extent to which societal institutions become more responsive to community demands, and changes in real social conditions.

Moving beyond the psycho-social: the role of alliances and partnerships in creating 'healthy communities'

Within this context community development approaches to health need to aim not only for psycho-social changes, but also for the development of alliances or partnerships between members of marginalized groupings and more powerful individuals and agencies who have the structural power to assist them in addressing the social circumstances that undermine their health (Campbell, 2003). Grassroots community groupings need to build alliances with powerful actors and agencies working together to create community contexts that support and enable the likelihood of health.

Community psychology: Radical praxis or panacea?

This emphasis on alliances or partnerships takes account of the fact that marginalized groupings often lack the economic and political power and resources to change their life circumstances. However, community psychologists involved in partnership-building exercises are sometimes criticised for naively assuming that more powerful groups will be motivated to collaborate with less powerful ones in projects to redistribute these resources. Such critics argue that a focus on community-level determinants of health has the potential to displace attention from the well-established links between health on the one hand, and phenomena such as poverty and racism on the other (Muntaner and Lynch, 1999). It is our view that neither community-level nor macro-social determinants of health can be understood without reference to the other. Community-level factors will often play a key role in mediating between social disadvantage and health.

Thus, for example, poverty is clearly a primary cause of health inequalities, and the economic regeneration of deprived communities is essential for reducing such inequalities. However, if one of the effects of poverty is to disempower people to undermine the likelihood of the construction of health-enhancing participatory community networks and relationships, *economic regeneration* must be accompanied by *social regeneration* (community strengthening) if they are to have optimal success in improving health (Gillies *et al*., 1996).

Concern has been expressed that community psychology's emphasis on concepts such as community and participation are dangerously ambiguous. On the one hand, they serve as potential tools for critical social theorists who argue that it is only through grassroots participation in strong community-based organizations that socially excluded people will gain the power to lobby governments and other powerful bodies to recognize and meet

their needs. On the other hand, such concepts have the potential to be 'hijacked' by neoliberal, free market theorists, who argue that grassroots organizations and networks have the power to take over many functions (e.g. welfare) previously assigned to governments or international development agencies. Such arguments can serve as justifications for cuts in welfare spending in the more affluent countries of the North, and reduced development aid to poorer countries in the South. In order to avoid this perversion of the radical potential of the concept of community psychology, it is vitally important that conceptualizations of participation and community development are located against the backdrop of wider conceptualizations of politics and power.

In response to such cynical criticism of the community psychology enterprise it is our belief that, while many participatory grassroots projects have indeed had disappointing results, there are also many examples of successful community projects, where marginalized people have succeeded in improving their health, and even in contributing to the possibility of more lasting social change. In ideal circumstances, small-scale collective action has been shown to have the potential to feed into multi-level movements towards social change. Furthermore, while not having access to material resources, poor people may often have other strengths and other assets that they can – under some circumstances – mobilize to their advantage.

Arguments of this nature, are, for example, currently being played out in debates about HIV-prevention in Africa. On the one hand are those who argue that community development approaches to HIV prevention have little power to address the wider extra-local economic and gender inequalities that are implicated in HIV transmission. However, in response to such arguments, others have argued against the tendency to view

poor people or women as passive victims of paralysing macro-social forces beyond their control, incapable of acting to improve their lives. Conceptually, there is a sound case to be made that social changes of the kind needed to address the HIV epidemic are best achieved through a combination of top-down and bottom-up efforts. Powerful groupings are unlikely to cede power without pressure from the grassroots. As Bulhan (1985, p. 278) has argued: “Power concedes nothing without a demand.” Such an understanding of social change underpins the argument that, in principle, community-led health promotional networks provide the potential for ordinary people to add their voices and contribute their views to debates about the kinds of social changes that need to be made, and how best to implement these. Active citizen participation has a strong role to play in struggles for social change.

Against this background, we would argue that community psychology has an important role to play in theorising the processes whereby small marginalized communities become empowered to make demands in their on-going struggle for rights and resources, and, where possible in working hand in hand with members of such communities to promote such processes of empowerment, in the context of broader local, national and international struggles against the economic and political inequalities characteristic of global capitalism.

Contributions to this special issue

All the papers in this special issue share a common interest in the role of social context in shaping opportunities for health, and in the role of participation in community

level action in the challenge of creating community contexts that enable and support health-enhancing behaviours.

Four of the papers provide an account of change-oriented community projects seeking to promote the health of particular marginalized communities. In the first of these, Bradley, Deighton and Selby report on a successful ‘action research’ project aiming to develop the capacities of young people (at risk of suicide, substance abuse and mental health problems) to mobilise for political change to improve health outcomes in a previously highly change-resistant town in Australia. This paper provides a powerful demonstration of the potential of the methodology of ‘participatory action research’ (PAR) not only for assessing the capacity of young people at risk, but also for building their capacity to bring about significant change in their local community. The authors locate their PAR approach within the theoretical context of Beck’s account of the impact of reflexive modernisation on young peoples’ well-being, and Bandura’s concept of collective self-efficacy.

Closely related to the concept of collective self-efficacy are the concepts of empowerment, participation and partnerships, which frame the paper by Nelson, Pancer, Hayward and Kelly, who report on a programme seeking to improve the health of children and families in a low-income, multi-ethnic community in Canada. The paper describes obstacles to citizen participation, as well as strategies to address such obstacles.

Citizen participation is also the theme of the paper by Jovchelovitch and Guareschi, who seek to emphasise the psycho-social dimensions of political action in their on-going research into the role of participation and community resources in the implementation of primary health care in the shanty towns of south Brazil. Drawing on the concepts of

dialogue, recognition and levels of consciousness, the authors describe how participation allows individuals to develop a critical consciousness of their deprived living conditions, and to construct strategies for improving them.

The fourth of the papers to report on an intervention is a South African study by Visser, Schoeman and Perold, which provides a critical analysis of a schools-based HIV-prevention and life skills training programme. Within a systems theory framework, the authors illustrate the way in which school-based efforts to promote safer sexual behaviour were hampered by a range of multi-level contextual factors including social norms and the cultural meanings attached to HIV/AIDS, the context of teacher-learner relationships, the organisation and structure of particular schools within the context of on-going problems and challenges facing the wider national educational system.

Similar issues relating to health, community and participation are taken up in three research papers that seek to refine various elements of the conceptual toolkit available to critical community health psychologists with an interest in collective action. Cornish's paper critiques multi-level models that draw attention to the impact of social context on health (such as the biopsychosocial model) for their static depiction of levels of analysis, and their failure to theorise the dynamic interaction between these levels. Drawing on dialogical and socio-cultural theory, she introduces the concepts of 'mediating moments' and 'reflected mediating moments' to address this gap. She illustrates her argument with research into factors shaping condom use by sex workers in India, in the light of her particular interest in the agency of women to challenge the contexts that put their sexual health at risk.

Howarth, Foster and Dorrer interrogate the potential of social representations theory (SRT) for research in the field of community health psychology, arguing that SRT provides a promising and fertile framework for research into the role of competing knowledge systems (especially lay and professional) in shaping peoples' experiences of health; the role of representations in sustaining or challenging the stigmatisation of the "ill"; and the way in which representations of health impact on peoples' social identities in ways that enable or constrain their agency, particularly in relation to resisting stigmatising representations. They illustrate their arguments with data from studies of mental illness in England, and of women's representations of healthy eating in Scotland and Tobago.

The themes of different knowledge modalities, and of the interaction of representations and identities, are taken up in De-Graft Aikins' important research into understandings of diabetes in Ghana, a country in which virtually no community psychology research has been conducted to date. Challenging the simplistic tradition-modernity dichotomy that has characterised much research into health beliefs in Africa, her research maps out the complex interface between knowledge systems and illness action, and highlights how the action goals of people living with diabetes are compromised by structural, community/family and emotional factors. She concludes by highlighting the potential of community-level interventions such as community financing and self-help groups for empowering diabetics to best negotiate their needs for medical, psycho-social and economic support.

Community-level participation is also the central theme in a very different paper by Canadian researchers Mitchell, Steward, Griffin and Loba. They add a community

psychological perspective to another under-researched area, namely that of local responses to major disasters in their study of the 1998 Swissair crash. They examine the impact of disasters on rescue and support volunteers, drawing attention the need for culturally appropriate support and follow-up, including the development of volunteer protocols to address and minimise long-term health impacts.

The special edition concludes with a paper by Murray and colleagues outlining the distinctive nature of the values underpinning critical community health psychology, in the context of their interest in developing frameworks for training. They argue that such values provide a strong framework for the training of community health psychologists who are committed to action in addition to analysis, and to working in alliance with academics from other disciplines and with the disadvantaged communities within which they work. These values are seen as part of the wider challenge of providing conceptual, epistemological and practical alternatives to the more individualistic and clinical orientations that dominates mainstream (or what Seedat would call accomodationist) community psychology programmes. These include caring and compassion, an emphasis on prevention and empowerment, an appreciation of the political nature of human problems, respect for diversity and a strong commitment to social justice.

Conclusion

The rapidly changing and increasingly unequal world confronts health psychologists with the challenge of reflecting on our social and moral responsibilities. We live in a world in which poverty and inequalities in wealth and access to resources are the major causes of ill-health. The challenge is to develop strategies to work with communities to overcome

social deprivation and enhance health and well-being. An activist community health psychology needs to be aware of the political obstacles to progressive social change, and to become a participant in the broader struggle for personal and social liberation. This requires 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 though the broader struggle for social justice. The papers in this special issue touch on these and some other challenges. Whilst we do not seek to provide a fully developed program of research and action, we do hope to provide some pointers to encourage health psychologists to begin to participate in the broader discussions about the wider contexts of their work.

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