3

A socially situated approach to inform ways to improve health and wellbeing

Christine Horrocks and Sally Johnson

The problem with health as a form of 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 have been devolved to responsible, rational individuals (Lemke 2001). This ideology has become entrenched in health promotion, in which self-management is 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 understanding which can be used to manage domains such as health. Health psychology is a form of expertise that informs many contemporary approaches to health promotion and policy.

Mainstream health psychology and approaches to health behavioural change assume a particular ontology of personhood that is in concordance with neoliberalism. It centres on the idea that people are driven and cognitively motivated as individuals; and their health beliefs and attitudes are 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 of our time. These models essentially conceptualise health behaviour, or more commonly intentions, within a cost-benefit, decision-making framework.

However, critiques of these cognitive approaches to health behaviour change emerged during the 1970s and 1980s. A more contextualised understanding of health and 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, Blaxter 1983, Herzlich 1973). 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, a problematisation of the view that people are rational

decision-makers, questioning the degree to which the social context is taken into account, and highlighting the problems in the quantification of health-related activities.

Firstly, cognitive approaches are seemingly premised on the idea that health behaviour is easily identified and unitary in character, with meanings that do not change across the diverse range of contexts and settings in which they might be carried out. Mielewczyk and Willig (2007) argue that health behaviour defined in this way does not exist. They reconceptualise behaviour as a set of health-related activities that 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 the '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 that cognitive approaches in health psychology conceptualise people crudely as naive scientists (simplistically testing hypotheses as in attribution theory) or accountants (calculating the costs and benefits in theories of behaviour change) rather than social actors. Further, the price of a decision-making, neoliberal approach is that a self-determining, good citizen is characterised as one who makes the right choices and takes personal responsibility for their health (Crawford 2006, Davies 2005); therefore being blamed if they make seemingly irresponsible or irrational choices.

Certain cognitive models do take into account social aspects of behaviour. For example, the theory of planned behaviour includes the concept of subjective norms, which consist of beliefs about the attitudes of important others, and their behaviour and motivation to comply with others (see, Ajzen and Madden 1986). However, the third critique points out that these models 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 behaviour; 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 the 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 the 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 a set of social and situated practices. To this end they adopt different epistemological, ontological and theoretical stances from those of mainstream health psychology (including social constructionism, post-structuralism, feminism and Marxism). In addition, they tend to employ qualitative and participatory methods (for example, discourse analysis, participatory action research and narrative analysis) to develop more socially grounded and relational understandings. This involves investigating health-related practices (rather than behaviour) 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 the initial focus of critical health psychologists 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 articles in the *Journal of Health Psychology* 11, 3, 2006, and Crossley, 2008 for

an extended discussion of these debates). Recent directions include developing action to improve health (see Horrocks and Johnson 2012). In this chapter 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 health care. 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 on 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 2009). There are also ongoing debates on proposed reforms and restructuring, with claims that managerialism has replaced professionalism in the social organisation of health care (Kitchener 2000). Alongside what is termed modernisation and different modes of interaction come new forms of governance in health care with ever-changing relationships.

The involvement of the public in the management and provision of public services is now prominent in economically developed countries. This involvement connects with notions of co-production, whereby those in receipt of services are no longer characterised as passive. Instead, there has been a shift towards the notion of exchanging information and shared decision-making (Realpe and Wallace 2010). In the UK the concept of patient and public involvement (PPI) in health is promoted in which 'citizens' are encouraged to participate in the difficult process of managing and commissioning health care, and 'service users', who have experiential knowledge and treatment insight, are 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 characterisation of service user involvement that is a priority for this section of the chapter.

As has been noted above, in the health psychology domain the focus is primarily on individuals, and health promotion efforts attempt to change individual behaviour by promoting self-management by rational decision-makers. Embedded in this notion is an implicit narrative of responsibility, in that, if we are unable to self-manage our health and wellbeing, 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 aegis of co-production and democratisation, has emerged in the 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 service users are conceived as expert and informed patients who are able to articulate their individual needs (self-manage), thus deploying their expert knowledge and exercising informed decision-making in relation to appropriate treatment and action. Without doubt patients often have expertise in their own illnesses and on how to promote their health, and they have intimate knowledge of the circumstances in which they live. Nevertheless, this may not in itself be sufficient to understand the technical complexities of the causes of disease (Prior 2003).

However, it is claimed that, with the growth of web-based health-related information, interactive forums and consumer websites, people have been transformed into reflexive

consumers of health care (Henwood *et al*. 2003). This growth is enhanced by the availability of a range of other media in which the apparent information needs of patients/consumers are being met (see Eysenbach 2000). Arguably, this availability of information has served to usurp the monopolies of health professionals over their knowledge base. Nonetheless, these changes should not blind us to the recognition that, as Fox *et al*. 2005: 1308) suggest that:

> 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.

A cautionary message is embedded in such observations, which demonstrate that people are being positioned as being responsible for the self-management of their health and wellbeing. Notions of empowerment, sharing of power and user-led health care do offer avenues for action and change by resisting the imposition of power, but it is important to also envisage other implications embedded in these concepts.

Significantly, not all patients may wish to or are able to lay claim to the material resources and 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 in which to operate, as we generally understand it. 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 this information to achieve positive outcomes. Hence self-management requires more than merely being positioned as a rational decision-maker; the individual is also required to be skilful and able to garner expertise and technical competence in order to secure their health and wellbeing. Here, practising health as an activity is the key. Martin (2008) explains that now that the clinician is no longer conceived as the sole source of expertise; experiential sensibility becomes enmeshed with the technical detail of medical science. Arguably, the delivery of lean health care requires of the self-managing patient lay expertise and compliance. This prompts the question 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. It 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 serve to demonstrate how these modernising and democratising developments in health care 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 health care. Martin-Baro (1994: 22) asks us to consider how individualism reinforces existing structures, reducing all structural problems to personal problems. He goes on to argue that psychologists should adopt a 'preferential option for the poor'. While there has long been a focus on the ways in which people live their lives, it is fair to say that individualised approaches in health psychology are indifferent to the endemic social inequalities that prevail both at a global and a national level. *Fair Society: Healthy Lives* (Marmot Review 2010) corroborates the extensive

existing evidence of the widespread nature of health inequalities in the UK (Menville *et al.* 2009, Scarborough *et al.* 2008). Also acknowledged in such work is the stark fact that social and economic inequalities underpin the determinants of health with associated interacting variables shaping health and wellbeing. 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 include smoking, exercise and diet and psychosocial factors include the perceived personal and emotional costs of living in an unequal society. It is widely accepted that these factors are clustered with people in low 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 2008, 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 underpinned by the social cognitive models outlined earlier that are targeted at changing individual lifestyles. 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 the idea that people have a choice in the lifestyles they adopt, and are able to engage in positive health behaviour and to refrain from engaging in negative health behaviour (Lyons and Chamberlain 2006). Often overlooked is the much wider application of health promotion outlined by, for example, Tones and Green (2002), who suggest that health promotion has a dual purpose: to reduce the existing external barriers 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. This formulation acknowledges that people live as socially situated selves and are engaged and active, while at the same time experiencing certain restrictions. The need to empower individuals and communities is at the centre of the Marmot Review's vision for reducing health inequalities. However, empowerment is a much used term that can indicate both a process and a 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 it means more of an end-point or goal, being 'both a psychological sense of personal control or influence and a concern with actual social influence, political power and legal rights'.

CH has recently been involved in evaluating a public health-promoting intervention that 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 (HSW) 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 92 per cent of tenants in the pilot project naming health issues as a priority ($n = 327$). Action for change is not easily achieved, many of tenants had lifestyles that were impacting on their health and wellbeing, with alcohol and drug use an issue for some and for many exercise and more general activity, low. Financial worries were prevalent for 38 per cent ($n = 124$) of those working with the health support workers. Poverty and social

exclusion are known to limit 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) calls involuntary social marginality due to a range of social, economic and cultural issues. Similarly, Burton and Kagan (2003) refer to psychosocial-ideological threats: certain communities have a marginalised identity that has become internalised, impacting on individuals' self-esteem and motivation.

When interviewed about the services provided by HSWs, it was revealing to hear just how far some of the participants were from the notion of empowered choice and active engagement. Their talk showed that the work of the HSWs was crucial in terms of providing essential support to families who had not become reflexive consumers of health care. Many clients said they did not know 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 HSW was able to get a bath adapted for her disabled nephew:

And the HSW just went to the right people and just moved it along, moved it along and got things moving. I mean it took me 12 months to get somebody to come out and have a look at it. The HSW spoke to somebody and within 3 month they actually said, 'Yes we can do it'.

Rather than being reflexive consumers those receiving support from the HSW required a navigator, someone to guide their journey through services. The primary focus of the pilot project was to 'support wellbeing and independent living' for families and communities. For tenants and families experiencing multiple disadvantages, supporting action to improve their life situations may be ameliorative, targeted at the personal and relational level, rather than politically transformative, framed more in terms of collective wellbeing and challenging the status quo (Nelson and Prilleltensky 2005). This being accepted, there is a danger that the rush toward democratisation of health care and the continuation of health promotion will leave some people further disempowered, more isolated and marginalised.

This is not to suggest that participation in health care and taking informed action should be discouraged. However, together with the Internet revolution and the growth of technical competence we need to consider their 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 their self-esteem and self-confidence and this in turn improves their health and wellbeing (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 position of the UK government at the time of writing with regard to civic society taking the lead in combating disadvantage (Page 2010). However, Bandura (2009: 505), who is 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 sug-

gests 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 the lack of 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 HSWs is no less important than that of the Google search engine for those in need of information and support.

Mothers' engagement with responsible health practices

Being informed about, and individually responsible for, one's health has since the mid-1970s increasingly become a middle-class, western, moral stance (see Crawford 2006). In the extracts described above, such middle-class ideologies seem far removed the everyday lives of the participants. In this section, the example of mothers taking responsibility for the health of their child in the practice of immunisation is explored. Engagement in this practice is discursively explored 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, being informed about, and taking responsibility for health is an obligation not only to oneself but, in certain circumstance, to others as well. Lee *et al.* (2010) state 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 that is further intensified when it intersects with constructions of motherhood. This intersection of risk and motherhood therefore ensures that mothers are morally accountable to make responsible health choices in relation to their children. Within the 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 a good mother.

In research conducted by the SJ 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, was explored. Since the controversy (widely covered in the media) surrounding the MMR vaccination erupted following a report by Wakefield *et al.* (1998) that linked the MMR vaccination to autism and Crohn's disease there has been a proliferation of research investigating its impact on the uptake of the MMR. In 2010 the journal retracted the original paper (Editors 2010). 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 (for example, Wroe *et al.* 2005). In a review of these studies, parents were shown to be behaving in line with their attitudes towards the MMR (see Brown *et al.* 2010). In order to change their 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 these parents' compliance with the vaccination (for example, Casiday *et al.* 2006, Hilton *et al.* 2007, Smailbegovic *et al.* 2003). One such cognitively informed approach is the development of decision aids that 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 graphic information related to healthcare decisions. Aids generally are said to help people to make informed choices through developing more accurate expectations of possible benefits and harms in a given action, 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 (for example, Wroe *et al.* 2005) and web-based forms (for example, 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 graphic 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 neo-liberal notions of choice, but choice through self-regulation governed through expertise and action at a distance (Miller and Rose 2008). They also support the goals of lean health care and co-production in that information is expected to be 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 an exploratory 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 being out of the mothers' control in contrast to the previous literature (Capdevila and Johnson 2012). The mothers questioned the trustworthiness of the 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' [vaccinations] (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 and mechanical metaphors were used to convey an unstoppable system-deep 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 that 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 that 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 'coz, 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 'coz 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 responsibility of taking decisions in relation to the MMR to be evaded. The negotiation of MMR decisions did not occur in the context of their attitudes and beliefs but rather in practical, contextual issues (busyness, tiredness, 'too much on their plate'). This example shows 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 (Lee *et al.* 2010, Murphy 2004), 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 details becoming a burden that provokes 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 utilise 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, changes in healthcare delivery, framed as modernisation and democratisation, generally have at their core outmoded and reductionist conceptualisations of human action. This may be due to a political and economic climate that points towards the government's role as enabling rather than providing, but the extent to which these operating practices are effective, feasible, efficient or desirable remains open to question. In a time when there is a drive for lean health care, 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 are presented as alternatives suggesting empowering practices, the question remains: empowering of whom?

In a world of widening social inequalities health psychology, as an area of practice, should engage more fervently and critically with the debate on giving people responsibility for their own health. The sustained reliance on social cognitive statistical models serves to distance health psychology from the communities that Martin-Baro (1994) suggests should be its 'preferential option' when collaborating to improve health and wellbeing. The democratisation of knowledge and health promotion activities, such as decision aids that rely on a notion of faulty cognition, hardly seems relevant in the health-related contexts we have discussed above. People live their lives as socially situated beings and, as we have seen, all too often an information flow can be either ineffective or overwhelming when set within the whirlwind of people's lives. In addition, the smokescreen of democratisation and choice masks constraints and the imperative to maximise compliance with certain healthcare regimes. Such approaches to health will be only 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 them 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.

References

Ajzen, I. and Madden, T.J. (1986) Prediction of goal-directed behaviour: attitudes, intentions, and perceived behavioral control, *Journal of Experimental Social Psychology*, 22, 5, 453–74.

Arendell, T. (2000) Conceiving and investigating motherhood: the decade's scholarship, *Journal of Marriage and the Family*, 62, 4, 1192–207.

Bandura, A. (2009) Social cognitive theory goes global, *Psychologist*, 22, 6, 504–6.

Bassin, D., Honey, M. and Kaplan, M.M. (1994) Introduction. In Bassin, D., Honey, M. and Kaplan, M.M. (eds) *Representations of Motherhood*. New Haven: Yale University Press.

Bennett, K.M. (2002) Low level social engagement as a precursor of mortality among people in later life, *Age and Ageing*, 31, 3, 165–8.

Blaxter, M. (1983) The causes of disease: women talking, *Social Science & Medicine*, 17, 2, 59–69.

Brown, K.F., Kroll, J.S., Hudson, M.J., Ramsay, M., *et al.* (2010) Factors underlying parental decisions about combination childhood vaccinations including MMR: a systematic review, *Vaccine*, 28, 6, 4235–48.

Burton, M. and Kagan, C. (2003) Community psychology: why this gap in Britain?, *History and Philosophy of Psychology*, 4, 2, 10–23.

Campbell, C. and Jovchelovitch, S. (2000) *Journal of Community and Applied Social Psychology*, 10, 4, 255–70.

Campbell, C., Cornish, F., Gibbs, A. and Scott, K. (2010) Heed the push from below: how do social movements persuade the rich to listen to the poor?, *Journal of Health Psychology*, 15, 7, 962–71.

Capdevila, R. and Johnson, S. (2012) 'Mother knows best?' Exploring mothers' engagement with scientific-based advice on MMR immunization. Paper presented at the British Psychological Society Psychology of Women Section Annual Conference, 11–13 July, Windsor.

Casiday, R., Cresswell, T., Wilson, D. and Panter-Brick, C. (2006) A survey of UK parental attitudes to the MMR vaccine and trust in medical authority, *Vaccine*, 24, 177–184.

Crawford, R. (2006) Health as a meaningful social practice, *Health*, 10, 3, 401–20.

Crossley, M. (2008) Critical health psychology: developing and refining the approach, *Social and Personality Psychology Compass*, 2, 1, 21–33.

Davies, B. (2005) The (im)possibility of intellectual work in neoliberal regimes, *Discourse: Studies in the Cultural Politics of Education*, 26, 1, 1–14.

Davies, B., Browne, J., Gannon, S., Hopkins, L., *et al.* (2006) Constituting the feminist subject in poststructuralist discourse, *Feminism and Psychology*, 16, 1, 87–103.

de Souza, L.B. (2009) Trends and approaches in lean healthcare, *Leadership in Health Services*, 22, 2, 121–39.

Department of Health (2000) *The NHS Plan. A Plan for Investment*. A Plan for Reform. London: Department of Health.

Department of Health (2001) *The Expert Patient: a New Approach to Chronic Disease Management for the 21st Century*. London: Department of Health.

Editors (2010) Retraction – Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children, *Lancet*, 375, 9713, 445.

Eysenbach, G. (2000) Consumer health informatics, *British Medical Journal*, 320, 7251, 1713–6.

Fox, D., Prilleltensky, I. and Austin, S. (eds) (2009) *Critical Psychology: an Introduction*, 2nd edn. London: Sage.

Fox, N.J., Ward, K.J. and O'Rourke, A.J. (2005) The 'expert patient': empowerment or medical dominance? The case of weight loss, pharmaceutical drugs and the Internet, *Social Science & Medicine*, 60, 6, 1299–309.

Graham, H. (2000) *Understanding Health Inequalities*; Buckingham: Open University Press.

Gutierrez, L.M. (1990) Working with women of colour: an empowerment perspective, *Social Work*, 35, 2, 149–53.

Hays, S. (1996) *The Cultural Contradictions of Motherhood. New Hale*: Yale University Press.

Henwood, F., Wyatt, S., Hart, A. and Smith, J. (2003) 'Ignorance in bliss sometimes': constraints on the emergence of the 'informed patient' in the changing landscapes of health information, *Sociology of Health & Illness*, 25, 6, 589–607.

Herzlich, C. (1973) *Health and Illness: a Social Psychological Analysis. (Transl. Graham, D.*) London: Academic Press.

Hilton, S., Petticrew, M. and Hunt, K. (2007) Parents' champions vs. vested interests: who do parents believe about MMR? A qualitative study, *BMC Public Health*, 7, 42, 1–8.

Horrocks, C. and Johnson, S. (eds) (2012) *Advances in Health Psychology: Critical Approaches*. Basingstoke: Palgrave Macmillan.

Jackson, C., Cheater, F.M., Peacock, R., Leask, J., *et al.* (2010) Evaluating a web-based MMR decision aid to support informed decision-making by UK parents: a before-and-after feasibility study, *Health Education Journal*, 69, 1, 74–83.

Kitchener, M. (2000) The bureaucratization of professional roles: the case of clinical directors in UK hospitals, *Organization*, 7, 1, 129–54.

Lee, E.J., Macvarish, J. and Bristow, J. (2010) Risk, health and parenting culture, *Health, Risk & Society*, 12, 4, 293–300.

Lemke, T. (2001) 'The birth of bio-politics': Michel Foucault's lecture at the College de France on neo-liberal governmentality, *Economy & Society*, 30, 2, 190–207.

Leonard, P. (1984) *Personality and Ideology: Towards a Materialist Understanding of the Individual*. London: Macmillan.

Lyons, A.C. and Chamberlain, K. (2006) *Health Psychology: a Critical Introduction*. Cambridge: Cambridge University Press.

Marmot Review (2010) *Fair Society, Healthy Lives*. Available at http://www.marmotreview.org/ (accessed 29 October 2013).

Martin, G.P. (2008) 'Ordinary people only': knowledge, representativeness, and the publics of public participation in healthcare, *Sociology of Health & Illness*, 30, 1, 35–54.

Martin-Baro, I. (1994) Toward a liberation psychology. In Aron, A. and Corne, S. (eds) *Writings for a Liberation Psychology: Igancio Martin-Baro*. Cambridge: Harvard University Press.

Menville, G., Boshuizen, H., Kunst, A.E., Dalton, S.O., *et al*. (2009) The role of smoking and diet in explaining educational inequalities in lung cancer incidence, *Journal of the National Cancer Institute*, 101, 5, 321–30.

Mielewczyk, F. and Willig, C. (2007) Old clothes and an older look: the case for a radical makeover in health behaviour research, *Theory and Psychology*, 17, 6, 811–37.

Miller, P. and Rose, N. (2008) *Governing the Present: Administering Economic, Social and Personal Life*. Cambridge: Polity Press.

Murphy, E. (2004) Risk, maternal ideologies and infant feeding. In Germov, J. and Williams, L. (eds) *A Sociology of Food and Nutrition*. Oxford: Oxford University Press.

Murray, M. (2012) Social history of health psychology: context and textbooks, *Health Psychology Review*, 1, 1, 1–23.

Murray, M. and Poland, B. (2006) Health psychology and social action, *Journal of Health Psychology*, 11, 3, 379–84.

Nelson, G. and Prilleltensky, I. (eds) (2005) *Community Psychology. In Pursuit of Liberation and Wellbeing*. Basingstoke: Palgrave Macmillan.

Nettleton, S. and Bunton, R. (1995) Sociological critiques of health promotion. In Bunton, R., Nettleton, S. and Burrows, R. (eds) *The Sociology of Health Promotion*. London: Routledge.

Nettleton, S. and Burrows, R. (2003) E-scaped medicine? Information, reflexivity and health, *Critical Social Policy*, 2, 22, 165–85.

Page, R.M. (2010) David Cameron's modern conservative approach to poverty and social justice: towards one nation or two?, *Journal of Poverty and Social Justice*, 18, 2, 147–60.

Prior, L. (2003) Belief, knowledge and expertise: the emergence of the lay expert in medical sociology, *Sociology of Health & Illness*, 25, 1, 41–57.

Rappaport, J. (1987) Terms of empowerment/examplars of prevention: toward a theory for community psychology, *American Journal of Community Psychology*, 15, 2, 122–44.

Realpe, A. and Wallace, L.M. (2010) *What Is Co-production?*. London: Health Foundation.

Scarborough, P., Allender, S., Peto, V. and Rayner, M. (2008) *Regional and Social Differences in Coronary Heart Disease 2008*. London: British Heart Foundation.

Smailbegovic, M.S., Laing, G.J. and Bedford, H. (2003) Why do parents decide against immunization? The effect of health beliefs and health professionals, *Child Care Health Development*, 29, 4, 303–11.

Stacey, D., Bennett, C.L, Barry, M.J. and Nananda, F. *et al*. (2011) Decision aids for people facing health treatment or screening decisions. The Cochrane Library. Available at http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001431.pub3/full (accessed 29 June 2012).

Stainton Rogers, W. (1991) *Explaining Health and Illness: An Exploration of Diversity*. Hemel Hempstead: Harvester Wheatsheaf.

Stainton Rogers, W. (2012) Changing behaviour: can critical psychology influence policy and practice? In Horrocks, C. and Johnson, S. (eds) *Advances in Health Psychology: Critical Approaches*. Basingstoke: Palgrave Macmillan.

Tones, K. and Green, J. (2002) The empowerment imperative in health promotion. In Dooher, J. and Byrt, R. (eds) *Empowerment and Participation: Power, Influence and Control in Contemporary Health Care*, Vol. 1. London: Quay Books.

Wakefield, A.J., Murch, S.H., Anthony, A., Linnell, J., *et al*. (1998) Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children, *Lancet*, 351, 9103, 637–41.

Wallace, C., Leask, J. and Trevena, J. (2005) Effects of a web based decision aid on parental attitudes to the MMR vaccination: a before and after study, *British Medical Journal*, 332, 7534, 146–9.

Waring, J.J. and Bishop, S. (2010) Lean healthcare: rhetoric, ritual and resistance, *Social Science & Medicine*, 71, 7, 1332–40.

Weedon, C. (1997) *Feminist Practice and Poststructuralist Theory*. 2ⁿᵈ edn. Oxford: Blackwell.

Wilkinson, R. and Pickett, K. (2009) *The Spirit Level: Why More Equal Societies Almost Always do Better*. London: Allen Lane.

Wroe, A.L., Turner, N. and Owens, R.G. (2005) Evaluation of a decision-making aid for parents regarding childhood immunizations, *Health Psychology*, 24, 6, 539–47.