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Catherine Campbell and Flora Cornish

Abstract

This special issue celebrates and maps out the ‘coming of age’ of community health psychology, demonstrating its confident and productive expansion beyond its roots in the theory and practice of small-scale collective action in local settings. Articles demonstrate the field’s engagement with the growing complexity of local and global inequalities, contemporary forms of collective social protest and developments in critical social science. These open up novel problem spaces for the application and extension of its theories and methods, deepening our understandings of power, identity, community, knowledge and social change – in the context of evolving understandings of the spatial, embodied, relational, collaborative and historical dimensions of health.

Keywords

collective action, community psychology, health inequalities, identity, knowledge, power, social change, social movements

Introduction

In what ways might community health psychology (CHP) be extended and rejuvenated to take account of the rapid and often dramatic changes in social relations of the past 50 years? The *Journal of Health Psychology* (JHP) is widely regarded as a lively and thriving mix of mainstream and critical work. The authors in this special issue share a commitment to advancing CHP in line with the journal’s critical thrust, mapping out new problem spaces for conceptual and methodological development in the field and new directions for activism. Recent developments in critical theory across the social sciences have disrupted many of CHP’s original assumptions about core concepts such as power, identity and solidarity. There are growing calls

for approaches to community and collective action that are more sensitive to the new and more complex forms of local and global inequalities spawned by the onward march of global financial capitalism, with devastating impacts for the well-being of many groups. The rapid burgeoning of new forms of social protest and collective action that has accompanied the rising crisis of political legitimacy across the

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globe opens up new directions for exciting and potentially very productive new understandings of social change, and the role of communities in advancing it.

In this special issue, we demarcate CHP as that body of theory and practice that focuses on the processes of collective action through which communities collectively identify the impacts of oppressive social relations on their well-being and engage in social struggles to create more health-enabling social environments. Such forms of collective action obviously have centuries-long histories in the spontaneous activism and resistance of local communities against various forms of social inequality and social injustice (Campbell et al., 2010; Hadjez-Berrios, 2014; Reicher, 2004). In this special issue, we focus more narrowly and specifically on the articulation of CHP as part and parcel of the western academic canon of critical social psychology, aired in earlier editorials (Marks, 1996, 2002) and special issues of JHP (Campbell and Murray, 2004; De-Graft Aikins and Marks, 2007; Murray and Marks, 2010). This canon aligns itself with left-wing political interests in challenging the social inequalities that undermine the health of those who suffer from multiple and interlocking forms of economic, political and symbolic marginalisation (Estacio, 2009; Hepworth 2006; Hodgetts and Chamberlain 2006; Kulkarni, 2013; Ng, 2010; Ratna and Rifkin, 2007; Stephens, 2010).

Each of the articles in this collection¹ presents a new perspective on some aspect of CHP. Several draw on insights from outside of psychology, including sociology, law, geography, philosophy, anthropology, political science, development studies and social policy. While a handful focus predominantly on conceptual issues, the majority reflect insights arising from authors' participation in community activist projects of various stripes across six continents, working with marginalised or subordinate groups, including children, beer sellers, the urban poor, social protesters and activists, junior doctors, hospital nurses, patients, the disabled, asylum seekers, soldiers and sex workers and a variety of 'partners' or allies from the

public, private and non-governmental organisation (NGO) sectors. Articles varyingly invite the field to pay more attention to factors such as the historical, political, embodied, unconscious and spatial nature of health and collective action. Some, though not all, articles will take JHP readers into unfamiliar territory, and we ask readers to bear with us if some of the material seems obscure or unfamiliar. Many, though not all, of our contributors believe strongly that many of the field's core ideas have become outdated and that others have lost their critical edge through becoming mainstreamed. For despite its critical origins in, and explicit commitment to, tackling social inequalities, CHP is too often associated with, even defined by, a range of ideas that unintentionally serve to stabilise and affirm, rather than disrupt, an unequal status quo. The articles are presented in the spirit of promoting such disruption.

What is CHP?

Community health psychologists are united by a commitment to exposing and challenging harmful social inequalities, against the background of a broad definition of health as a state of physical, mental and social well-being (World Health Organization (WHO), 1948). Beyond this, they can broadly be categorised into two groups. The first group shines their critical spotlight on academic and professional psychology and the role these forms of knowledge play in supporting health-damaging social relations. A second group – with which we align this particular special issue – looks at real-world instances of social inequality in contexts beyond the academy and the role marginalised groups and supportive allies (including community health psychologists) can play in tackling these.

Work in the ethos of the first group includes Fryer and colleagues' work on the 'psy-complex' (e.g. Fryer and Laing, 2008; Fryer and MacCormack, 2012). Such work is rooted in wider Foucauldian critiques of the way in which the production of academic and professional psychology has led to the 'governing of the

soul' – through a range of 'technologies of subjectivity' that regulate human behaviour, often in ways that sustain deeply problematic power relations (Cromby and Willis, in press; Foucault, 1977, 1982; Rose, 1990; Walker, 2012). Psychologists and their associated academic and professional networks stand accused of acting as 'servants of power', with their work more often sustaining rather than challenging the interests of the dominant classes in unjust societies (Campbell and Burgess, 2012; Fryer, 2008). A frequently used psychological concept that receives particular critical scrutiny by this first group is that of 'the individual', viewed as ontologically prior to, and analytically distinct from, 'the social', a mode of thinking that critics often refer to as the 'individual–social binary' (Nic Giolla Easpaig, Fryer, Linn et al., 2014; Nolas, 2014). This concept of the individual is rejected because it fails to capture the complex and always-already-social nature of personhood (Henriques et al., 1984), and the mutual co-constitution of individual and society through the process of subjectification (Biehl et al., 2007). It is also regarded as deeply problematic because it masks the social rootedness of human ill health, deflecting the blame for human suffering away from social inequalities through locating illness and distress within the decontextualised body and psyche (Summerfield, 2012).

The second body of community health psychologists, represented in this special issue, focus on the additional challenges of tackling social inequalities in the world beyond the academy. They share a commitment to the construction of psychological knowledge and practice that aim to be 'emancipatory' and 'transformative' of health-damaging social relations. Like the first group, they are also deeply committed to deconstructing the problematic concept of the decontextualised individual and to disrupting the individual–social binary. However, this is regarded as the first step of a programme of further politicised action – in which 'scholar-activists' (Murray, 2012a, 2012b, 2012c) work to contribute to wider acts of real-world activism that go beyond academic critique. The resulting activism is often

guided by Paulo Freire's (1970, 1973) conceptualisation of the reflection–action cycle. This is the process through which an external change agent works with marginalised groups to develop new understandings of the roots of their ill health in social inequalities. Such critical insights then form the basis of collective action to resist and ideally transform such inequalities. The challenge of providing new theories, methods and topic areas for such activism will be the aim of the current special issue.

The 'crisis in social psychology'

The spirit of both approaches to CHP by Western academics resonates historically with the literature on the 'crisis in social psychology' that was articulated by critical psychologists in the 1970s (Gergen, 1973; Wexler, 1973). At a time of relative social optimism in the wake of the civil rights movement, women's movement and anti-Vietnam movements, critical social psychologists were acutely aware of how little they had to contribute to wider debates about the possibilities of progressive social change. This led to a great deal of soul-searching. Efforts to explain the political irrelevance of social psychology highlighted its tendency to explain complex forms of social experience and behaviour in terms of properties of the individual or the decontextualised 'group', with groups often conceptualised as secondary to individuals and society often conceptualised as little more than a static backdrop in analyses. Critical attention was also given to social psychology's overdependence on experimental methodologies conducted in laboratory conditions bearing little resemblance to the real world and the ill effects of a situation where most psychological research was funded by government agencies searching for ways to wield power more effectively, and big businesses seeking to increase their profits.

By contrast, community psychology's emphasis on the theory and practice of community mobilisation seemed to offer greater possibilities for social and political relevance

through the following: its explicit anti-individualism emphasising the community rather than the individual as its level of analysis; its explicit commitment to action research centred on issues relating to social and health inequalities in real-world settings and its focus on working in partnership with marginalised social groupings on projects seeking to resist or tackle social inequalities. CHP projects were more likely to be sponsored by agencies sympathetic to the plight of the marginalised, and the sub-discipline was driven by a very explicit commitment to the ‘empowerment’ of excluded groups as a key enabler of individual health and well-being.

Community health psychologists have sought to tackle many of the problems identified in the ‘crisis’ literature, working long and hard to develop frameworks and models for research and action. However, their efforts have not always yielded sustainable increases in opportunities for health among marginalised groups, leading to calls for theoretical renewal (Campbell, 2014). Furthermore, there is a growing sense that the field needs to renew its conceptual and methodological base to take account of new developments in critical social theory, new forms of social inequality highlighting the complexity of power relations and new forms of political protest. There is also a sense that this evolving field has a key contribution to make to a wider range of topic areas. We now provide an overview of this special issue’s articles against this background. We emphasise that each article involves a kaleidoscope of insights, touching on many or all of the debates and issues we are only able to flag up in a cursory way below. This introduction is intended as a taster, and certainly not an exhaustive account of the rich complexity or contribution of any single article.

Reimagining CHP for the 21st century

The key intellectual challenge facing CHP remains, as in the ‘crisis’ years, the challenge of

talking about embodied and always-already-social human subjects in ways that avoid the Scylla of the decontextualised individual, and the Charybdis of the dreaded individual–social binary. The latter refers to a conceptualisation of individual and society as if they could meaningfully be spoken of as separate entities. The challenge facing CHP is sometimes seen as that of explaining the relationship between the two. Community is sometimes postulated as a third, also distinct and separable, level of analysis – often positioned as a ‘mediator’ between the individual and society. Other targets for criticism are onion-like models of micro-, meso- and macro-levels of analysis postulating each as distinct ‘layers’ of experience, the notion of ‘person-in-context’ (with context as a static independent variable impacting person as a dependent variable) and the structure–agency binary (Cornish, 2004).

It is probably the case that colleagues who use onion models or talk about ‘persons in context’ often do so metaphorically, and as an analytical shorthand to indicate complexity, rather than through iron-clad commitments to ontologically distinct layers of existence. However, there is now general agreement that while this shorthand mode of thinking may have served as a useful stepping stone in the development of CHP, there is a need to move beyond it. Through their failure to capture the complexity of the processes through which social inequalities become inscribed on human minds and bodies, these concepts have become blunt tools for action that aims to facilitate emancipatory social change.

Beyond binaries

Albeit in very different ways, all the special issue articles deal with the way in which binary thinking constrains the theory and practice of CHP. In a theoretical article, Nolas (2014) talks about ‘working the hyphens’ between binaries. She argues that De Certeau’s (1984) theory of practice, rooting social science in the everyday experiences of ordinary people as they go about

their business, opens up a new terrain for understanding social relations. It also opens possibilities for new forms of transformative collective action in ways that are faithful to the complexities of human experience and social change that elude schematic or dualistic thinking. Similarly, Nic Giolla Easpaig et al. (2014) highlight the straitjackets that binary notions of ‘person-in-context’ have placed on understandings of identity, difference and gender – all core concepts in CHP. They show how Queer Theory, and more particularly Butler’s (1990) notion of subjectivity as a performance, opens up new understandings of the way in which subjectivities are simultaneously constitutive of and constituted by power relationships in ways that are effaced by simplistic binary thinking.

In a very different empirical article, Tucker (2014) draws on Lewin’s (1936) topological account of psychological life spaces to undercut the individual–social binary in his study of photographs of a mental health service user’s home. He argues that psychological distress is spatially distributed, with spaces constituted by the mutual co-construction of individual bodies, social environments and action, all equally implicated in the psychological organisation and management of health-related experience.

Embracing messiness

In addition to problematic binary thinking, many other standard tools of CHP are also criticised for their inability to apprehend the messy nature of complex health contexts. In a theoretical article on health communication, Gillespie, Reader, Cornish et al. (2014) highlight how the daily realities of relationships between disabled people and informal carers, senior and junior hospital doctors and multi-stakeholder participants in participatory public health programmes operate outside the boundaries of the Habermasian ideals of dialogue (Habermas, 1981), so often postulated as guides to best practice in our field. In a very different context, Haaken and O’Neill’s (2014)

methodological article highlights the way in which the narrative frames used by well-intentioned supporters of African asylum seekers trap them into flat stereotypes that fail to capture the complexity of their moral claims and their life histories. They draw on psychoanalytic feminist theory to inform their use of participatory action research to develop more complex narratives, with women asylum seekers using photos and videos to narrate the textured and nuanced accounts of their daily engagement in seeking a place of safety in the United Kingdom.

Along with several other authors, Haaken and O’Neill warn against methods of research and practice that ‘write out’ the humanity of peoples’ lives and experiences. Hodgetts, Chamberlain, Tankel et al. (2014) centre their article around the suffering and humiliation arising from the rotten teeth and resulting bad breath of Jade, a welfare claimant in their poverty study. Tucker pays close attention to the link between the positioning of the dishwasher in the kitchen of Steve, a mental health service user, and his coming to terms with his mother’s death. Haaken and O’Neill also remind us that part of the messiness of CHP often lies in the relationship between researcher-activist and ‘the excluded other’ in the collaborative process of knowledge production. As researcher-activists, we bring a raft of our own projections and fantasies to our engagements with ‘the other’. The unconscious emotional investments we bring to this work are an important but neglected area of exploration in CHP. Haaken’s (2010) discussion of the ways in which the unconscious projections of community health psychologists shape responses to domestic violence in the United States could be a useful starting point for further work in this area.

Nolas (2014) and Speer, Tesdahl, Ayers et al. (2014) also emphasise the messiness involved in translating the ideals of CHP into action in real social settings. In working with communities, rather than abstract theoretical concepts, Nolas speaks of the ‘hard graft’ facing community health psychologists who must continually adapt

to the unexpected and complex ways in which communities and other 'stakeholders' respond to their input, subverting or resisting the best-laid plans. As a result, improvisation is a key skill for community activists.

Speer et al. illustrate such improvisation in their account of a coalition of faith-based organisations in the United States. The group campaigned vigorously for improved public transport only to find that as soon as the rail line they supported had been approved, the three stops that would most benefit communities of colour had been erased from the plan, and they had to regroup and commence a new campaign. If community realities are messy, community health psychologists might be less well served by abstract theories or dogmas about how the world is 'supposed' to be and about the direction in which social change 'should' proceed, and better served by ideas for useful processes and practices that can be adapted to local contexts.

Attention to process

Close attention to the organic processes that constitute identity and the possibility of particular forms of collective action and social change in particular real-world settings is a core theme in many of the articles. This emphasis is postulated as a critique of the 'grand narratives' of change implicit in 'planned social change' approaches taken by many CHP programmes, which envisage a linear process from identifiable inputs (e.g. empowerment workshops and advocacy training) to predictable outputs (e.g. increased health service access by previously excluded groups). Cornish, Montenegro, van Reisen et al. (2014) outline lessons CHP can learn from the Occupy movement, focusing on the movement's refusal to lock itself into instrumental models of action, and its profound commitment to open-ended, anti-hierarchical and inclusive modes of community action. The movement is an example of 'pre-figurative politics', instantiating examples of emancipatory forms of community and organising, as both

experiments for the future, and a critique of the present (Unger, 2007; Wright, 2010). Occupy teaches scholar-activists of CHP the possibility of 'trusting the process', allowing for an activism of open-ended exploration rather than operating with clear accounts of fixed goals and objectives, nestled in a 'grand narrative'.

The relational nature of knowledge production: Collaborations, alliances and social movements

Cornish et al. highlight the centrality of new forms of knowledge and imagination in enabling creative and timely community mobilisation. Several authors also take up this point, emphasising the processes of development of new forms of actionable and health-enabling knowledge in various contexts. They emphasise the need for knowledge that integrates insights from the worldviews and expertise of diverse participants in the process of community mobilisation in projects where the inputs of all participants are equally valued, irrespective of their social status.

Rose (2014) considers the role of mental health service user researchers in producing scientific knowledge. She argues that researchers, be they medically qualified or 'experts by experience', all come from 'standpoints' (Harding, 1993) that substantively affect the knowledge they produce. Patient-centred systematic reviews of Electroconvulsive therapy in the United Kingdom produced different findings to those conducted by medical researchers who systematically understated the negative effects of the therapy. Involving patients in health research is not simply an ethical, empowering process for the patients, but a process that leads to radical changes to scientific knowledge itself.

The networks and processes through which programmes of community mobilisation generate new ways of being, seeing and doing are implicit in the concept of the 'partnerships' (between communities and potential support agencies in the public and private spheres and

civil society) that lie at the heart of many community health projects. However, they are notoriously difficult to set up and manage in a way that reflects the interests of marginalised groupings (Li, 1999), and much remains to be learned about how best to conceptualise and manage them. Bourdieu's (1986) account of the rationale for partnerships provides a helpful starting point, in his claim, that differential access to supportive social networks and relationships is a key driver of social inequalities and that activism by highly marginalised communities is unlikely to impact complex health problems without alliances with more powerful groups. Several articles focus on the role of partnerships in framing knowledge that reflects the experiences of marginalised groups.

Drawing on case studies of community health projects in Cambodia and Brazil, Aveling and Jovchelovitch (2014) characterise multi-stakeholder partnerships as knowledge encounters. The latter are understood as situated and evolving processes through which diverse participants unite in reflecting critically on their respective health-related knowledge. Ideally, this process of mutual exchange, learning and growth goes hand in hand with the development of new and more health-enhancing ways of being, seeing and acting by all participants. As such, the process of developing partnerships should *in itself* be seen as the intervention and criterion for intervention success rather than being seen as a tool for intervention as is usually the case.

Stephens (2014) discusses how resistance by dominant groups often undermines the best efforts of collaborative participatory action research programmes to generate health-relevant knowledge that reflect the needs and interests of subordinate groups. However, she draws attention to the potential for social movements to pull together activist networks that strengthen the voice of the marginalised (Crossley, 2002), highlighting the way in which the social media have expanded opportunities for enabling interactions between an increasing range of allies.

Vaughan (2014) highlights the painfully fraught efforts of young people in Papua New Guinea to bring their own knowledge of their needs and experiences to the attention of powerful groups. She draws on Fraser's (1990) concept of 'counter-public spheres' and the notion of 'in between spaces' to explore the spaces between the new and more agentic self-narratives developed by youth in peer education groups – and the brutal and limiting nature of their social worlds outside of these nurturing spaces. These social worlds provided scant recognition of youths' lifeworlds and minimal access to education, physical safety or pathways out of poverty – all cornerstones of young peoples' own articulations of their hopes and dreams.

Power, 'empowerment' and social change

The concept of power is a central theme in every article in one way or another. In a wide-ranging review, Campbell (2014) weighs up the value of both materialist (Freire, 1970) and social constructionist (Gibson-Graham, 2006) understandings of power and social change for health struggles in different contexts. She argues that while social constructionist perspectives may often be useful for framing health and other forms of social activism by groups with access to the preconditions for 'life itself' (food, physical safety and life-saving health care), materialist perspectives may often be more productive analytical tools for framing health activism in favour of those who do not.

Lubek et al.'s (2014) work looks at marginalised women who sell beer for international companies in Cambodia. They caution against an overhasty reframing of CHP by non-binary and fragmented understandings of power that obscure attention to the need for fairly 'grand' programmes of resistance to oppressive labour practices by profitable international businesses in poor countries. Beer sellers' access to health is repeatedly undermined by the persistent refusal of global businesses to implement

appropriate health and safety standards for their workers, and by the seemingly insurmountable challenges facing efforts to persuade them to do so.

Ansell (2014) also draws attention to the irreducibly material dimensions of power in her critique of the concept of 'empowerment' of AIDS-affected children in sub-Saharan Africa. She argues that efforts to empower children need aim for not only the 'enlightened self-transformation' of children themselves but also the transformation of the economic factors that threaten their survival, and the intertwined cultural and relational practices that silence their voices in their families and in the national and international contexts that contextualise efforts to improve their health (Ruddick, 2007a, 2007b).

Reflecting on advocacy work with urban poverty and health inequalities, Hodgetts et al. (2014) also refer to the multifaceted nature of the lives, frustrations and dilemmas of New Zealand families in poverty. They frame their work within an academic tradition explicitly committed to the fight against social inequalities, including participatory action research (Kindon et al., 2007), the public intellectual movement (Posner, 2001), liberation psychology (Martin-Baro, 1994) and the scholar-activist tradition (Murray, 2012a). Speaking of 'embodied deprivation', they highlight how poverty impacts materially and psychosocially through social and economic exclusion, educational challenges, stigma, physical hardship, underemployment, hunger, violence and limited service access. These cannot be tackled without committed alliances between communities and powerful groups across a range of social sectors, and not just health and welfare. Community health psychologists can play a key role in such alliances, but need to work not only with local communities, but also with scholars from other disciplines and activists from a range of public, media and civil society groupings.

Speer et al.'s (2014) community project sought to go beyond small-scale volunteerism aimed at 'helping' afflicted individuals to tackle

government policies at the state level, through forging such alliances. Starting as a collaboration between small grassroots groups, it gradually extended its networks. Activists used a 'power analysis' (Mondros and Wilson, 1994) to forge strategic relations with powerful public health, research and policy networks sympathetic to the relationship between health, transport, food, work, education and affordable housing, finally winning the fight for rail stations in minority neighbourhoods.

New topics

Historically, CHP has focused on the theory and practice of health activism in small local communities, expanding over time to pay attention to the contexts of small-scale local mobilisation (Campbell and Cornish, 2010). Several authors challenge the field to extend its sights, flagging up new 'problem spaces'. New topics enable us to increase the impacts of our concepts and methods to new topic areas that might benefit from what we have to offer. They also afford opportunities for us to refine our thinking through testing and honing it in new situations.

Reader, Gillespie and Mannell's (2014) article on patient neglect in UK hospitals argues that the insights of CHP are urgently needed, in a context where neglect is too often regarded as an issue of individual behaviour to be bureaucratically managed. Treating hospitals as communities (i.e. as people with relationships), rather than as bureaucratic institutions (i.e. as structures with targets) offers transformational potential (Habermas, 1984). Hospitals have not been a traditional focus of CHP, but this article shows how they could be.

Like hospitals, schools are institutions but also communities. Andreouli, Howarth and Sonn (2014) examine how British schoolchildren engage in multicultural life, given the contribution of racial discrimination to health inequalities. Attempts to promote inclusion have been too top-down, assuming majority children need to be taught not to be prejudiced,

rather than recognising the ‘convivial multiculturalism’ (Gilroy, 2004) and everyday acts of resistance to racism that children practice. They open up both the topic of prejudice/multiculturalism and the site of schools as appropriate ground for CHP.

Moving from large-scale institutions to health-related behaviour, Kagee, Swartz and Swartz (2014) open up the personal act of adhering to medical treatment to a historical and political analysis. Drawing on Nguyen’s (2004) work on therapeutic citizenship, they argue that adherence to AIDS drugs in South Africa – traditionally treated as an individual-level issue – is a deeply historical and political act, and show how the meanings patients give to adherence has shifted at different moments of the country’s fraught AIDS history. Like Reader et al., they make the case for the crucial contribution of a contextual, community analysis to understanding health behaviour in a clinical context.

In another historical article, Hadjez-Berrios (2014) seeks to expand CHP’s focus on small-scale local intervention projects, to take account of spontaneous community action as part of more widely conceptualised historical and political currents of change. His study examines the role of popular mobilisation in Chile during the 1970s in achieving a well-functioning public health and primary care system (Navarro, 1974; Waitzkin et al., 2001). Hadjez-Berrios argues that traditional attention to ‘community participation’ as small-scale local efforts by NGOs fails to acknowledge the major role of community mobilisation in demanding progressive health policies and producing social change in wider historical and political contexts that fall beyond CHPs traditional remit.

All these authors highlight ways in which insights from CHP are relevant to topics beyond the traditional focus on small-scale-planned local projects. CHP is founded on respect for the agency and wisdom of communities, believing that the foundation for human sociality, organisation and creativity lies in the everyday human relationships and practices in communities. This insight is applicable to topics from individual behaviour such as adherence (Kagee et al.,

2014) or patient neglect (Reader et al., 2014) to institutions, including schools (Andreouli et al., 2014) and hospitals (Reader et al., 2014), and science (Rose, 2014) or institutional partnerships (Aveling and Jovchelovitch, 2014). If community health psychologists and activists have a good understanding of the social psychology of power and of human relationships, they have something to offer all of these new domains.

Conclusion: Embracing maps and journeys

The articles gathered in this special issue of JHP have each, in their own way, extended an invitation to scholars and activists to reimagine CHP in ways that disrupt received wisdoms and open up new ways of being, seeing and doing. This introduction has only scratched the surface of the richness and complexity of individual articles, and a careful reading of each will generate a depth and breadth of insights that goes way beyond the points we have raised here.

Authors have varyingly generated debate on ways of reconceptualising binary notions (such as individual–society, male–female or powerful–powerless) that have so often constrained effective action and practice. Some have emphasised the need for scholar-activists to make greater efforts to embrace the messiness of real-life social change projects, which often defy the restrictions of predetermined models of planned social change generally favoured in the community health field. Others have called for a more improvisational approach to collective action that is grounded in real social situations and unfolds in an organic way, ‘trusting the process’. This emphasis is encapsulated in Nolas’ (2014) vision of a version of CHP that pays less attention to maps, and greater attention to journeys.

However, other authors, particularly those centred on groups in the most severely marginalised settings, caution against an overenthusiastic faith in completely unplanned and fragmented theory and practice, and an overemphasis on the symbolic dimensions of human health and

experience, in settings where people lack the material wherewithal for basic survival. They caution against an overhasty rejection of understandings of power and social change that fail to take account of the degree of material and embodied disadvantage facing those groups who often suffer the poorest health in the most oppressive social settings.

It may be the case that not all binaries are equally problematic in different contexts. Clearly, individual–society binaries that deny the social constitution of human experience and health are deeply problematic, as are binary distinctions between male and female in many contexts. However, binaries such as powerful–powerless may sometimes be useful tools for conceptualising the health and well-being of those who die from preventable diseases, or from avoidable work accidents, due to a lack of political will by governments or employers with the power to prevent such deaths. Such deaths represent a limit to agency in a way that cannot be accounted for in many social constructionist frameworks.

Campbell (2014) argues that it may be time to stop seeing social constructionist and materialist approaches to power and social change as mutually exclusive. She argues that each might be regarded as a toolkit for conceptualisation and action in particular settings – varyingly appropriate to the experiences of citizens of a global world in which experiences of inequality are often grounded in vastly differing degrees and forms of deprivation and marginalisation, inviting different conceptualisations of power and change on a case-by-case basis.

Several authors provide promising new perspectives on the relational nature of health-related knowledge production in the unequal social settings that constitute many community health projects. They focus on the possibilities and limitations of collaborations, partnerships, counter-public spaces and social movements in efforts by diverse groups to co-construct actionable understandings of health and society that further emancipatory social change. Each article provides a different perspective on ways in

which projects of collective action might best succeed in constructing knowledge that gives full recognition to the worldviews, needs and interests of groups historically excluded from the health-related public sphere – rather than foregrounding the expertise of health professionals and of powerful groups as is often the case.

The variety and complexity of the articles and the diversity of ideological positions and topic areas embraced by the contributors indicate the ‘coming of age’ of the discipline of CHP in two interrelated ways. First, they indicate the ongoing and productive expansion of CHP beyond its traditional focus on small-scale local community health projects, casting its net to take account of a far wider set of complexities, contexts and relationships that frame the possibilities and practices of community and of collective action. Second, they suggest that CHP’s range of theories, methods and practices are evolving to keep pace with the ongoing transformation of social relations and social inequalities, as well as new forms of collective action and social protest, that characterise the new millennium.

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