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A socially situated approach to inform ways to improve health and well-being

Abstract

Mainstream health psychology supports neoliberal notions of health promotion with self-management as central. The emphasis is on models that explain behaviour as individually driven and cognitively motivated with health beliefs framed as the favoured mechanisms to target in order to bring about change to improve health. Utilising understandings exemplified in critical health psychology, we take a more socially situated approach focusing on practicing health, the rhetoric of 'modernisation' in UK healthcare and moves toward democratisation. While recognising that within these new ways of working there are opportunities for empowerment, and user-led healthcare, other implications become evident. Explored is how these changes link into simplistic, cognitive behavioural ideologies of health promotion and rational decision-making. Utilising two different empirical studies, this paper highlights how self-management and expected compliance with governmental authority in relation to health practices position not only communities who experience multiple disadvantage but also more seemingly privileged social actors. Presented is a challenge to self-management and informed choice, with the importance of 'navigational networks' evident. The ways in which healthcare can become remote and inaccessible to certain sections of the community, yet pervasive and deterministic for others, conveys the need for multiple levels of analysis and different forms of action.

Key words: health psychology, democratisation, empowerment, self-management, health promotion

The problem with health as a 'behaviour'

The dominant neoliberal ideology pervasive in late capitalist societies is based on the expansion of an economic rationality to all domains of social life. This ideology encourages a particular kind of individual entrepreneurial enterprise whereby what were previously deemed to be the state's responsibilities are devolved to responsible, rational individuals (Lemke 2001). This ideology has become galvanised within health promotion, with self-management central to the project. However, Miller and Rose (2008: 39) argue that the achievement of such political ends is exercised indirectly through the notion of 'action at a distance'. They argue that self-regulation is normalised through 'expertise'. This expertise includes psychological understandings which can be used to manage domains such as health. Such expertise includes health psychology which informs many contemporary approaches to health promotion and policy.

In concordance with neoliberalism, a particular ontology of personhood is assumed in mainstream health psychology and approaches to health behaviour change. The emphasis is on individually driven and cognitively motivated people; with health beliefs and attitudes framed as the favoured mechanisms to target in order to bring about behaviour change. This cognitive approach is epitomised by the dominant social cognition models. These models essentially conceptualise health behaviour, or more commonly intensions, within a cost/benefit, decision-making framework. However, critiques of the cognitive approaches to health behaviour change emerged through the 1970s and 80s. A more contextualised understanding of health and

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illness emanating from anthropological, sociological and psychological scholarship began to develop. This scholarship emphasised, for instance, the importance of social representations and culture in understanding health behaviour (see, for example, Herzlich 1973, Blaxter 1983). In conjunction with this literature, the developing critique of psychology as a discipline over the past 20 years (see, for example, Fox *et al.* 2009) provided the conditions for a similar critique of health psychology; to the extent that critical health psychology is now a movement in its own right. Criticisms of mainstream health psychology centre on epistemology, ontology and methodology. Four interrelated key areas of critique include questions about the nature of health behaviour, problematisation of the view that people are rational decision makers, questions about the degree to which the social context is taken into account, and a highlighting of problems with the quantification of heath related activities.

Firstly, cognitive approaches are seemingly premised on the idea that health behaviours are easily identified and unitary, with their meanings unchanging across the diverse range of contexts and settings in which they might be carried out. Mielewczyk and Willig (2007) argue that 'health behaviours' as defined in this way do not exist. They reconceptualise 'behaviours' as health related activities which cannot be divorced from the meaning and importance bestowed upon them by wider social practices. Therefore they argue it would be better to focus on 'wider social practices of which such actions form a part' (Mielewczyk and Willig, 2007: 829). Secondly, despite the early promise of cognitive psychology, Stainton Rogers (2012: 46) argues cognitive approaches in health psychology conceptualise people crudely as 'naïve scientists' (simplistically testing hypotheses in attribution theory) or 'accountants' (calculating costs and benefits in theories of behaviour change) rather

than social actors. Further, the price of a decision-making, neoliberal approach is that the self-determining, 'good' citizen is characterised as making the 'right' choices and as taking personal responsibility for their health (Crawford 2006, Davies 2005); therefore being blamed for making seemingly irresponsible or irrational 'choices'. Thirdly, though certain models consider social aspects of behaviour, for example, the theory of planned behaviour includes subjective norms which consist of beliefs about important others' attitudes, and behaviour and motivation to comply with others (see, Ajzen and Madden 1986), they do not substantially incorporate social and contextual aspects of health and illness. This is because they investigate social cognitions such as attitudes and control beliefs (Mielewczyk and Willig 2007) which are, inevitably, individual perceptions of social phenomenon. Finally, the value of social cognitive models rests on their ability to predict health behaviours; which they do in a particular way. Variables such as attitudes towards the behaviour, self-efficacy, perceived costs and perceived barriers, which aim to assess subjective dimensions of behaviour, are 'measured' by means of questionnaires. In what Stainton Rogers (1991: 55) refers to as 'cognitive algebra' models, these variables are subject to increasingly sophisticated methods of statistical analysis. However, Crossley (2008: 23) suggests that critical health psychologists ask important questions about such techniques, specifically: 'Is something essential being lost in the attempt to quantify subjective experiences in this way?' She suggests that quantification of health related activities results in simplistic representations of experience which, by their nature, are infused with ambiguity and complexity.

Therefore critical health psychologists are broadly in agreement that it is more useful to focus on 'health behaviour' as social and situated practices. To this end they largely adopt different epistemological, ontological and theoretical stances to

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mainstream health psychology (including social constructionism, post-structuralism, feminism and Marxism). In addition, they have largely employed qualitative and participatory methods (e.g. discourse analysis, participatory action research and narrative analysis) to develop more socially grounded and relational understandings. This involves investigating health related practices (rather than behaviours) which can only be understood through their relationship with wider social activities. As Crossley (2008) and Murray and Poland (2006) make clear, health and illness are rooted in more than biomedical explanations, they are enmeshed in broader social, cultural, political and historical contexts. While critical health psychology's initial focus was on critiquing mainstream health psychology, recent debates have moved on to consider how a reformulation of health psychology might take place (see the collection of papers in *The Journal of Health Psychology* volume 11, part 3, 2006, Crossley 2008) for an extended discussion of these debates). Recent directions include developing action to improve health (see Authors, 2012). In this paper we therefore draw upon our own research which has adopted a socially situated and relational position, acknowledging the interactive and structural nature of health practices.

Contemporary healthcare relations: responsible and reflexive consumers

In engaging with some of the more situated and relational positioning of health practices it is important to consider the nature of contemporary healthcare. In a time of economic austerity, governments are looking for ways to limit and reduce healthcare spending while at the same time engaging in a dialogue that offers assurances around maintaining levels of service. There is growing interest in the delivery of 'lean healthcare' (see Waring and Bishop 2010) with an emphasis on eliminating waste and simultaneously adding value to customer/patients (de Souza

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2009). There are also ongoing debates regarding proposed reforms and restructuring, with claims that managerialism has replaced professionalism in the social organisation of healthcare (Kitchener 2000). Alongside what is termed 'modernisation' and different modes of interaction, come new forms of governance in healthcare with ever changing relationships. The involvement of the public in the management and provision of public services is now prominent throughout economically developed countries. This connects with notions of 'co-production' whereby those in receipt of services are no longer characterised as passive, rather there is a shift toward information exchange and shared decision-making (Realphe and Wallace, 2010). In the UK we have the promotion of 'Patient and Public Involvement' (PPI) in health with 'citizens' participating in the difficult process of managing and commissioning healthcare, and 'service users' who have experiential knowledge and treatment insight being consulted in relation to their care. While issues of representation and inclusion are fundamental challenges linked to PPI and the notion of participating citizens, it is the later distinction of service user involvement that is a priority for this section of the paper.

As has already been outlined within the health psychology domain, the focus is primarily on individuals, with health promotion attempting to change individual behaviour, promoting self-management by rational decision-makers. There is an implicit narrative of responsibility in that if we are unable to self-manage our health and well-being then we are in deficit at a very personal level. Associated with the emphasis on self-management is the notion of the 'expert patient' which under the guise of co-production and democratisation has emerged in UK health policy (Department of Health 2001, Fox *et al.* 2005). Work to transform the healthcare professional/doctor-patient relationship from a professional led interaction to one that

is more of a healthcare professional-patient partnership seems a laudable goal. Here 'expert' and 'informed' patients are service users who are able to articulate their individual needs (self-manage) thus deploying their expert knowledge and exercising informed decision-making in relation to appropriate treatments/action. Without doubt patients often have expertise in their own illnesses, how to promote health and have intimate knowledge of the circumstances in which they live. Still there is a need to consider that this may not be sufficient to understand the technical complexities of disease causation (Prior 2003). However, with the growth of web-based health related information, interactive forums and consumer websites, it is claimed that people have been transformed into 'reflexive consumers' of healthcare (Henwood *et al.* 2003). This is alongside a range of other media in which the apparent information needs of patients/consumers are being met (see Eysenback, 2000). Arguably, this availability of information has served to usurp health professionals' monopolies over their own knowledge base. Nonetheless, these changes should not blind us to the recognition that as Fox *et al.* (2005: 1308) suggest, 'if the 'expert patient' is to be understood as a reflexive project of self-governance, then it is indeed a 'technology of the self', a disciplining of the body in relation to systems of thought.' Within these observations is embedded a cautionary message which demonstrates that people are being positioned as responsible for self-management of health and well-being. Notions of empowerment, sharing of power and user-led healthcare do offer avenues for action and change by resisting the imposition of power but it is important to also envisage other implications. Significantly, all patients may not wish, or are able, to lay claim to the material resources and/or technical competence necessary to take responsibility for their health. Alternatively, constraints related to the discursive environment, including moral obligations and medical authority, may be so strong

that they leave little room for questioning and decision-making as we generally understand it to operate. Nettleton and Burrows (2003) specifically point out that the utility of internet information relies on the reflexive capacities of users to interpret, discern and marshal such information to achieve positive outcomes. Hence the move becomes more than merely being positioned as rational decision-makers; the individual is required to be skilful and able to garner expertise and technical competence in order to secure health and well-being. Here 'practicing' health as an activity is key, with Martin (2008) explaining that with the clinician no longer the sole source of expertise; 'experiential sensibility' becomes enmeshed with the technical detail of medical science. Arguably, the delivery of 'lean healthcare' is requiring of lay expertise, self-management and compliance. This prompts questioning of whether the democratisation of knowledge we are seeing is responsible for constructing us all as able to make fully 'informed' health/lifestyle choices that ensure we are aligned with current governmental authority. There are a range of intersecting difficulties and constraints entangled within these conceptualisations of individual action. Such positioning fails to take account of the wider social, relational and discursive environments in which people operate and live their lives. Therefore, the two research examples we now move on to present serve to demonstrate how these modernising and democratising developments in healthcare may empower some but can also effectively bypass certain groups and impose choice on others.

Socially situated action for change

Notions of self-management and alignment are critical to understanding existing approaches to health promotion and the impact of aspects of democratisation in

healthcare. Martin-Baro (1994: 22) asks us to consider how individualism reinforces the existing structures reducing all structural problems to personal problems. He goes on to argue that psychologists should adopt the 'preferential option for the poor'. While there has long been a focus on the ways people live their lives, it is fair to say that individualised approaches within health psychology are indifferent to the endemic social inequalities that prevail both at a global and more national level. The Strategic Review of Health Inequalities in England Post 2010 (Marmot Review 2010) corroborates extensive evidence stressing the widespread nature of health inequalities in the UK (Department of Health 2009, Menvielle *et al.* 2009, Scarborough *et al.* 2008). Also acknowledged is the stark fact that social and economic inequalities underpin the determinants of health with associated interacting variables shaping health and well-being. Graham (2000) describes these interacting variables in terms of *material, behavioural* and *psychosocial* factors. Material factors relate to the physical environment of the home, the community and the workplace, and standards of living obtained through forms of income; behavioural factors might include smoking, exercise and diet; and psychosocial factors, the perceived personal and emotional costs of living in an unequal society. It is widely accepted that these factors cluster together with people in lower socioeconomic groups experiencing an increased risk of being exposed to all three factors. As argued earlier, health and illness are enmeshed in broader social, cultural, political and historical contexts (Crossley 2001, Murray and Poland 2006). Therefore, self-management and alignment with governmental authority may not be possible for some people due to a range of intersecting factors.

Yet, much of the health promotion activity is predictable, being exemplified in campaigns that are targeted at individual lifestyle change underpinned by the social

cognitive models outlined earlier. Such campaigns are distanced from the sociocultural milieu of people's lives yet they often conveniently target the behaviour of those experiencing material disadvantage (Nettleton and Bunton 1995). Implicit in these campaigns is that people have choice in their lifestyles, being able to engage in positive health behaviour that is health enhancing and refrain from engaging in negative health behaviour which is detrimental to health (Lyons and Chamberlain 2008). Often overlooked is the much wider application of health promotion outlined by, for example, Tones and Green (2002), who advocate that health promotion has a two-fold purpose: to reduce the external barriers that exist to empowered choice developing 'supportive environments' and to build upon the capacities of individuals so they are better able to control the environment around them. In this formulation there is an acknowledgement that people live their lives as socially situated selves, with people engaged and active while at the same time experiencing certain restrictions. Notably, the need to empower individuals and communities is at the centre of the Marmot Review's vision for reducing health inequalities. Still, empowerment is a much used term that can be indicative of both a process and an ultimate goal. For example, Gutierrez (1990: 149) sees empowerment as a 'process of increasing personal, interpersonal or political power so that individuals can take action to improve their life situations.' Rappaport (1987: 121) suggest more of an endpoint or goal with empowerment being 'both a psychological sense of personal control or influence and a concern with actual social influence, political power and legal rights.'

The first author has recently been involved in evaluating a public health promoting intervention which was a joint initiative between a UK National Health Service (NHS) commissioning officer and a social housing provider. The NHS commissioned the

social housing provider to pilot a project where 'Health Support Workers' (HSWs) were actively working in the community to provide a 'support and signposting service' to people living in local rented accommodation. The aim was to work in the community supporting and enabling individuals and families to take action to make changes that might improve their health status. This work primarily involved listening to people and helping them to find solutions to some of the difficulties they were experiencing in their lives. One of the most revealing aspects of this work was that individuals and families were experiencing multiple mental and physical health difficulties with health issues highlighted as a priority for 92% (N=327) of tenants who engaged with the pilot project. Action for change is not easily achieved, many of tenants had 'lifestyles' that were impacting on their health and well-being, with alcohol and drug use an issue for some and exercise, and more generalised activity, low for many. Financial worries were prevalent for 38% (N=124) of those working with the HSWs. Poverty and social exclusion are known to undermine people's access to health-related knowledge (Campbell and Jovchelovitch 2000); they lack the power to shape their life course and are less likely to believe that they can take control of their health. Indeed, many of the communities targeted for community health interventions experience what Leonard (1984) terms 'involuntary social marginality' due to a range of social, economic and cultural issues. Similarly, Burton and Kagan (2003) refer to psychosocial-ideological threats with certain communities having a marginalised identity that has become internalized, impacting on self-esteem and motivation.

When interviewed about the services provided by HCWs, it was revealing to hear just how far removed some of the participants were from the notion of empowered choice and active engagement. Their talk showed that the work of the HCWs was

crucial in terms of providing essential support to families who had *not* become 'reflexive consumers' of healthcare. Many clients discussed not knowing about the support they could receive or where to go for services. Maggie described the time her husband came home from hospital and they did not know where to go to get benefits as they had always had paid work:

> *'…When he first had his stroke and he'd come home… it's like we'd just been dumped at home on us own and nobody told us where to go, what form to ask for, nothing. And we were living on I think it were about… what was it? A very, very small amount and I was feeding him and not myself.'*

Judith described how the HCW was able to get a bath adapted for her disabled nephew:

> *'…And the HCW just went to the right people and just moved it along, moved it along and got things moving. I mean it took me twelve months to get somebody to come out and have a look at it. The HCW spoke to somebody and within three month they actually said, 'Yes we can do it''…'*

Rather than being reflexive consumers those receiving support from the HCW required a 'navigator', someone to guide their journey through services. The pilot project had as its primary focus to 'support well-being and independent living' for families and communities. For tenants and families experiencing multiple disadvantage, supporting action to improve their life situations may be more 'ameliorative', targeted at the personal and relational level, rather than politically 'transformative', framed more in terms of collective well-being and challenging the status quo (Nelson and Prilleltensky, 2005). This being accepted, there is a danger that the rush toward democratisation of healthcare and the continuation of health

promotion will leave some people further disempowered, more isolated and marginalised. This is not to suggest that participation in healthcare and taking informed action should be discouraged. However, with the internet revolution and the growth of technical competence there is a requirement to consider the impact, or lack of impact, on the breadth of health practices. At the psychosocial level an emphasis on the importance of participatory democracy in all strata of life incorporates the view that involving people and communities affects self-esteem and self-confidence and this in turn improves health and well-being (Department of Health 2000). As an aside it is useful to note that ideology, rooted in individual action and participation, underpins 'modern conservativism' which is the current UK Government's position with regard to civic society taking the lead in combating disadvantage (Page 2010). However, Bandura (2009: 505), actually an advocate of social cognitive approaches, rightly argues that, 'Failure to address the psychosocial determinants of human behaviour is often the weakest link' in policy initiatives'. Research suggests that low levels of social integration and loneliness can significantly increase mortality (see for example Bennett 2002). Also, the most powerful sources of stress have been found to be associated with low status and lacking social networks, especially for parents with young children (Wilkinson and Pickett 2009). In a world of changing social relationships it is important to consider a range of social locations and participatory modes. Perhaps the role of navigator undertaken by the HCWs is no less important than Google for those in need of information and support.

Mothers' engagement with responsible health practices

As we have already argued individual responsibility for health is central to dominant contemporary initiatives. Being informed about, and individually responsible for,

ones' health has increasingly become a middle-class, western, moral ideology since the mid-1970s (see Crawford 2006). In the previous example, such middle-class ideologies seem far removed the participants' everyday lives. In this section, the example of, mothers' taking responsibility for the health of their child, is explored. The focus is on how mothers' negotiate the health-related practice of immunisation. Engagement in this practice will be explored discursively in order to elucidate the centrality of the social context. Crawford (2006) points out that, following the turn to language, scholars highlight the value of seeing social practices such as health as discursive events. Thus the obligation to be informed about, and take responsibility for, health is not only in relation to oneself but, in certain circumstance, to others. Lee *et al.* (2010) highlight that responsibility for another person's health, particularly a child's, has taken on a particular significance. Lee *et al.* draw on Murphy (2004) to argue that, in our increasingly risk-averse culture, the avoidance of harm has become a moral obligation which is further intensified when it intersects with constructions of motherhood. This intersection of risk and motherhood therefore ensures mothers are morally accountable to make responsible health choices in relation to their children. Within ideologies of motherhood, mothers are portrayed as devoted to caring for their children (Bassin *et al.* 1994) and children are primarily the responsibility of individual mothers (Hays, 1996). To meet these responsibilities mothers are said to engage in a range of 'maternal practices' including nurturing and protecting their children (Arendell, 2000: 1194). This meeting of ideologies of motherhood and risk means that mothers' engagement in responsible health practices in relation to their children is seen as a marker of 'good' motherhood.

In research conducted by the second author and a colleague, mothers' negotiation of decisions in relation to their child's health, childhood immunisation, specifically the combined measles, mumps and rubella (MMR) vaccination is explored. Since the controversy widely covered in the media surrounding the MMR vaccination erupted following a report by Wakefield *et al.* (1998) which linked the MMR to autism and Crohn's disease, there has been a proliferation of research investigating its impact on uptake of the MMR. Much of this research has investigated parents' (predominantly mothers) choices in relation to the MMR. Such studies are generally conceptualised within a decision-making framework, with participants seen as weighing up the costs and benefits of the MMR (e.g. Wroe *et al.* 2004). In a review of studies, parents were portrayed in terms of behaving in line with their attitudes towards the MMR (see Brown *et al.* 2010). In order to change attitudes and beliefs, which are seen to emerge from a lack of accurate or trusted information, the provision of appropriate support and information are seen as central to increasing compliance (e.g. Casiday *et al.* 2007, Hilton *et al.* 2007, Smailbegovic *et al.* 2003). One such cognitively informed approach is the development of decision aids which aim to 'empower' parents to make more 'informed choices' in relation to the MMR (Jackson *et al.* 2010: 75). Such aids provide both written and graphical information related to health care decisions. Aids generally are said to assist people to make informed choices through developing more accurate expectations of possible benefits and harms, and enable people to reach choices that are more consistent with their informed values (see Stacey *et al.* (2011) for a systematic review of decision aids). Decision aids in relation to the MMR have been produced and trialled in booklet (e.g. Wroe et al. 2005) and web-based forms (e.g. Jackson et al. 2010, Wallace et al. 2005) in the UK and Australia. The web-based aid consisted of an

assessment of parents' initial thoughts about the MMR; frequently asked questions; numerical and graphical data comparing risks of the vaccine with risks of measles, mumps and rubella; different views about the vaccination; a decision making exercise; and useful websites for information (see Jackson et al, 2010). Such aids therefore buy into neoliberal notions of choice but through self-regulation governed through expertise and action at a distance (Miller and Rose 2008). They also support the goals of lean healthcare and co-production in that information is resourcefully exchanged and decisions supposedly shared. However, this model of choice negates broader social and relational aspects of such health 'choices'.

The study undertaken involved a pilot focus group with UK mothers of children over 13 months of age (when the MMR is usually administered through the NHS) who had had their children vaccinated. In this study agency in relation to the MMR decision was largely constructed as out of mothers' control in contrast to the previous literature (Second author 2012). The mothers questioned the trustworthiness of advice available through the internet and were aware of concerns about the MMR, constructing media coverage as alerting them to the potential dangers in comparison to other vaccinations by using the metaphor of a 'red flag':

> *'I think it's a red flag, when you see it, a red flag. I remember seeing a news report about that whereas all of the others…' (Anna)*

Nonetheless, participants ultimately described conformity to, and compliance with, the system and society as determining MMR 'decisions'; as they put it *'you are driven by the system'* (Louise), *'it's one of the things you're just expected to do isn't it?'* (Anna), *'that's just what's expected of you… it's a society thing isn't'* (Louise). The process of having vaccinations was predominantly constructed as a mundane,

routine procedure with mechanical metaphors used to convey a systematic, unstoppable process: *'the wheel in motion…prompted by the whole, the cogs that go round when you have a child'* (Louise). Thus, the individualised decision-making framework which dominates the MMR literature did not capture the ways in which these mothers came to have their children vaccinated. We argue that these mothers largely followed the power of governmental authority surrounding medical advice and expertise. In addition, the guilt and worry which is inevitably associated with motherhood was said to be managed by having such decision taken away from you:

> *'You just can feel that you're doing the right thing [having your child vaccinated] and not stressed about it, feel guilty about it and worry about it cause, let's face it unfortunately, no one tells you that being a parent is all about guilt' (Louise)*

The decision being taken away was also linked to the time mothers have to make such decisions:

> *'Louise: Well I quite like that though, that I don't have to make that decision…I think, you know cause you have like you say, got so much on your plate ...*
> *Helen: hmm that's taken care of'*

Here the ideology of intensive mothering, whereby mothers are portrayed as investing a great deal of time and effort in raising their children (Hays, 1996), enabled the enrolment of an abdication responsibility of taking decisions in relation to the MMR. Negotiation of MMR decisions were not portrayed as relating to cognitive attitudes and beliefs but rather practical, contextual issues (busyness, tiredness, 'too

much on their plate'). In this example we can see how motherhood and risk intersect. This supports the view that health behaviour is not an individual act but is governed by dominant discourses of motherhood and governmental authority in relation to risk which intensifies the obligation of mothers to 'do the right thing' for their child and for society (Murphy 2004, Lee *et al.* 2010) thereby making them morally accountable for engaging in responsible health practices. Rather than the apparent democratisation of knowledge increasing choice, such knowledge exchange appears to be an imposition, with technological detail becoming a burden that is provoked compliance rather than the use of experiential sensibility and expertise.

Conclusions

Health psychology as an area of expertise is a relatively new field of research and practice (see Murray 2012 for a review) which, as demonstrated, has a tendency to utlilise social cognitive approaches making no reference to wider social structures and issues of power and authority. While there is a movement that provides a more critical, socially situated and contextual version of health psychology it remains evident that changes in healthcare delivery, framed as modernisation and democratisation, generally have at their core outmoded and reductionist conceptualisations of human action. Maybe this is due to a political and economic climate that points toward the government's role as one that adopts an 'enabling' rather than 'provider' function but the extent to which these operating practices are effective, feasible, efficient or desirable remains open to question. In a time when the drive is for 'lean healthcare', it might be wise to consider the breadth of implications and whether something *is* being lost in the apparent process of acting to bring about change. Self-management and individual responsibility for health is at the centre of the mainstream health psychology project as well as contemporary healthcare

systems, and while notions such as the 'reflexive consumer' at first present as alternatives suggesting empowering practices, the question remains for whom?

In a world of widening social inequalities health psychology, as an area of practice, should engage more fervently and critically with the debate around giving people responsibility for their own health. The sustained reliance on social cognitive statistical models serves to distance health psychology from the communities Martin-Baro (1994) suggests should be its 'preferential option' when collaborating to improve health and well-being. The democratisation of knowledge and health promotion activities such as decision aids which rely on a notion of faulty cognitions hardly seems relevant in the health-related contexts we have discussed above. People live their lives as socially situated and, as we have seen, all too often information flow can be either ineffective or overwhelming when set within the whirlwind of people's lives. In addition, the smoke screen of democratisation and choice masks constraints and the imperative to maximise compliance with certain healthcare regimes. Such approaches to health will only be partially successful as they do not substantially tap into the broader social landscape. Employing a critical health psychology approach enables this landscape to become visible and in doing so offers opportunities to work upon dominant ideologies in order to transform and reconstruct in less oppressive ways of working (Davies *et al.* 2006, Weedon 1997). While working with people in qualitative and participatory research is one avenue to achieve such change, lobbying for change and creating what Campbell *et al.* (2010) refer to as 'receptive social environments', that is, with those that hold the power, is also necessary. This said, investing in health interventions that provide 'navigational networks', may run counter to the tide of self-management currently underway. Even

so one would want to believe that health psychology could help people and communities navigate their way to better health practices.

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