



Critical Health Psychology

Foundations, Approaches
and Applications

Sarah Riley, Kathryn McGuigan,
Eleanor Brittain, Gareth Terry,
Aorangi Kora, Siobhán Healy-Cullen,
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Editors



TE KUNENGA | MASSEY
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Critical Health Psychology: Foundations, Approaches and Applications

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*EDITED BY SARAH RILEY; KATHRYN MCGUIGAN; ELEANOR
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Recommended citation: Riley, S., McGuigan, K., Brittain, E., Terry, G., Kora, A., Healy-Cullen, S., van Ommen, C., & Baken, D. (Eds.). (2025). *Critical health psychology: Foundations, approaches and applications*. Massey University. <https://doi.org/10.82376/6WW0-P679>

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ISBNs

eBook 978-0-473-75027-5

PDF 978-0-473-75026-8

ePUB 978-0-473-75025-1

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Ngā mihi

Tūtawa mai i runga
Tūtawa mai i raro
Tūtawa mai i roto
Tūtawa mai i waho
Kia tau ai te mauri tū,
Te mauri ora ki te katoa
Haumi e, hui e, tāiki e.

*Come forth from above
Come forth from below
Come forth from within
And come forth from the environment
Vitality
and wellbeing for all
Strengthened in unity.*

By Scotty Morrison, *Ngāti Whakaue*

We open with this **karakia** as a means of acknowledgement. The karakia offers strength and affirmation. Its significance to the book is in the emphasis on relationality and the recognition that from a Māori perspective, our wellbeing as people is fundamentally connected to the natural environment and our contexts.

This karakia is reproduced with kind permission from Scotty Morrison.

Acknowledgements

We want to express how grateful we are to the many who have made this book possible.

First, deep respect and gratitude go to Kerry Chamberlain, Chris Stephens, and Antonia Lyons, who laid the foundations of the Critical Health Psychology programme at Massey University and designed the original curriculum that inspired subsequent iterations and this textbook. Alongside them, we acknowledge the many people who have been part of the critical health psychology community, past and present, in Massey, Aotearoa New Zealand, and internationally, whose work, collegiality, values, and vision, have inspired us.

We could not have started this book had it not been for the Council of Australasian University Librarians (CAUL) Open Educational Resources Collective and their use of the Pressbooks platform, and Massey University Library, who fund our membership of the collective and for books to be hosted on it. We also thank the librarians for how they managed the competitive bid that gave us this opportunity, and a grant to support our work from the OER Collective. We also thank Kirsty Ross and the Health Psychology Teaching Team for additional funding.

We are especially grateful to our colleagues from Massey University Library for their knowledge, expertise, and support through every step of producing this book. They have taken on multiple roles — copyright management, wrangling with the code of Pressbooks, developing our interactive tools, cover design, teaching us how to meet accessibility standards — to name just a few. We acknowledge and thank deeply, Jane Clark (Manager, Library Information and Research Services), Katherine Chisholm (Manager, Library Information and Research Services), and Elizabeth Sturrock (Subject Librarian), who have been there for us, and with us, throughout the project, making this book happen. It has been a joy to work with you.

The librarians also had their own support, and specifically, we acknowledge the Copyright Officer, Jean Jacoby, and the learning designers at Massey who reviewed our multiple-choice questions, teaching us best practice. We also thank the copy editor, Lisa Morice, for her careful work in supporting our writing.

Specific thanks to Tracy Morison for her considerable work and input in shaping this text, and editing Part Two, as well as to those who co-authored or contributed chapters: Sonja Ellis, Gloria Fraser, Ally Gibson, Rebekah Graham, and Alex Walker, as well as to those who contributed case studies or examples: Paulina Bondaronek, Melinda Lewthwaite, Amber Rose, and Jessica Tappin. Thanks also to Kate Kersey for her advice on critical realism, and Siobhan Rawlinson and Hamish Riley Brown for their work on the cover.

Further thanks go to the people who gave us expert feedback on earlier drafts. We specifically acknowledge Wendy Stainton Rogers (Professor Emerita in Health Psychology, Open University, UK) and Martine Robson (Lecturer in Aberystwyth University, UK), who acted as peer reviewers for the whole book. Their expertise was invaluable. We are grateful to Tā Mason Durie for his review and considered input to the Hauora chapter. His support of Aorangi and Elle has, in turn, supported all of us who have been part of this book. We thank the students on the “Health the Social Context” 2025 course at Massey, who also gave us feedback on earlier drafts — allowing the book to be a little “road tested” before it went out.

We also acknowledge the Māori scholars, experts, and leaders in the health and psychology fields, who have carved paths to better understand and work with Māori health needs. Their work is threaded throughout the book, offering a bedrock for the ongoing development of a localised health psychology, and their efforts have been essential to advances in Māori health.

We also thank family and friends. Sarah would specifically like to thank her partner for his enduring support, and her father who valued girls’ education and has supported the success of many women, including his daughters. Elle and Aorangi give their utmost thanks to whānau (family), colleagues, and friends who encouraged and supported them throughout.

Ēhara tāku toa i te toa takitahi, engari he toa takitini

My success should not be bestowed onto me alone, it was not individual success but the success of a collective.¹

1. This whakatauaikī (proverb) is attributed to Pāterangi of Ngāti Kahungunu, who maintained that the collective effort of many was necessary for the completion of any task (Mead & Grove, 2001; cited in Quigan, Gaffney & Si'ilata, 2021).

Quigan, E.K., Gaffney, J.S. & Si'ilata, R. (2021). Ēhara tāku toa i te toa takitahi, engari he toa takitini: The power of a collective. *Kōtuitui: New Zealand Journal of Social Sciences Online*, 16(2), 283–306. <https://doi.org/10.1080/1177083X.2021.1920434>.

Mead, S.M., & Grove, N. (2001). *Nga pepeha a nga tipuna– the sayings of the ancestors*. Victoria University Press.

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Preface by Christine Stephens, Antonia Lyons, and Kerry Chamberlain

Health psychology is a very broad field concerned with applying psychological knowledge to all aspects of physical health and illness. Its development can be linked to a period of dissatisfaction and evolving critique of dominant biomedical frameworks of health and disease across the social sciences, including psychology. Psychologists became increasingly involved in issues of health and health care during the 1960s and 1970s, leading to the emergence of health psychology as a sub-discipline of psychology. Its establishment as a formal discipline was marked by the creation of Division 38 of the American Psychological Association in 1980.

Given the nature and prevailing directions of psychology and medicine at the time, it is no surprise that health psychology was dominated by positivist approaches to knowledge, an emphasis on 'scientific' research, and a strong focus on the individual. This focus on the individual and individual behaviour fits neatly within **neoliberal** perspectives and an ideology of health as the responsibility of an autonomous individual. As health psychology has grown and developed, different views and approaches to the field have emerged, including critical health psychology, which places emphasis on context, power, and social justice, considering macro-social processes that affect health and illness. This broader perspective is concerned with social, cultural, political, and economic influences as crucial in matters that include keeping people healthy, influencing health outcomes, accessing health care, and experiencing and recovering from illness. This approach has seen a major shift in research agendas, with qualitative research methods and methodologies being adopted and used more often, informed by social constructionism, feminism, and postmodernism. This approach has also been informed by theory and perspectives from other disciplines.

Many aspects of this broader development of health psychology were reflected in the burgeoning health psychology programme within the School of Psychology at Massey University. The initial foray into this area was the development of a single, broad and general, post-graduate course in 1990. However, a series of fortuitous appointments to the School over the next few years brought a number of critically-oriented scholars together in one place. Importantly, several of these people had strong interests in health psychology, and arrived at a time when the programme was expanding. This fostered the development of a strong critical health psychology at Massey, and by the early 2000s a full postgraduate programme was established, with three courses, a practicum, and research thesis. The three courses were critical in orientation, and unique in that all three utilised textbooks written by the lecturers involved (Lyons & Chamberlain, 2006; Stephens, 2008). For more detail of these developments, see Chamberlain et al. (2018). These texts are now dated so a new text on critical health psychology from a new generation of scholars at Massey University, and elsewhere in Aotearoa New Zealand, is a welcome development that continues the legacy of the Massey health psychology programme.

The book is a very timely contribution that covers the most recent developments in this flourishing field. It emphasises the value of understanding complex issues using theory and encourages critical reflection on the concepts used in health psychology to challenge taken-for-granted understandings of health and illness. Paying attention to issues of power and equity, *Critical Health Psychology: Foundations, Approaches and Applications* considers the structural and systemic factors influencing health and emphasises how health is shaped by broader social, cultural, political, environmental, and historical contexts. Importantly, the text adds to previous work by including diverse conceptual frameworks from both Western traditions and Indigenous perspectives to support professional practice grounded in ethics, cultural safety, and reflexivity in contexts like Aotearoa New Zealand (where **Te Tiriti o Waitangi** is central), or in any other social contexts. The key message here is the importance of local knowledge.

The editors have attracted established critical researchers in the field of health psychology from across

Aotearoa New Zealand to work together and co-author the sections of the book. The chapters together provide a comprehensive resource for students and practitioners of health psychology. At the same time, each chapter provides a comprehensive and scholarly overview of a specific area and will become an important reference for those seeking guidance in areas such as **hauora** (health) from a Māori perspective, different theoretical frameworks, or applications in health practice.

There are many ways in which the text builds upon previous writing for students who are studying critical health psychology (including our own early textbooks). One of the major strengths of the book is the contextually-grounded, local examples of applications of critical health psychology that are relevant well beyond their local contexts. They speak directly to international concerns about inequities in health and provide excellent tools that readers/students can draw on in their activism for social justice. Part One introduces the reader to foundational thinking and Part Two builds on this foundation to develop understanding of approaches to health and illness. In Part Three, the text takes the theories, concepts, contexts, approaches, and frameworks described in the previous two parts of the book and applies them in multiple ways, showing the interconnected nature of different aspects of application (such as ethics, cultural safety, and reflexivity) across different contexts (such as classrooms, clinics, and communities) and across different sectors of society (such as marginalised groups, disability communities, and Indigenous populations).

An exciting strength of this text is its accessibility, as the whole book is open access and freely available to download, either as a complete online text, or as separate chapters. The text can also be easily updated as new knowledge becomes available. This new approach to publishing means that practitioners, scholars, and students in health psychology are able to participate in more immediate meaningful relationships as knowledge is shared and reflected upon.

We commend the editors and authors for this text, which makes an impressive contribution to critical health psychology, presenting innovative and up-to-date ideas, theories, and research, and making this freely available to all. This book will be widely used and be highly influential in shaping the future of critical health psychology internationally.

Christine Stephens, Antonia Lyons, and Kerry Chamberlain

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Introduction

SARAH RILEY; KATHRYN MCGUIGAN; ELEANOR BRITTAIN; GARETH TERRY; AORANGI KORA; SIOBHÁN HEALY-CULLEN; CLIFFORD VAN OMMEN; AND DON BAKEN

Nau mai haere mai—come on in, you have been warmly welcomed to this book—and with it, to a community of scholars, students, activists, policy makers, and many others who are interested in critical health psychology. In this section, we introduce you to what we mean by critical health psychology, why we wrote this book, and what we hope it will offer you.

What is critical health psychology?

Health psychology is a subfield of psychology that focuses on producing and applying psychological knowledge to:

- promote and maintain physical health
- prevent illness
- enhance treatments for people who are ill
- support of disabled people¹
- improve healthcare systems and health policies.

Critical health psychology offers a distinctive approach to addressing these goals. In reviewing a range of critical health psychology literature for this book, we posit five “pou” that often underpin this work. “Pou” is a Māori (the Indigenous people of Aotearoa New Zealand) word. It refers to carved wooden poles or posts that can serve as boundary markers and support structures integral to the building of Marae, a traditional house and centre for Māori activities. The pou support the Marae, and for that reason this term is sometimes adopted by institutions to refer to the central values supporting the work that is done within them. We borrow from these ideas to offer five pou for critical health psychology. These pou explicitly, or implicitly, shape the chapters in this book. We outline them in the textbox below.

Key takeaways: The five pou for critical health psychology

- valuing theoretical and conceptual thinking
- challenging taken-for-granted understandings
- paying attention to issues of power and equity
- moving beyond the individualism that characterises much of (Western) psychology
- considering knowledge as produced in social context.

1. We have elected to use the phrasing “disabled people” in alignment with the New Zealand Disability Strategy, which foregrounds the interaction with the inaccessible environment as creating disability, rather than being located with the person.

(1) Valuing theoretical and conceptual thinking. This part encourages us to put theory and theoretical concepts at the centre of our work. Theories provide a framework for understanding and interpreting an issue. They provide a structured explanation of a phenomenon, allowing us to better understand, or make predictions about human behaviour. A theoretical framework thus offers a lens through which to examine an issue. Critical health psychologists often draw on theoretical frameworks that enable rich conceptual thinking, including bodies of philosophical thought. Putting theory explicitly at the centre of our work helps us think deeply about complex issues, encouraging us to engage in critical reflection on both the explicit and implicit concepts that we use in health psychology.

(2) Challenging taken-for-granted understandings. A key process in critical reflection is looking at what we take for granted. Taken-for-granted knowledge refers to ideas we rarely recognise or explain because we experience them as obvious, normal, and natural – a bit like how we imagine a fish with water. This means it takes effort and techniques to notice taken-for-granted knowledge. Critical health psychologists often use reflective practices to help them notice the kind of taken-for-granted knowledge underpinning their work, from which they can explore the advantages and disadvantages of this way of thinking, and start to imagine more enabling or equitable alternatives.

Michel Foucault's experience of recognising taken-for-granted knowledge

In the preface of his book *The order of things: The archaeology of the human sciences*, philosopher and cultural historian Michel Foucault recounts how reading a book describing what he considered to be an amusing Chinese categorisation of animals prompted a realisation: his own categories of thinking were not normal or natural, but simply another, equally arbitrary, socially constructed system of thought.²

“This passage quotes a ‘certain Chinese encyclopaedia’ in which it is written that ‘animals are divided into: (a) belonging to the Emperor, (b) embalmed, (c) tame, (d) suckling pigs, (e) sirens, (f) fabulous, (g) stray dogs, (h) included in the present classification, (i) frenzied, (j) innumerable, (k) drawn with a very fine camelhair brush, (l) *et cetera*, (m) having just broken the water pitcher, (n) that from a long way off look like flies’. In the wonderment of this taxonomy, the thing we apprehend in one great leap, the thing that, by means of the fable, is demonstrated as the exotic charm of another system of thought, is the limitation of our own, the stark impossibility of thinking *that*” (Foucault, 1970, p. xv).

(3) Considering knowledge as produced in context. In focusing on how people in specific social contexts make sense of themselves, each other, and their wider world, critical health psychology offers a different orientation to the universalising approach often evident in psychological research, which seeks to identify generalisable patterns across contexts. Instead, a foundational element of critical health psychology is that

2. The truth of this list has not been verified, and Foucault calls it a ‘fable’, but he went on to use this idea to demonstrate, through an analysis of historical documentations, how taken-for-granted ways of sense-making—or “the ordering of things”—significantly changes over time in Western culture in a fractured, arbitrary, and not necessarily progressive way.

we take seriously evidence showing a diversity of meaning and practice in people across time and place. For example, if someone stopped you on the street to ask you where you feel love in your body, most people would report feeling it somewhere near their heart, that somehow love originates there. But that has not always been the case historically, and it is not the case across contemporary cultures. Those of you who touch your heart centre if asked to say where your feelings are might be surprised to know that in Shakespearian England it was the liver. In Māori culture, the liver (ate) is still associated with deep emotions and feelings. For example, the phrase “Kai whea te tau o taku ate?” translates to “Where is my soul mate?”.

The above example shows how different ideas circulate in different contexts, which in turn shape how people can make sense of themselves.³ From this basis, critical health psychologists often study: (1) the ideas that are circulating in a particular context; (2) the wider socio-historic, economic, political, and material elements that enable these ideas to make sense to people in that context; and (3) the implications these ideas have for what people can say, think, feel, and do – and how this in turn impacts people’s health, wellbeing, and treatment outcomes.

(4) Paying attention to issues of power and equity. The ideas that people use to make sense of themselves and their health are connected to power. Power shapes what ideas are valued or agreed-upon in any given social context. Thus, we cannot separate power from meaning-making. And how we make sense of something, in turn, shapes where resources get directed. A focus on power also means that even though psychology is about understanding people’s thoughts, feelings, and behaviour, critical health psychologists also pay attention to structural and systemic factors that shape health. Relatedly, we advocate for policies and practices that address these factors, aligning with a social justice approach to health that seeks to address health inequities.

(5) Moving beyond individualism. Recognising the importance of the social context also moves us away from the individualism that often characterises psychology. Our concern with individualism is that when we centre the individual, the person and their social context are positioned as separate, if interacting, elements. This conceptual split between the person and their social context flies in the face of cross-cultural research and important theories suggesting that people are produced through, not just influenced by, their context (Burkitt, 1991; 2008). Individualistic psychology can also have embedded, taken-for-granted values that foreground autonomy and problematise dependency. This is despite how people are inherently dependent on each other and their environment, and can experience great joy and pleasure in feeling mutually connected. Critical health scholars argue that individualism often limits the ability of psychology to explain how and why people think, feel, and behave in the ways they do, because it fails to conceptualise the human experience as situated and relational.

Another concern we have with individualistic psychology is that it typically fails to theorise power, and so reproduces it. For example, individualistic Western, White, (often middle-class) perspectives are presented as universal norms or ideals, despite research suggesting these are the least representative of human populations (Henrich et al., 2010; Sanches de Oliveira & Baggs, 2023). Relatedly, when psychologists, researchers, and/or policy makers take an individualised approach to health, they align with existing powerful systems that shift responsibility for health onto individuals while downplaying state responsibilities for creating conditions that make good health more likely. Critical health psychology thus invites us to consider the application of psychological knowledge beyond behaviour change and “fixing” the individual, and towards community-led, societal, political, and environmental solutions that may have more substantial and lasting effects.

These five pou provide guiding principles for critical health psychology. In this book we take you on a

3. Although this is a useful example for showing how different peoples, across cultures or across time, can understand themselves differently, we also note that Māori have unique ways of feeling and expressing emotions that are ontologically embedded in Māori connections to the collective, to the land, and to the spiritual realm, which mean like-for-like translations such as ‘liver’ and ‘ate’ fail to recognise the complex, unique cultural meanings represented in these words (Hokowhitu, 2014).

journey to explore how we can better understand health when applying this framework. We acknowledge that some of the ideas we share may be new to readers, and warn you that when our taken-for-granted understandings are challenged, we can feel confused, anxious, or even angry. Learning theories suggest that if you encounter such difficult feelings, it helps to recognise they are part of your learning journey and reflect on where they come from. Our hope is that, ultimately, you will find the ideas in this book energising.

Indigenous scholarship

Our social context is Aotearoa New Zealand, a country whose institutions are accountable to Te Tiriti o Waitangi, a treaty between rangatira Māori (tribal chiefs) and British settlers that was signed in 1840. One outcome of Te Tiriti is that Aotearoa New Zealand may be considered a bicultural country, where Māori and non-Māori cultures are recognised, and partnerships expected (Dam, 2017; also see Brittain & Kora [Chapter 1.1](#), and Fraser & Walker [Chapter 3.1](#), this volume; and Hayward (2012) for a critique of biculturalism). You will therefore find both Indigenous and Western scholarship represented in this book, with some chapters more focused on Māori scholarship, others more strongly positioned within Western scholarship, but all showcasing important contributions to critical health psychology.

Our first chapter, “Hauora” (Brittain & Kora [Chapter 1.1](#)), is written by Māori scholars and introduces te ao Māori (Māori worldviews) as it pertains to health. We intend this chapter to be of interest for both Māori and non-Māori, and part of the foundation for learning critical health psychology in Aotearoa New Zealand. It should also be of interest to an international readership. Māori have distinct and unique ways of being and thinking in the world that are holistic, relational, and spiritual; recognising the interconnectedness between all things. These worldviews and assumptions, including the place of humans within the world, are critical to understanding Māori health and wellbeing, and for expanding health psychology more generally, especially in the context of climate change, which requires us to recognise our relational co-existence (Jones, 2019).



Figure 0.1.1 Braided River. ([Braided River](#), [Trey Ratcliff](#), on Flickr. [CC BY-NC-SA 2.0](#))

Other chapters in this book are informed by the awa whiria (braided river) analogy, in which Māori and Western traditions of knowledge are imagined as a braided river—typical in Aotearoa New Zealand—made up of a network of river channels that come together and diverge as they flow. As an analogy, awa whiria represents the weaving together of different knowledge systems, the valuing of diverse knowledge and shared understanding, and the usefulness of considering both the distinctions and connections between these knowledge systems (Clifford & Arahanga-Doyle, 2024; Martel et al., 2022). Te awa whiria illustrates how these world views may come together at times, yet remain quite distinct, each retaining its own integral value. We have also included research on Pacific people's understanding of health and illness, although our engagement with this scholarship remains limited.

Most of us are not Indigenous and since we draw on international, English language research, Western frameworks remain central in this book overall. This book is therefore not a decolonising psychology project; as a team, we do not have the capacity to offer that. Instead, we see our book as a small step towards such a project.

Why we wrote this book

Our motivation for producing this book was to create a significant resource that offers accessible and

comprehensive coverage of critical health psychology. The readership we have in mind is postgraduate students; as well as students in their final years of undergraduate study, scholars interested in learning more about critical health psychology, and people who are lifelong learners. We write for those based in Aotearoa New Zealand, where we are writing from, and those located elsewhere. Our focus has been on people studying psychology, but this book will also appeal to readers located in a range of disciplines and subdisciplines where people and health are of interest.

Our students regularly tell us they have learnt to see the world differently, and feel empowered from being on our courses. Here are examples of what our students say:

I feel like I'm not only receiving an education to get me a degree, but one that is expanding my horizons, challenging my worldviews, and making me more ready to be a successful psychologist

This course has changed me not only as an academic/upcoming psychologist but as a person too. I know I'm a better person after this course than when I first walked in!

When I first plunged back into postgraduate studies, I had no idea it would lead me here – to new perspectives that have unravelled not only my previous academic understandings, but also, understandings of myself, my identity, my intentions, and the world around me. From the confines of traditional, biomedical conceptions of mainstream psychology, to the emancipatory horizons of critical health psychology. [Blog post by Bella van Hattum.](#)

We want to continue to support our students to undertake study that will allow them to feel empowered and excited by their learning—and to extend this possibility to many other students. Our aim is to provide our readers with a foundation for engaging with the world, especially for those who go on to work in health, community, policy, and therapeutic settings. More broadly, we are offering people a range of tools to negotiate a world where health and wellbeing dominate so much of public discussion and private identity.

There is an appetite for teaching and learning about critical health psychology. The community of people interested in critical health psychology is significant, as evident in the membership of the International Society of Critical Health Psychology, which at time of writing comprises over 1,000 people spanning the Global South and North. This means that across the world, people are teaching, researching, learning, and thinking with and about critical health psychology. Although there are resources that enable this work, these are limited; they are either dated, less comprehensive, or behind a paywall that reduces people's ability to share and discuss these ideas. In receiving a grant from the [Open Education Resources \(OER\) Collective](#), managed by Massey University Library staff, we have been able to break through that barrier and offer a unique resource that can be read by anyone with Internet access or a printed copy.

The Massey University health psychology team is uniquely placed to make this contribution. We are the custodians of a Masters programme with a 30-year history of shaping the field. This calls on us to be ambitious in continuing the vision of those who built the programme and who have seeded the ground for critical health psychology to grow across both Aotearoa New Zealand and internationally. Speaking to this ambition, our aim has been to provide a textbook that can take the reader through the foundations, approaches, and applications of critical health psychology by showcasing cutting-edge scholarship from Aotearoa New Zealand and internationally in an accessible and well-structured format, with real-life, relatable examples throughout. And we have tested it on our students:

I really enjoyed this textbook, as not only was it simple to follow and easy to read, but it felt relatable and real. A lot of the theories had real world examples and used real people and cultures to elaborate on this, and made me think of my own life and the people in it... I also enjoyed reading the historical context of Māori, the colonisation they have faced, and how it is still seen in today's structural systems.

Although we are delighted with this, and other, feedback (see [peer review statement](#) for our review process and external review comments), it does not mean that every decision we made was the right one, or that

this is the perfect textbook. Our ambition has been to do the best that we can, with the resources we have, and as the people we are. We have sought consultation at every step of the way, reaching out to many people in our wider community who have supported us to do this work, for which we are deeply grateful (see [contributors](#) and [acknowledgements](#)).

Positionality

This book is rooted in a belief that knowledge is never neutral, and that how we see the world is shaped by where we come from. It is therefore important to acknowledge some of the positions we write from. As a concept, 'positionality' helps us recognise that our social locations and personal experiences shape our identities, vantage points, and perspectives, and these in turn shape the kind of work we do, including our attempts to write a critical health psychology book.

Positionalities are fluid, relational, and embedded in complex power dynamics. Researchers and educators who recognise the importance of positionality often draw on intersectional theory to consider how our racialised, gendered, and embodied positions, as well as our disability, sexuality, class and socio-economic status interconnect to shape how we understand ourselves and may be understood by others (e.g., CTLT (nd); Collins & Bilge, 2020; Crenshaw, 1989; Collins 2000; Misawa, 2010).

Reflexivity involves considering such elements without producing a hollow "shopping list" (Folkes, 2023, p. 1301), and there is a body of work to help with this (e.g., Bolam & Chamberlain, 2003; Lumsden, 2019; also see Fraser & Walker [Chapter 3.1](#)). Building on Wilkinson (1988), Braun and Clarke (2021), for example, suggest considering personal, functional, and disciplinary levels of reflectivity that include our values; positions of privilege and marginality; methodological, theoretical, philosophical, political, or disciplinary assumptions or commitments; and our hopes, expectations, anxieties, and fears for our work. Although there are multiple ways to do reflexivity, the aim is to help consider the complex relationships between the knowledge producer and the production of knowledge and recognise that values are important because they shape our work. Therefore, in our position statements below, we describe some elements of who we are, and how these have shaped our values and scholarship.

Position statements

Sarah: British born, I lived in several countries as a child, and as an adult, in Northern Ireland, England, Scotland, Wales, and now, Aotearoa New Zealand. My early childhood experiences were of living in both working and middle-class contexts, which years later a friend said had made me a social scientist because I had learnt to "see culture". From an early age, I was sensitive to gender inequity, and feminism gave me the words to make sense of those feelings. A confronting moment of my White privilege occurred when a Southeast Asian friend was told to get off the library photocopier so I could use it. The development of discourse analysis in psychology introduced me to theories of power and meaning making, and these ideas resonated and became a career long focus (you can hear some of my key influences on Dave Nicoll's [ParaDoxa substack](#)). Studying a PhD in a pre-ebook era meant that I had to go to the library, where, when there weren't many psychology books on the subject, I turned the corner and read sociology and

anthropology. This started a career of doing trans-disciplinary research, and I have enjoyed being part of many generative interdisciplinary collaborations. In 2019, I joined the Health Psychology Masters programme at Massey, a flagship programme both for the University and – in my previous experience – a beacon for those doing critical psychology elsewhere. On this programme, I have taught and supervised students in critical health psychology and qualitative research methods, and the first section of this book maps onto one of those courses. I have been subtly shaped by the opportunity to live and work in Aotearoa New Zealand, and am on a journey to better understand te ao Māori (Māori worldviews).

Kathryn: I am a cis-gender heterosexual Pākehā woman. I grew up in rural South Canterbury and attended Otago University in the early 90s. I came to critical health psychology at Massey University as a mature student and found my home within this area. I am married with three daughters. The youngest is autistic and has a range of mental health issues. She continues to inspire my research interests and my desire to create inclusive spaces within tertiary spaces and in the wider world. My positionality is as an ally – an ally for diversity, inclusion, and respect for difference regardless of ethnicity, gender, learning style, or ability.

Elle: I belong to the **iwi** Ngāti Kahungunu ki te Wairoa, Ngāti Rākaipaaka, and Rongomaiwahine. My maternal **whānau** are from the villages of Nūhaka and Te Whakakī in the Hawke's Bay, where I spent my early years. In Te Whakakī, our ancestral **maunga** is Ōrangī, our **awa** is Te Ewe, and our **marae** is Whakakī. In Nūhaka, our ancestral maunga is Moumoukai, our awa is Waitirohia ki Nūhaka, and our marae is Kahungunu. My father is a White Australian, born and raised in Tasmania. I have three sisters, and I am a **wahine** Māori. Growing up I knew our whenua (land) intimately and I felt connected to where we come from and our wider **whānau**, I did not realise until my late teens that this was not the experience of all Māori. During my upbringing our family was working-class; my parents valued education and had high expectations that my sisters and I would seek tertiary qualifications. I often reflect on the ways education was also highly valued by my maternal grandparents, and I view these kinds of expectations within my whānau as a privilege. I am clear that I am Māori first, and a practitioner second; a scholar, researcher, educator, and clinical psychologist. My research and teaching are mainly situated within the Centre for Indigenous Psychologies at Massey University, focusing on Māori and Indigenous psychologies and wellbeing. In my doctoral research, I explored narratives of **wairua** as related to psychological distress, healing, and recovery for Māori. My clinical practice has primarily been with adults who experience mental distress and substance use harms. I am committed to developing understandings about Māori psychological experiences, and addressing issues affecting Māori communities to contribute to meaningful change.

Gareth (he/him, they/them): I grew up in a working-class Pākehā home in Tāmaki Makaurau (Auckland), Aotearoa New Zealand. I have lived most of my life in the shadow of Maungakiekie (one of Auckland's volcanic cones). My family is of English and Irish ancestry, with most of my mother's side arriving in the late 19th Century from Kent in England and Cork in Ireland, and my father's side coming from Kent in the early 20th Century. I am a cisgender man, in a long-term heterosexual relationship, identify as childfree, and live with a chronic autoimmune condition that sometimes locates me at the edges of disability. Although I grew up in a context infused by racism, misogyny, and

heterosexism, I benefitted from key people throughout my life who were willing to give me important privilege-checking nudges. It wasn't until a late start at university that I began to build on these nudges with the language to develop critical consciousness. An undergraduate critical psychology course at the University of Auckland changed my planned direction from clinical to critical psychology and then to critical health psychology. My research is informed by social justice values, and an investment in seeing change to a status quo defined by inequity and unhelpful individualism. This has meant exploring the social production of masculinities, reproductive justice, the involvement of Pākehā in Māori-centred research, and disability and access. I take seriously the opportunities to grow in my identity and actions as Tangata Tiriti, and in other forms of allyship. I joined the Health Psychology programme at Te Kunenga ki Pūrehuroa/Massey University in 2023.

Aorangi: I am a **wahine** Māori PhD student who descends from multiple iwi (tribes) around Aotearoa, including Rangitāne, Ngāti Kauwhata, Te Whakatōhea, Ngāti Porou, Rongowhakaata, and Kai Tahu. I am the second eldest of four children, and a single mother to two. I have had the privilege of growing up strongly grounded by my **whānau**, my culture, my **reo**, and my **tūrangawaewae**. I was born in Ōpōtiki, a small town in the Eastern Bay of Plenty rich in whānau (family), culture, beaches, and rivers. Ten minutes out of town is my **marae**, Ōpape, which sits on the top of a hill overlooking my **moana** Ōpape, my **awa** Ōpepe, my **maunga** Tarakeha, and the **urupā** where my ancestors lie. My teen and adult years have predominantly been spent closer to my other tūrangawaewae, Aorangi marae, which lies just out of a small rural town, Feilding. While going to university wasn't common in my pāpā's whānau, it was normalised in my mum's whānau, who over the years have dedicated their careers to Māori health and education, both in practice and through the academy. The legacies of my **tūpuna** and my connection to my ancestral lands instil in me a distinctly Māori worldview and the values of education, whānau, te reo Māori (the Māori language), collective wellbeing, and tūrangawaewae. Motherhood and getting older have increased my awareness of the inequities, injustices, and **mamae** being experienced by our people, and I grew equally **hōhā** with society's expectations and stereotypes of Māori, especially **wāhine**. I returned to study psychology at Massey University where I gained a Master of Science in Health Psychology, and am now pursuing a PhD. Alongside study, I have worked in various teaching and research roles within the Centre for Indigenous Psychologies at Massey University. Over the years it became apparent to me that Māori "mental health" is not an isolated issue that can be fixed with therapy. It is a manifestation of a web of underlying biological, psychological, social, political, cultural and historical factors; mostly stemming from White supremacy and colonisation. My passions and research are therefore centred on **kaupapa Māori** perspectives of Māori wellbeing and aspirations, and exploring the social, political, and cultural contexts within which Māori health is understood and experienced. (Please hover your cursor over the Māori words for an English translation).

Siobhán (she/her): I was born in Canada and spent the first four years of my life there before returning to Ireland with my Irish mother. I grew up in Kilkenny, a small town in the southeast of Ireland. I was born "out of wedlock", and raised in a middle-class "blended" family, a fact that mattered in the cultural and religious context of that time and place. Growing up in a Catholic community, and attending a public Catholic school system, shaped my early awareness of the quiet politics of shame and respectability. Now, from my position as a White, cisgender, heterosexual woman, I am interested in

feminist, social justice-oriented approaches to research that challenge narrow or pathologising framings of sex/uality and health. I came through a conventional psychology education that left me disillusioned with its often-reductive lens on human experience. It wasn't until arriving at Massey University, Aotearoa New Zealand, that I found a disciplinary home in critical health psychology. In moving from a postcolonial republic with a history of cultural erasure to a settler-colonial state still deeply marked by the ongoing impacts of colonisation, I've been continually challenged to reflect on the responsibilities that come with being a Tauīwi (immigrant), living and working on Māori land. One of the most meaningful parts of that journey has been learning from Māori relational values: deep connections to whenua (land), to those around us, and to those who came before. These values, alongside my connections across Ireland, Aotearoa New Zealand, and Canada, continue to colour how I think about community, identity, belonging, and the complicated pull of place.

Clifford: I was born in apartheid-era South Africa, my parents having immigrated from the Netherlands in the mid-1950s with my brothers and sisters. My parents had survived the Nazi occupation of the Netherlands during the Second World War and these traumatic experiences left their mark across them and their children. I grew up in Benoni, a former mining town east of Johannesburg, and was educated in a whites-only Christian education system. Racism, sexism, homophobia, and physical violence were common elements of this scene and there was little space for someone who seemed to move through the world differently. Fortunately, I had the refuge of a large family, a community of Dutch aunts and uncles, and a second family of English migrants. University provided me with a space for critical thought and reflection, an undergraduate course in critical psychology being an important spark, and I appreciated the sense of freedom and wonder this provided. I witnessed anti-apartheid activists and leaders of immense courage and integrity, who provided an important yardstick. The democratic election in 1994 demonstrated that emancipatory social change is possible but also that the struggle for social justice is interminable. Moving to Aotearoa well over a decade ago I found a new home, and value a country where many seek to challenge the deep traces left by colonialism and neoliberalism whilst celebrating difference and indigeneity, recognising the deep well of hope, strength and creativity this provides.

Don: I was fortunate enough to do a special topic in health psychology with Professor Kerry Chamberlain and then a health psychology PhD with Professor Christine Stephens. Following that, I trained to be a clinical psychologist and have worked most of that career focusing in psycho-oncology. Members of my family have chronic illnesses that significantly affect their lives so I have some understanding of caring for people with chronic illness and also the limits of our systems to 'fix' these problems. This has also helped me understand some of the impacts of economics, beliefs, personal interests, and social influence on the generation of knowledge and the provision of healthcare. My work as a clinical psychologist in psycho-oncology provided a different angle as I supported people to make a difference in their own lives. I've always believed there are two sets of knowledge in the room, which work together to achieve the client's goal. During this time, I have seen that health professionals are clever, generous, and hardworking people who do their best in overburdened systems. I have worked with them and consumers to seek to improve these systems and the experience of consumers where we can.

Approach of the book

We have sought to provide an accessible and interesting resource, that showcases some of the best of critical health psychology and takes you through key ideas and research that relate to this subfield. In so doing, our hope has been to provide a comprehensive textbook that offers an in-depth exploration of the foundations, approaches, and applications of critical health psychology. Accordingly, we have divided this book into three parts:

- Part One describes the theoretical foundations that underpin critical health psychology and shows how these help us understand people's experiences of illness and treatment.
- Part Two examines a range of approaches in critical health psychology as they relate to health and illness.
- Part Three explores how critical health psychology can be applied in practice.

Pedagogical features

The book has a range of pedagogical features. Its online format enables us to hyperlink between sections in the book. Words in the glossary are also hyperlinked where they are used—if you hover your cursor over them, the glossary definition will appear in a pop-up box. The glossary words include terminology related to critical health psychology as well as English translations for te reo Māori (Māori language).

The book uses a variety of text boxes designed to support your learning, including examples, key takeaways, discussion points or activities, and links to videos. Each chapter also ends with a “Want to know more?” section, which recommends resources you can read, listen to, or watch, to make these ideas come alive. Practical activities to help you test your knowledge, such as interactive multiple-choice questions, are also embedded.

Scope

As noted above, health psychology is the application of psychology to health issues. These health issues tend to be physical health issues, based on the argument that if we want people to have better physical health outcomes, we need to think about their psychology. For example, if we want people to adhere to their physiotherapy exercise regimes, we should probably consider the psychology behind what makes people do them. The focus on physical health also distinguishes health psychology from other fields such as medical sociology and anthropology (Stam, 2015), and from other branches of psychology (e.g., clinical psychology with its focus on mental health).

These distinctions are useful, especially when they prime us to understand that different (sub/)disciplines can offer different perspectives on the same issue. Equally, it is important to recognise that physical and mental health issues are deeply interconnected, and that these boundaries are arbitrary in the sense they are conceptual distinctions created by humans. In terms of the scope of the book, this means that in general we focus on physical health issues, but bring in mental health issues where we think relevant.

Open access

This book is released as an open access textbook, or open educational resource (OER). It is free for anyone with online access to read, download, save, print, or share. OERs aim to reduce the financial burdens on

students and remove barriers to education, aligning with our **pou** of paying attention to issues of power and equity.

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Riley, S., McGuigan, K., Brittain, E., Terry, G., Kora, A., Healy-Cullen, S., van Ommen, C., & Baken, D. (Eds.). (2025). *Critical health psychology: Foundations, approaches and applications*. Massey University. <https://doi.org/10.82376/6WW0-P679>

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Terminology

We also want to mention some broader discussions we had about terminology.

Mainstream psychology: We chose to use the term “mainstream psychology” when talking about the kind of individualist, often socio-cognitive psychology that dominates English-language psychology. We use this term because it emphasises how these ideas are centred in psychology (Toomela, 2014). It is also a term used in other critical health psychology literature. For example, in their discussion of critical health psychology, Horrocks and Johnson (2014, p. 176) explain:

Mainstream health psychology and approaches to health behavioural change assume a particular ontology of personhood that [...] 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.

As we have started to unpack in our discussion of **pou** above, and will continue to do so in the book, these ideas contrast significantly with a “critical psychology” that centres meaning making, power, the social context, and desires for psychology to develop more socially grounded and relational understandings.

Practices: Critical health psychologists tend to use the word “practices” rather than “behaviour” when talking about things that people do. Rather than locating behaviour as an outcome of individual decisions, the word “practices” recognises that our behaviours are shaped by a range of social and relational elements, such as social norms, expectations, power relations, and the contexts in which we live and interact with others.

Global South, Global North, & Western: “Global South” and “Global North” are terms used to describe shared characteristics of a range of countries. Global South countries are mostly in the southern hemisphere and have socio-economic and political characteristics that produce multiple health inequities, including those resulting from colonisation. Global North countries tend to be in the northern hemisphere and are characterised as post-industrial nations with significant influence in the global economy. These terms highlight geographical divisions in power and inequity.

Although these terms are linked to broad geographical regions, many countries in these North/South

categorisations do not map onto where they are in the Earth's hemispheres. This is just one of many critiques of this terminology (e.g., da Silva, 2021; Dados & Connell, 2012; and Palomino, 2019). However, we have used it when we want to talk broadly about countries with similar socioeconomic characteristics, when it makes sense to do so in relation to health issues.

Similarly, despite various critiques of the word “Western”, sometimes we find it useful as shorthand for talking about a shared perspective or worldview, and associated social norms and customs that draw from historical European civilisations and which connect to contemporary Anglo-American cultures. When discussing our use of these terms, we decided to use them where we felt they were useful to explain the ideas we wanted to talk about, while recognising they are problematic. We have also capitalised the words “Western”, “Black”, and “White” to show that these are politicised terminology and not taken-for-granted descriptions of the world as it is.

Want to know more?

As with all words that do a lot of “heavy lifting”, the above terms have interesting histories. If you want to know more about them, you could:

Read:

Kwame Anthony Appiah's (2016) Long Read article for the Guardian newspaper, “There is no such thing as western civilisation”. <https://www.theguardian.com/world/2016/nov/09/western-civilisation-appiah-reith-lecture>

Cyma Hibri's (2023) Article for The Conversation, “Orientalism: Edward Said's groundbreaking book explained”. <https://theconversation.com/orientalism-edward-saids-groundbreaking-book-explained-197429>

Watch:

[Western Values Explained](#) by Mr Beat

[The Global North versus South divide \(explained in three minutes\)](#), The Helpful Professor Explains!

People working in health psychology: This is a book about health psychology, aimed at people – especially students – interested in health psychology. Some students studying health psychology go on to become registered psychologists, and many will apply health psychology in a range of roles, including research and policy development. The term “people working in health psychology” thus describes the range of people who apply knowledge of psychology in relation to health. In the interests of parsimony, we sometimes shorten “people working in health psychology” to terms like “health psychologists”. However, we highlight that in many countries, only those people who are registered psychologists and approved by an appropriate governing body (e.g., the New Zealand Psychologist Board; the UK Health and Care Professionals Council, and so forth), can call themselves a “Health Psychologist”. Addressing these issues when considering the application of critical health psychology, Part Three also uses the term “practitioners of critical health psychology”.

People, patient, service user, customer, client: There are multiple ways in which we can describe people

who use health services, each of which connects to a range of debates. For example, in mental health contexts “service users” tends to be the preferred term, while people using services for physical health issues are more likely to consider themselves “patients”. Psychologists generally use the term “client” to describe the people they are treating. In the New Zealand healthcare system, people are often called “consumers”, to highlight that they are using services and should be accorded consumer rights. In other countries, this market-oriented language might seem inappropriate for healthcare. Because of this variation, we have used different terms we felt most appropriate to the context about which we were writing. When in doubt, to emphasise their (and our) common humanity, we have used the term “people”.

How to use this book

We have tried to be true to our principle of knowledge being produced within social context by writing from our social context, while also creating a book that can be read by, and be of value to, people outside of Aotearoa New Zealand.

Part One and Part Two support two postgraduate courses/modules in critical health psychology at Massey University, while the chapters in Part Three contribute readings to two Massey University courses related to professional psychology and work-integrated learning. Readers outside of Massey are invited to use this book in a similar way, or differently, so that it works for your context. You might selectively choose chapters that are most relevant for your learning or teaching, or produce a new course or module through a novel combination of chapters, or by building a course around the chapters in one part of the book. The whole book could form a course – or be read for personal study. Regardless of how you use it, our sincere hope is that the book provides you with the confidence and resources to enjoy learning and teaching critical health psychology. We hope it facilitates your journey in supporting, or becoming, the next generation of critical health psychologists.

Ngā mihi nui/with best wishes from

Sarah, Kathryn, Elle, Gareth, Aorangi, Siobhán, Clifford, and Don.

Want to know more?

Study at Massey University: Massey’s Master of Science (MSc) endorsement in Health Psychology programme has a proud 30-year history of leading the field in critical health psychology. Founded by internationally recognised scholars, it continues to attract top academics and students passionate about enhancing health and impacting healthcare systems and communities. You can find out more, including student testimonials, at: <https://sites.google.com/view/chp-practicum/home>

You can apply to study at: <https://www.massey.ac.nz/study/all-qualifications-and-degrees/master-of-science-PMSCN/psychology-health-psychology-PMSCN1SPSHP2/>

You can also join the critical health psychology community by becoming a member of the [International Society for Critical Health Psychology](https://ischp.net/subscribe/) (it’s free) at <https://ischp.net/subscribe/>

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PART 1 - FOUNDATIONS IN CRITICAL HEALTH PSYCHOLOGY

Part One: Foundations in critical health psychology

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Part One explores foundations in critical health psychology. People working in health psychology are involved in multiple activities that aim to support health and wellbeing. These activities include helping people to maintain health, prevent illness, or have better treatment experiences or outcomes. They also do broader work focused on improving healthcare systems and health policies. To do this work well, people working in health psychology need to know about specific theories or approaches in health and to reflect on the broader ideas shaping their thinking and practice. We often take these broader ideas for granted, but questions about how we conceptualise a person, what counts as knowledge, or what constitutes equitable health outcomes can have surprisingly varied answers.

Part One of the book unpacks these ideas, introducing you to a wealth of deep thinking about what it means to be a person and what kind of knowledges we might be working with. We cover some big conceptual approaches in health psychology:

- Māori ways of understanding people and their health
- Western traditions of conceptualising the person – including:
 - the biopsychosocial approach in mainstream psychology
 - phenomenologically informed work in psychology that focuses on individual interpretation and experience
 - narrative approaches that highlight the role of the stories in people's sense making
 - social constructionist and discursive approaches that conceptualise both people and knowledge as produced within their social context and through relations of power
 - more-than-human theories that emphasises the co-constituted, dynamic nature of the material and discursive world.¹

We use the first four chapters to outline these frameworks, first focusing on Indigenous Māori health, with each subsequent chapter using a different health issue—coronary heart disease, cancer, and weight. Read as a whole, the chapters give you insights into some of the health and illness topics addressed in health psychology, with a particular focus on dominant health issues: cardiovascular diseases are a leading cause of illness and death worldwide; cancers are the second leading cause of death globally; and weight is often treated as a proxy for health and a key focus in healthy lifestyle advice—despite being discredited by many researchers (Calogero et al., 2019; World Health Organization, 2021; World Health Organization, n.d.). As noted in the [introduction](#) to the book, we argue that Indigenous knowledge should be part of foundational learning for critical health psychology, and writing from the context of Aotearoa New Zealand, for us that means foregrounding **te ao Māori** as it pertains to health. We finish Part One with two chapters focusing on the experience of illness and of treatment, respectively. These chapters show how the ideas that we have introduced you to in the earlier chapters can be applied to better understand personal experiences of health, illness, and treatment.

1. The theories we draw on here come from Western traditions in thinking, but they also align with Indigenous, holistic ways of knowing, opening opportunities for shared dialogue and vision and the need for Western more-than-human theorists to engage with Indigenous scholarship.

Throughout Part One, we connect our discussion to the critical health psychology **pou** discussed in the introduction to our book: valuing theoretical and conceptual thinking; challenging taken-for-granted understandings; paying attention to issues of power and equity; moving beyond individualistic psychology; and considering knowledge as produced in context. The chapters engage with all the pou, but read as a whole, they especially speak to the centrality of the social context in shaping knowledge and experience. Specifically, they evidence the way people's individual experiences of health and illness are produced in, and through, interpersonal relationships, personal and family histories, social norms, cultural perspectives, wider discourses, politics, economics, and the materiality of technologies, buildings, bodies, and parts of bodies.

The chapters in Part One lay out substantial foundational thinking that underpins the wide range of work represented in the term "critical health psychology". We have sought to cover this substantial ground in an accessible and interesting way. Our rationale for unpacking these concepts is to give you agency. We all carry with us taken-for-granted ideas that then shape how we think about the world and how we act in it. When we start to explicitly learn about different conceptual approaches, and the perspectives they offer, we can be more choiceful in our thinking.

The metaphor of a map might be useful here. Just like conceptual approaches, different maps offer us different, and only ever partial, ways of interpreting the world. For example, a geologist's map can tell you about types of rock, while a travel map gives information about roads. Both offer different representations of the same land, and depending on context, one may be more, or less, useful to you. Importantly, having more than one map increases our capacities for action, because now we have more than one way to explore and engage with the territory. Similarly, different conceptual approaches can expand our possibilities of thought, and thus practice, in relation to health psychology.

The chapters in Part One of the book therefore offer multiple conceptual maps to make sense of key issues of concern for health psychology. We hope they will provide you with strong foundations for the work you are doing now, and with tools for the work you might do in the future. As such, our aim is to offer you a toolbox of analytical concepts, so that whether you are writing essays, researching a topic, designing a research project, deciding on a treatment plan, or writing policy for business, NGOs or government, you are empowered to consider the needs of that particular piece of work, and can choose the approach that will best allow you to meet those needs. The aims of Part One thus align with how the French philosopher Michel Foucault described his work:

I would like my books to be a kind of tool-box which others can rummage through to find a tool which they can use however they wish in their own area (Foucault, 1974, p. 523-4).

Overview of chapters

Chapter 1.1 Hauora addresses the questions, "How do Māori worldviews and experiences inform their conceptualisations of health?" and "How can critical health psychology engage appropriately with Māori knowledges and perspectives?" It explores Māori worldviews and knowledges and how these shape Māori understandings of people, and their health and wellbeing. The importance of historical and socio-political context is highlighted, including key events in the history of Aotearoa New Zealand, and their impacts for Māori health. The chapter finishes with a review of Māori models of health and dimensions of wellbeing and their application and relevance for contemporary health psychology.

Chapter 1.2 What do we mean by "people"? builds on Chapter 1.1 by considering three approaches from Western traditions that offer different ways to address this question. These approaches are (1) the biopsychosocial approach and associated health psychology models of psychological processes; (2) phenomenologically informed psychology, which focuses on individual interpretations of their lived

experience; and (3) social constructionist approaches that conceptualise the person as produced through, and thus inseparable from, their context. Coronary heart disease provides a running theme to show the similarities and differences of these approaches when applied to the same health condition.

Chapter 1.3: What do we know? addresses the question, “What kind of knowledge do people working in health psychology produce and use?” We consider five approaches that conceptualise knowledge differently. These are (1) the objectivist science of mainstream psychology, (2) phenomenologically informed psychology, (3) social constructionism, (4) more-than-human theoretical approaches, and (5) Kaupapa Māori research. We engage with each of these systematically, exploring how they conceptualise what we can know, and our methods for knowing it. Using cancer as our health topic that threads throughout the chapter, each section has a research example to give you a sense of how these ideas are put into practice.

Chapter 1.4 Equity and power asks, “How do our concepts of health shape possibilities for in/equitable health outcomes?” It starts by distinguishing between equity and equality before introducing poststructuralism, a social constructionist aligned approach that centres relationships between power, meaning making, and psychology. We then introduce “healthism”, an individualist orientation to health, and evaluate how it shapes people’s sense of self and possibilities for equitable health care. We finish with some of the ways we might work with, challenge, or destabilise healthism. Within each section, we thread through examples relating to health and weight, since weight is often treated as a proxy for health.

Chapter 1.5 Experiencing illness asks, “How do people experience illness?” It starts by considering the elements that shape people’s experience of illness, showing the importance of the social context. We then introduce the concept of “illness narratives” to show how stories help people make sense of illness. We follow this with a discussion on “biographical disruption”, a term that describes how the onset of illness can profoundly interrupt a person’s sense of self and relations with others, requiring them to craft new stories about themselves. We finish with the limits of biographical disruption as a concept by discussing how social and economic factors shape illness expectations and thus the narratives people tell about their illness.

Chapter 1.6 Experiencing treatment asks, “How do people experience treatment?” It starts by considering the elements that shape people’s experience of treatment, showing how treatment experiences are not purely individual, but shaped by complex, intersecting psycho-socio-material elements. In highlighting the importance of these multiple elements, the chapter demonstrates treatment experiences as complex and embedded in power relations. Returning to more-than-human theory, introduced in Chapter 1.3, it discusses the “assemblage” as a conceptual framework for understanding the interplay between these multiple elements and tool for evaluating treatment.

Combined, these chapters cover a lot. Depending on your background, some or all of these ideas may be new to you. Our aim is to take you through these ideas in an accessible and interesting way – to be a companion as you explore the different conceptual approaches on offer. Even so, learning new ways of thinking can be difficult because there is nothing to “hook” onto in relation to ideas you already hold. We can think of this in terms of *lovely knowledge* versus *difficult knowledge* (Lather, 2007). Lovely knowledge adds to what you already know. It is “lovely” because it does not significantly push or challenge you, which means that you remain in your comfort zone. But lovely knowledge is unlikely to develop you very deeply, and comfort zones can get boring after a while. So, the challenge is to face *difficult knowledge* – the ideas that unsettle or do not fit easily within an existing framework. One way to do this is to recognise those feelings if they happen, and understand they are part of a learning journey. It is also useful to know that the more time you spend with difficult knowledge, the more it becomes part of your thinking—to eventually become lovely knowledge.

There is an expression in te reo Māori, a **whakatauāki** attributed to the late Professor James Te Wharehuia Milroy, that orients to the moment just before something important happens, a sense of fear, but also of an

anticipated action to come—"Tūwhitia te hopo, mairangatia te angitū!" (The essence of this whakatauākī is, "Feel the fear and do it anyway".²)

Taken together, the chapters in Part One of this book offer a comprehensive overview of conceptual approaches that students, researchers, and practitioners can use when seeking to understand how the social context shapes personal experiences of health, illness, and treatment.

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2. A direct translation is: Tūwhitia te hopo – eliminate the negative; mairangatia te angitū – accentuate the positive. You can hear how it sounds at this link: <https://kupu.maori.nz/kupu/T%C5%ABwhitia-te-hopo%2C-mairangatia-te-angit%C5%AB/>

1.1 Hauora

ELEANOR BRITTAIN AND AORANGI KORA

Overview

Cultural understandings inform how we think about people and their health. In this chapter we introduce Māori cultural understandings of health and wellbeing, with specific considerations for critical health psychology. We begin by presenting Māori worldviews and knowledges and discuss how these inform Māori notions of wellbeing. We examine the historical and socio-political context in **Aotearoa New Zealand**, with a focus on **Te Tiriti o Waitangi**, and consider the ways contexts shape how we think about people and their health. Subsequently, we outline Māori models of health and then concentrate on specific dimensions of wellbeing for Māori, with relevant examples of application for contemporary health psychology.

The topics in this chapter are not new concepts, however discussing them here offers opportunities and possibilities to critically consider and re-conceptualise health psychology. These issues are equally important for all who study, teach, research, and engage with critical health psychology in **Aotearoa New Zealand**. Although our focus is on Māori worldviews and foundational understandings for those working in Aotearoa New Zealand, this chapter also serves a broader remit of sharing knowledge for people interested in decolonising psychology. We recognise the potential for Māori understandings to enrich and extend critical health psychology, which may in turn be influential to cultural contexts globally.

The questions we address in this chapter are: **How do Māori worldviews and experiences inform their conceptualisations of health? How can critical health psychology engage appropriately with Māori knowledges and perspectives?** We focus on the following learning objectives:

Learning objectives

- Explore Māori worldviews and knowledges and evaluate their relationship to Māori understandings of health and wellbeing.
- Recognise the importance of historical and socio-political context, including key events in the history of Aotearoa New Zealand, and discuss the impacts for Māori health.
- Review Māori models of health and dimensions of wellbeing and examine their application and relevance for contemporary health psychology.

Positionality

Positionality is important from the standpoint that all knowledge and research is inherently subjective, as we all view and understand the world through our own cultural lenses. We recognise and acknowledge the cultural assumptions we hold about reality, what we deem as constituting knowledge, and how these assumptions inform the processes we use in research and in practice. Māori are not a homogenous people, and the perspectives presented in this chapter are shaped by the authors' own worldviews and lived

experiences, **hapū** and **iwi** affiliations, educational backgrounds and academic experiences, gender, socioeconomic status, and more (see [positionality statements in the Introduction](#) to the book). Therefore, based on our understandings of Māori worldviews, and drawing together various discussions from the areas of Māori psychology and Māori health, the perspectives we offer are intended to offer a broad coverage. Our aim is to encourage critical thought to shape a new, or renewed, appreciation for Māori health moving forward.

Māori notions of health and wellbeing – What is hauora?

Māori notions of health and wellbeing are holistic, relational, and grounded in Māori cultural worldviews. Sir Mason Durie, a respected leader in Māori health, emphasises cultural connection as foundational to Māori health:

*Platforms for Māori health are constructed from land, language and **whānau**; from **marae** and **hapū**; from **Rangi** and **Papa**; from the ‘ashes of colonisation’; from adequate opportunity for cultural expression; and from being able to participate fully within society. Like other New Zealanders Māori are not immune from the effects of unhealthy policies, nor from unacceptable standards of living, but all too often Māori have encountered expectations that they should abandon a Māori base. Yet being Māori itself is a foundation for health. (Durie, 2001, pp. 35-36).*

Health and wellbeing are conceptualised within several **te reo Māori** terms:

- **Hauora** describes the breath of life and spirit; it refers to a physical sense of wellbeing for an individual and it is interdependent with collective qualities such as **whanaungatanga** (Henare, 1988; Pihama et al., 2023).
- **Mauri ora** represents the life-giving essence, the spark and vitality of life that binds the spiritual and physical (Barlow, 1991; Mead, 2016).
- **Waiora** encompasses total wellbeing and strength of spirit, denoting flowing and life-sustaining waters, and has bases in Māori creation narratives (Pere, 1997).
- **Whānau ora** pertains to family and collective wellbeing and it is a term promoted in contemporary Māori health policy (Ministry of Health, 2024).

We have chosen to call this chapter **Hauora**, to reflect the connection between the physical, psychological, relational, and spiritual.

Māori beliefs about the universe, reality, and knowledges

Māori have distinct and unique ways of being and thinking in the world. Māori beliefs about the universe, reality, and knowledges emphasise relational and spiritual understandings; there is an inherent interconnectedness between all things. In this section we describe these worldviews and assumptions from **te ao Māori** and discuss how they are relevant to Māori perspectives and experiences of health.

Cosmologies and cosmogonies

Cosmologies encompass beliefs about the nature of the universe and **cosmogonies** are understandings of the origins of the universe. Māori cosmologies and cosmogonies are multiple and rich. Commonly they describe the creation of the universe and the emergence of life in three phases: **te kore**, **te pō**, **te ao mārama**.

- **Te kore** is the most distant phase in time, the beginning. Te kore is the source of all life, meaning “the void” or “nothing”. However, te kore is also understood as energetic and the space of infinite potential.
- **Te pō** is the second phase. Te pō, meaning “darkness”, refers to periods of time and gradations of perceptual and mental darkness. Te pō is described as the realm of becoming, with the development of earth and life. To Māori, **atua** are also considered to be **tīpuna** and during te pō, **Papatūānuku** and **Ranginui**, who are regarded as primordial atua, come into existence. They procreate many more atua, but the closeness of their embrace prevents light and growth. The children grow tired and rebel, plotting against their parents to separate them. The separation is achieved by **Tāne**, who let light into the world.
- **Te ao mārama** is the third phase and from darkness comes the world of light. This is the realm in which human life and life on earth develops. In te ao mārama there is space for growth and the pursuit of knowledges and physical and mental enlightenment is possible. Humankind comes into being when **Tāne** shapes the first woman, **Hine-ahu-one**, from the Earth.

(To read more, see our sources: Barlow, 1991; Marsden, 1992; Mead 2016; Walker 1992).

While this is a summary of extensive knowledges and a sole perspective, what it shows is that Māori creation narratives provide the basis for understanding and interpreting reality and give meaning to everyday life.

Ontologies

Ontologies refer to understandings about reality and human nature. Based on Māori narratives about the origins and nature of the universe, Māori ontologies emphasise connectedness, relationships, and a spiritual element. These are established within cultural concepts:

- **Whakapapa** means genealogy, although more specifically it refers to layers of genealogy. Māori narratives and whakapapa describe human life as descending from **atua**, and as therefore related to the natural environment. Whakapapa is the structure by which all things are connected (Barlow, 1991).
- **Whanaungatanga** refers to relationships and kinship. These concepts highlight connections between the natural world, **atua**, **tīpuna**, and humankind. Whanaungatanga encompasses collective interdependence (Henry & Pene, 2001).
- **Wairua** and recognition of the spiritual and unseen is also central to Māori assumptions about reality and human life. Wairua is described as the ultimate reality of existence for Māori (Marsden, 1992).

Taken together, Māori cosmologies and ontologies view human life as emanating and descending from the universe and from **atua**. These worldviews emphasise interconnectedness between everything in existence, on earth, and in the universe. Importantly, we recognise our existence as part of a whole, spanning physical and spiritual, across past, present, and future. Existence does not begin, nor does it end, with us.

Epistemologies

Epistemologies entail understandings about the nature of knowledges. Just as **whakapapa** is centred in Māori ontologies, whakapapa is also significant to Māori epistemologies as a means by which Māori record, remember, and impart knowledges about the world (Barlow, 1991). In this way Māori epistemologies and ways of engaging with knowledges reinforce the connectedness between human kind, the environment, and to space, in temporal and spiritual terms (Smith, 2008).

Similarly, Māori use narratives and metaphor to preserve and communicate knowledges. These narratives are often referred to as **pūrākau**, and use of pūrākau encourages multiple meanings and interpretations

(Lee-Morgan, 2019). Narratives and the knowledges they contain reflect a uniqueness derived from the pūrākau inherent to **whānau**, **hapū**, and **iwi**.

Recapping cosmologies and cosmogonies, ontologies, and epistemologies from a Māori perspective

By **cosmologies** and **cosmogonies** we mean understandings about the nature and origins of the universe. **Te kore**, **te pō**, and **te ao mārama** are common representations for Māori of the creation of the universe and life.

By **ontologies** we mean understandings about the nature of reality and human nature. From a Māori perspective this is relational and underpinned by **whakapapa** and **whanaungatanga**.

By epistemologies we mean understandings about the nature of knowledges. **Whakapapa** and **pūrākau** are significant to Māori ways of recording, preserving, and communicating knowledges.

You can also see Riley et al. [Chapter 1.3](#) for further discussion of these “ologies”.

Want to know more about Māori creation stories and worldviews?

- **Read:** Te Ahukaramū Charles Royal on Te Ara: <https://teara.govt.nz/en/maori-creation-traditions>
- **Watch:** Kiri Prentice (Ngai Tūhoe, Ngāti Awa), Psychiatrist and creator of Māori Minds – a brief video on, [An Ontology of Whanaungatanga](#)



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Mātauranga

With a foundational understanding of Māori beliefs about the universe, reality, and knowledges, we now focus on Māori knowledges more intently. **Mātauranga** is often used as a term for knowledges and it is described as:

- a contemporary phrase for a body or continuum of knowledges with age-old origins.
- referring to something unique and valuable about the Māori world (Royal, 2012).

In exploring **tikanga** and a range of Māori practices, Sir Hirini Moko Mead, a leading Māori scholar, emphasises the sheer breadth of **mātauranga**:

The term “mātauranga Māori” encompasses all branches of Māori knowledge, past, present and still developing. It is like a super subject because it includes a whole range of subjects that are familiar in our world today, such as philosophy, astronomy, mathematics, language, history, education and so on. And it will also include subjects we have not yet heard about. Mātauranga Māori has no ending: it will continue to grow for generations to come. (Mead, 2016, p. 245).

Examples of **mātauranga** in Māori traditions and customs include **pūrākau**, **whakataukī**, **karakia**, **waiata**, **mōteatea**, and **rongoā**. We also do not need to look far to see mātauranga as continuing to develop in our contemporary context. The growth of Māori scholarship across academic disciplines, including health psychology is one example, and in the public sphere the revitalisation of mātauranga about **Matariki** and associated Māori practices is another.

Mātauranga has often been dismissed and undermined by Western science and researchers (for discussion of a recent issue, see Stewart, 2021). However, Māori worldviews and mātauranga have been, and continue to be, valid. Indeed mātauranga is relevant and drawn on in research and practice in contemporary health settings. For example, in a surgical outpatient setting a collaborative treatment approach was used by Koea et al. (2024) to implement **rongoā** practices alongside routine Western medical practice. Rongoā and Māori healing traditions are founded in mātauranga and this feasibility study identified factors to promote effective collaboration of knowledges and practices from Māori and Western perspectives in a health setting in Aotearoa New Zealand.

Kaupapa Māori

Kaupapa Māori is embedded in Māori worldviews, philosophies, and **mātauranga**. It takes for granted the validity and legitimacy of Māori knowledges, culture, and **te reo Māori**. Kaupapa Māori is essentially related to being Māori (Nepe, 1991; Smith, 2021). We can view mātauranga as labelling knowledges and as informing Kaupapa Māori (Pihamā, 2010). However, whereas mātauranga does not infer any particular action, Kaupapa Māori indicates action based on **tikanga** and practices (Royal, 2012).

The eminent example of **Kaupapa Māori** in action is the establishment of alternative forms of education for Māori, **Te Kōhanga Reo** and **Kura Kaupapa Māori**. In the 1980s there was growing political consciousness among Māori, including increased energy to recognise **Te Tiriti o Waitangi**, and the revitalisation of **te reo Māori**. The developments in Kaupapa Māori education became a symbol of Māori efforts to embody **tino rangatiratanga** (Smith, 2017).

For Linda Tuhiwai Smith the implications of **Kaupapa Māori** are substantial:

There is more to Kaupapa Māori than our history under colonialism or our desires for self-determination. We have a different epistemological tradition, one which frames the way we see the world, the way we organize ourselves in it, the questions we ask and the solutions that we seek. It is larger than the individuals in it and the specific ‘moment’ in which we are currently living. (Smith, 2021, p. 244).

The term **Kaupapa Māori theory** emphasises Māori cultural ways and knowledges, and Graham Hingangaroa Smith (2017) is clear that Kaupapa Māori theory is transformative. Specifically, it is transforming **praxis**, which means it involves a cycle of consciousness raising, resistance, and transformative action. In other words, Smith asks, “How is your theorising work linked to tangible outcomes that are transformative?” (p. 70). To be of benefit to Māori, Kaupapa Māori theory must be connected to Māori lived experiences and be focused on practice and transformative outcomes (Pihamā, 2010).

A whānau-led project in cancer research

A prime example of **Kaupapa Māori** in action is seen in an innovative partnership between members of the McLeod **whānau** and their community, geneticists, and clinicians. Spanning almost 30 years, together they identified a genetic mutation that was causing members of the McLeod whānau to die from stomach cancer at a young age. In our view what makes this project Kaupapa Māori is that it was initiated by whānau and has been led by whānau throughout, with a commitment to improving whānau health outcomes. Components of the project have also incorporated Māori knowledges, **te reo Māori**, and **tikanga** to inform work with **whānau Māori** throughout Aotearoa New Zealand, in order to provide better services in care.

Read: <https://pmscienceprizes.org.nz/finding-a-genetic-cause-for-stomach-cancer-in-a-whanau-now-saves-thousands-of-lives/>

Watch: Karyn Paringatai, [My whakapapa saved my life.](#)



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Kaupapa Māori theory challenges prevailing Western methods of defining, accessing, and creating knowledge about Māori, with Māori maintaining autonomy over the research agenda (Bishop, 1998). Māori cultural specificities, preferences, and practices warrant that Kaupapa Māori theory retains cultural relevance and reverence (Irwin, 1992). Kaupapa Māori theory is inherently critical; it critiques systems of power and unequal power relations (Smith, 2017).

A tradition within Western science and research focused on preserving colonial values and interests, that has undermined Māori knowledges and displaced Māori lived experiences. These oppressive practices have denied Māori agency, authority, and voice (Bishop, 1998). Routinely positioned as “objects” and “others” in research, Māori have been dehumanised and pathologised, where Māori knowledges have been treated as a commodity for colonial exploitation, just as natural resources have been. Decolonisation in research therefore entails centring Māori worldviews and concerns, and engaging in research from a Māori perspective, for purposes that are relevant to Māori (Smith, 2021).

Want to hear directly from the leaders of Kaupapa Māori about its development?

Watch: An online **kōrero** between Professor Linda Tuhiwai Smith and Professor Leonie Pihama.
[Kaupapa Māori theory and methodology series 06 04 2020](#)



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Historical and socio-political contexts

As well as cultural worldviews, historical and socio-political contexts also play a role in how we understand and respond to **hauora** for Māori in contemporary settings. Like Māori approaches to health, critical health psychology also understands health as produced *through* wider historical, social, political, and economic contexts. Both are therefore concerned with social justice agendas.

The history of **Aotearoa New Zealand** and colonisation have had significant impacts on the state of Māori health today. By drawing attention to the contexts that shape **hauora**, we can frame and interpret health issues differently. What if we stopped seeking solutions to “fix” people, and instead shifted the focus to consider people’s environments and contexts as being “sick” and needing to be fixed? This kind of approach encourages us to critically think about health experiences as natural or understandable responses to environments and wider contexts that are harmful, rather than attributing issues solely to individuals.

The historical context of Aotearoa New Zealand

For a fuller appreciation of **hauora** and health experiences for Māori today, it is vital that we have an accurate understanding of history. Surely a basis of knowledge about the historical and social context of **Aotearoa New Zealand** is *critical* to critical health psychology.

Early history of Māori and European settlement in Aotearoa New Zealand

To set the scene, there are some key dates and historical events to know about that contribute to the story of **Aotearoa New Zealand** as nation. Around AD 800 to 900 voyagers from Polynesia navigate **Te Moana Nui a Kiwa** in double-hulled sailing vessels and begin to settle in Aotearoa New Zealand. These Polynesian voyagers are the ancestors of Māori and settlements are established in favourable sites throughout the North and South Islands. Māori were living here for at least 800 years before the arrival of Europeans.

In 1642, the first European ship visited, captained by Abel Tasman. It would then be almost 100 years until another European vessel arrived in Aotearoa New Zealand, with James Cook first visiting in 1769, and a second time in 1773. Subsequently early visitors to Aotearoa New Zealand sought trade and included seal-hunters, timber traders, and whaling ships. In this early phase of contact, there were major economic benefits for Māori and European visitors alike. However, with visitors came the introduction of contagious diseases and Māori did not have immunity. From around 1790 there were several epidemics that severely impacted Māori. Introduced diseases and intensified fighting with muskets amongst Māori in the 1820s contributed to a decline in the Māori population.

Missionaries introduced Christianity from 1814. Based on ideas of ethnic and cultural superiority, missionaries were motivated to “civilise” Māori. With the first Bible scriptures printed in 1827, Māori demonstrated a keen interest in literacy, with children and adults alike attending mission schools to learn. However, conversion to Christianity negatively impacted Māori culture and customary practices.

Since the visits of explorers in the eighteenth century, hundreds of British and people of other nationalities had settled in Aotearoa New Zealand. By the mid-1830s there were increasing encounters between Māori and Europeans, bringing together peoples with contrasting ways of viewing and relating to the world. Generally Māori continued to welcome Europeans for the benefits they brought, including access to goods, technology, ideas, and relationships. Māori also sought to maintain control over relationships with settlers and traders, and to ensure the newcomers abided with **tikanga**.

(To learn more, see our sources: Waitangi Tribunal, 2014; Walker, 2004).

He Whakaputanga – The Declaration of Independence

In 1831, in the context of unruly behaviour by Europeans who had settled predominantly in the Bay of Islands and Hokianga, leading **rangatira** petitioned the King of England to control British nationals and highlighted the importance of trade. Britain, too, wanted peace, trade, and control of its own disorderly subjects. In this context James Busby was appointed as British Resident, and in 1834 one of his initial acts was to meet with **rangatira** to select a flag.

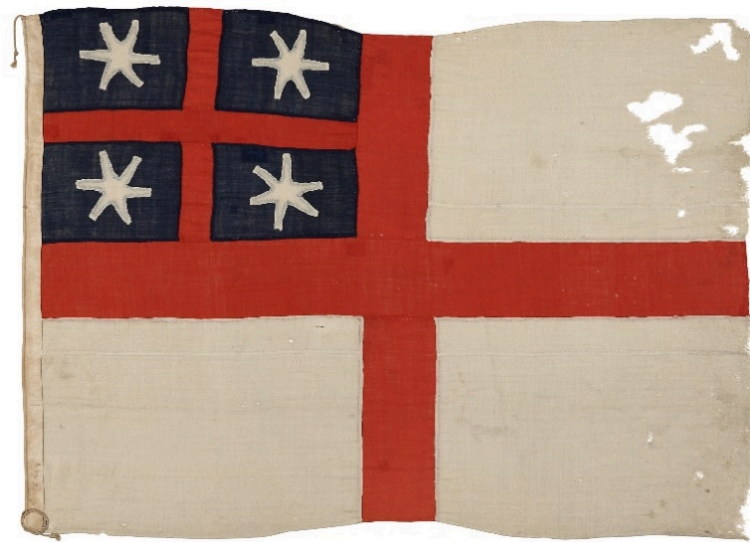


Figure 1.1.1 Te Kara o Te Whakaminenga o Ngā Hapū o Nu Tirenī, United Tribes Flag, adopted in 1834. ([New Zealand Company/United Tribes Flag](#). Gift of Andrew Haggerty Richard Gillespie, Te Papa. [CC BY-NC-ND 4.0](#))

On 28 October 1835 James Busby convened another significant meeting at Waitangi with 34 **rangatira** to sign **He Whakaputanga o te Rangatiranga o Nu Tirenī** (He Whakaputanga), The Declaration of Independence. He Whakaputanga declared the independence of rangatira and asserted Aotearoa New Zealand as an independent state, while formalising and strengthening the relationship between Māori and Britain (Waitangi Tribunal, 2014). Importantly, He Whakaputanga was a declaration that Māori authority would endure, and it rejected any foreign authority over Māori people and territories (Walker, 2004). Furthermore, many **hapū** consider He Whakaputanga to be the founding document of Aotearoa New Zealand, and refer to it when exercising their independence and authority (Mutu, 2019). The context of He Whakaputanga is significant because it demonstrates Māori efforts and commitments to exercise independence and sovereignty from their earliest encounters with the British Crown.

Te Tiriti o Waitangi

He Whakaputanga and **Te Tiriti o Waitangi** (Te Tiriti) are both essential to the story of nationhood in Aotearoa New Zealand. Before we delve into Te Tiriti, there are important terms and details to be familiar with:

- There are two texts; **Te Tiriti** is the **te reo Māori** text and **The Treaty of Waitangi (The Treaty)** is the English text (these are sometimes referred to as the Māori version and the English version).
- The **provisions** are the specific terms of agreement, that is, what the text of Te Tiriti and The Treaty state.
- The **principles** are the current day consideration of the terms of agreement (there are several principles).

Te Tiriti is the founding document of Aotearoa New Zealand as a nation and representative of the relationship between the British Crown (the Government) and Māori. On 6 February 1840 at Waitangi, Te Tiriti was signed by over 40 **rangatira** and William Hobson as a representative of the Queen. In subsequent months more than 500 rangatira signed from around Aotearoa New Zealand (Mutu, 2011; Waitangi Tribunal, 2014).

Suffice to say there are considerable analyses and ongoing debates about the intentions, meanings, and effects of **Te Tiriti** and **The Treaty**. Here we want to highlight the significance of the **provisions** of Te Tiriti, because they have important implications for how contemporary health psychologists ought to think about health for Māori and Māori communities.

Professor Margaret Mutu is an expert in **Te Tiriti** and emphasises that in line with international law, it is Te Tiriti that is the official treaty. Furthermore, Te Tiriti was the document **rangatira** understood at the time and it was the document almost all rangatira signed (Mutu, 2011).

Professor Margaret Mutu on the provisions set out in Te Tiriti

*On the part of the British, the Queen of England wished there to be peace and good order between her subjects and the Māori people, and to achieve that she needed to control her own **Pākehā** subjects living throughout the land already who were being lawless, as well as those who would be coming in the future. She asked the **rangatira** [...] to allow her to do so using a mechanism called **kāwanatanga**. [...] If the rangatira agreed to this she would respect and uphold their **tino rangatiratanga** and hence their **mana**, their ultimate and paramount power and authority over all their territories and people. She asked that in future the Queen or her agent be allowed to trade for use rights to lands of the **hapū** for prices agreed to by the agent and the owner of the land. Finally, in reciprocation for the care and protection provided by Māori to her Pākehā subjects, she likewise would care for and protect Māori and make available to Māori her own English culture and customs. (Mutu, 2011, p. 37).*

What does Te Tiriti mean for hauora?

So far we have focused on the **provisions**, however we recognise that the **principles** are often at the forefront in discussions about **Te Tiriti**, especially in health contexts. While we detail the links between provisions, principles, and implementation of such, we emphasise that knowledge of the provisions is central to contemporary understandings about Te Tiriti (Te Atakura Educators, 2023).

- **Kāwanatanga**, meaning governance, is a provision of Article 1 of Te Tiriti. It is related to the current day principles of good governance and partnership. What this means is working together with Māori to improve health outcomes.
- **Tino rangatiratanga** is a provision of Article 2, and it refers to Māori maintaining independence over their lands and all their treasures. This is interpreted in current day principles as self-determination and active protection. This means Māori have control of Māori knowledges and self-determination over their health, across policy, delivery, content, and outcomes.
- **Ngā tikanga katoa rite tahi**, meaning all of the rights, is a provision of Article 3. It is related to the principles of participation and equity. In health contexts, this means that Māori have equitable access and opportunities to participate in health services and delivery at all levels.
- **Te ritenga Māori**, referring to Māori spiritual practices, is a provision of Article 4 (often described as the “Oral Article”). This is interpreted in current day principles and implementation as honouring Māori spiritual practices (Te Atakura Educators, 2023; New Zealand Psychologists’ Board, 2009).

Dr Moana Jackson (2020), lawyer and renowned **Te Tiriti** expert, summarised the intent of Te Tiriti as a vision of a prosperous partnership and peaceful co-existence between Māori and newcomers. It is our view that this vision also encompasses promoting hauora for Māori and the wellbeing of all people in **Aotearoa New Zealand**.

Want to know more detail about Te Tiriti and its relevance today?

- **Read:** For introductory and accessible coverage of the texts, you can read a summary by Professor Margaret Mutu.
Mutu, M. (2011). Constitutional intentions: The Treaty of Waitangi Texts. In M. Mulholland & V. Tawhai (Eds.), *Weeping waters: The Treaty of Waitangi and constitutional change*, (pp 16–33). Huia Publishers.
- **Watch:** For a contemporary perspective unpacking current political issues, watch another expert critical analyst and Te Tiriti educator, Veronica Tawhai:
Tawhai, V., Thompon, H., & Dewes, T. [RNZ] (2024, November 12). *Hori on a hīkoi – Ngā porokāte: Episode 4: “Te Tiriti Party” (Part 1) – Veronica Tawhai*. [Video]. YouTube. https://youtu.be/QEx0yrFWP6k?si=Q_OG8FxebkyRt6QQ



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/critical-health-psychology/?p=794#oembed-5>

Colonisation – past and present

Despite the signing of **Te Tiriti**, the terms agreed to were not upheld by the Crown. In the subsequent decades, Māori were dispossessed of their lands and therefore their capacity to sustain themselves, both in practical and cultural terms (Walker, 2004). The history of **Aotearoa New Zealand** includes several events and Crown actions, including extensive land confiscation, warfare, and prohibition of **te reo Māori** in schools, which were extremely detrimental to the health and wellbeing of **whānau**, **hapū**, and **iwi** (Smith, 2021).

The assault on Māori health and wellbeing via legislation has been wide-reaching. Oftentimes discussions of colonisation frame it as an isolated event that occurred in some distant past. But, colonisation is present and ongoing; it continues in the laws and institutions in Aotearoa New Zealand, and its legacy impacts on the lived experiences of contemporary Māori (Reid et al., 2019). A defining feature of colonisation for Māori is the undermining of **mana** and **rangatiratanga**, or rather the denial of Māori independence and rights to be self-determining (Smith, 2021). Here we outline a selection of legislation and Crown or government actions since the signing of **Te Tiriti** to demonstrate the mechanisms by which colonisation operates.

- **Native Land Act 1862** created the Native Land Court to decide ownership of Māori lands and to transform communally owned land into individual titles. Land is a basis of identity for Māori and this law was extremely destructive to Māori wellbeing, with significant impacts culturally and economically (Walker, 2004).
- **Native Schools Act 1867** established education for Māori, however in 1905 teachers were instructed to encourage only English be spoken in playgrounds. This led to the prohibition of **te reo Māori** within schools, which persisted over the subsequent 50 years and was at times enforced with corporal punishment. The suppression of language and identity has had a lasting harmful effect psychologically for Māori (Walker, 2004).
- **Tohunga Suppression Act 1907** had a direct impact on Māori approaches to health. It undermined the legitimacy and ostracised **mātauranga** regarding healing, **wairua**, the environment, human behaviour, and arts (Durie, 2005).
- **Foreshore and Seabed Act 2004** vested ownership of the foreshore and seabed with the Crown, limiting Māori ownership and control. A protest in opposition to the legislation travelled to Parliament. The concern for Māori was that **tino rangatiratanga** was being compromised, with many **hapū** and **iwi** viewing it as the largest seizure of land and resource since the nineteenth century (Spoonley, 2009; Walker 2004).
- **Treaty Principles Bill 2024** was proposed to redefine the principles of **Te Tiriti o Waitangi**. The Waitangi Tribunal (2024) highlighted that the Bill breached **tino rangatiratanga** and recommended that it be abandoned, arguing it would hinder Māori access to justice and negatively impact social cohesion. There was significant opposition throughout Aotearoa New Zealand, including a protest to Parliament of over 42,000 people (RNZ, 2024). In April 2025, the bill was not supported at its second reading and it was terminated (New Zealand Parliament, 2025).

Our aim in giving attention to the historical and socio-political context of **Aotearoa New Zealand** has been to highlight events and associated narratives based in evidence. Many inaccurate retellings have proliferated over the years, perpetuating the colonial agenda by reinforcing mistaken ideas that Māori are inferior (Jackson, 2020). All of this relates to critical health psychology because historical events have long-lasting impacts on health status and colonisation affects contemporary health outcomes for Māori.

Māori health models and dimensions of hauora

The development of Māori health models grounded in Māori worldviews has provided culturally meaningful frameworks to engage in efforts towards optimal health and wellbeing for Māori. Broadly, Māori frameworks and initiatives that centre cultural understandings have contributed to significant gains in the health of Māori in the past 100 years, including improved life expectancy, lowered mortality rates, improved educational participation, and growth in **te reo Māori** acquisition (Durie, 2001; Tomlins-Jahnke & Mulholland, 2011).

In this section we summarise well-known and commonly used Māori health models. Then, in the subsequent section we explore core dimensions of hauora, with a focus on application. Consistent across

Māori models of health and wellbeing are the themes of integration, balance, and relationality. Importantly, individual health is considered in the context of the environment and wider systems; there are no clear-cut distinctions between spiritual, psychological, physical, and collective dimensions (Durie, 2001). As we will cover, Māori health models readily use **te reo Māori** and metaphors derived from a Māori worldview. This provides ways of conceptualising hauora that are distinctly Māori, with solutions to uphold Māori health that are specific to Māori lived experiences.

Reflecting on your own positionality

Before we explore Māori health models, we need to revisit the ideas of **positionality** mentioned at the start of the chapter. We encourage you to consider your own positionality. We also bring to your attention the notion of **cultural safety**, a cornerstone of which is, “to produce a workforce of well educated, self-aware [practitioners] who are culturally safe to practice, as defined by the people they serve” (Ramsden, 2002 p. 94). Ongoing critical reflection of your own positionality and the ways it shapes your engagement with, and interpretation of, the world around you is essential. This necessitates cultural humility; to be open-minded, to develop awareness of your own positionality, and to learn from cultures different to your own (Christopher et al., 2014). Even with seemingly good intentions, using culturally based knowledges and health models in the absence of self-awareness and cultural humility can at best be improper, and at worst, harmful.

A starting point for reflection on your own positionality if you live in Aotearoa New Zealand

- What are my own cultural identities? How do these locate or position me in **Aotearoa New Zealand**?
- How am I connected to Māori communities?
- What is my understanding of Māori knowledges?
- What and whose interests are served by my engaging with Māori knowledges and Māori health models?
- You can see Fraser and Walker [Chapter 3.1](#) to further explore these ideas in terms of reflexivity.

Te Whare Tapa Whā

A seminal Māori health model, **Te Whare Tapa Whā**, frames wellbeing as achieved through balance across four domains: **te taha tinana**, referring to physical wellbeing; **te taha hinengaro**, mental and emotional wellbeing; **te taha whānau**, representing family and social wellbeing; and **te taha wairua**, spiritual wellbeing (Durie, 1985, 2001). The **whare** is also conceptualised as sitting on the **whenua**, representing the importance of Māori connection to ancestral lands and the natural environment. Wellbeing is flourishing when all four domains are cared for and in balance, whereas illness or dysfunction develop when one or more of the domains are compromised. Te Whare Tapa Whā has been established and endorsed across psychology and health disciplines, reinforcing the importance of a holistic understanding and approach to health for Māori.

Te Wheke

Another well-recognised Māori model of health, **Te Wheke**, affirms that individual wellbeing is inseparable from **whānau** wellbeing (Pere, 1997). Represented as an octopus, the head symbolises whānau and the eyes represent **waiora**, which in the model is understood as the overall wellbeing of whānau. Each of the eight tentacles represent a dimension fundamental to Māori wellbeing, including those encompassed in **Te Whare Tapa Whā** (**wairuatanga**, **hinengaro**, **tinana**, and **whanaungatanga**) as well as a further four dimensions: **mauri**, referring to life essence; **mana ake** as unique identity; **hā a koro mā, a kui mā**, representing breath of life from ancestors; and **whatumanawa** as healthy expression of emotions.

Meihana Model

The **Meihana Model** provides a practical guide for clinical assessment and treatment and is represented as a **waka hourua** traversing the ocean (Pitama et al., 2007, 2017). The Meihana Model places **whānau** at the centre, alongside the individual, and similarly includes the four core dimensions of **Te Whare Tapa Whā**. It also extends to account for the historical and social context of Aotearoa New Zealand, represented as **ngā hau e whā**, the four winds, and in so doing recognises the ongoing impact of colonisation, migration, marginalisation, and racism for whānau. In addition, the Meihana Model identifies components from **te ao Māori** that may influence a person and their whānau. These are depicted as **ngā roma moana**, ocean currents, and comprise: **āhua**, referring to personalised indicators; **tikanga**; **whānau**, specifically roles and responsibilities within families; and **whenua**, representing spiritual and ancestral connections to land.

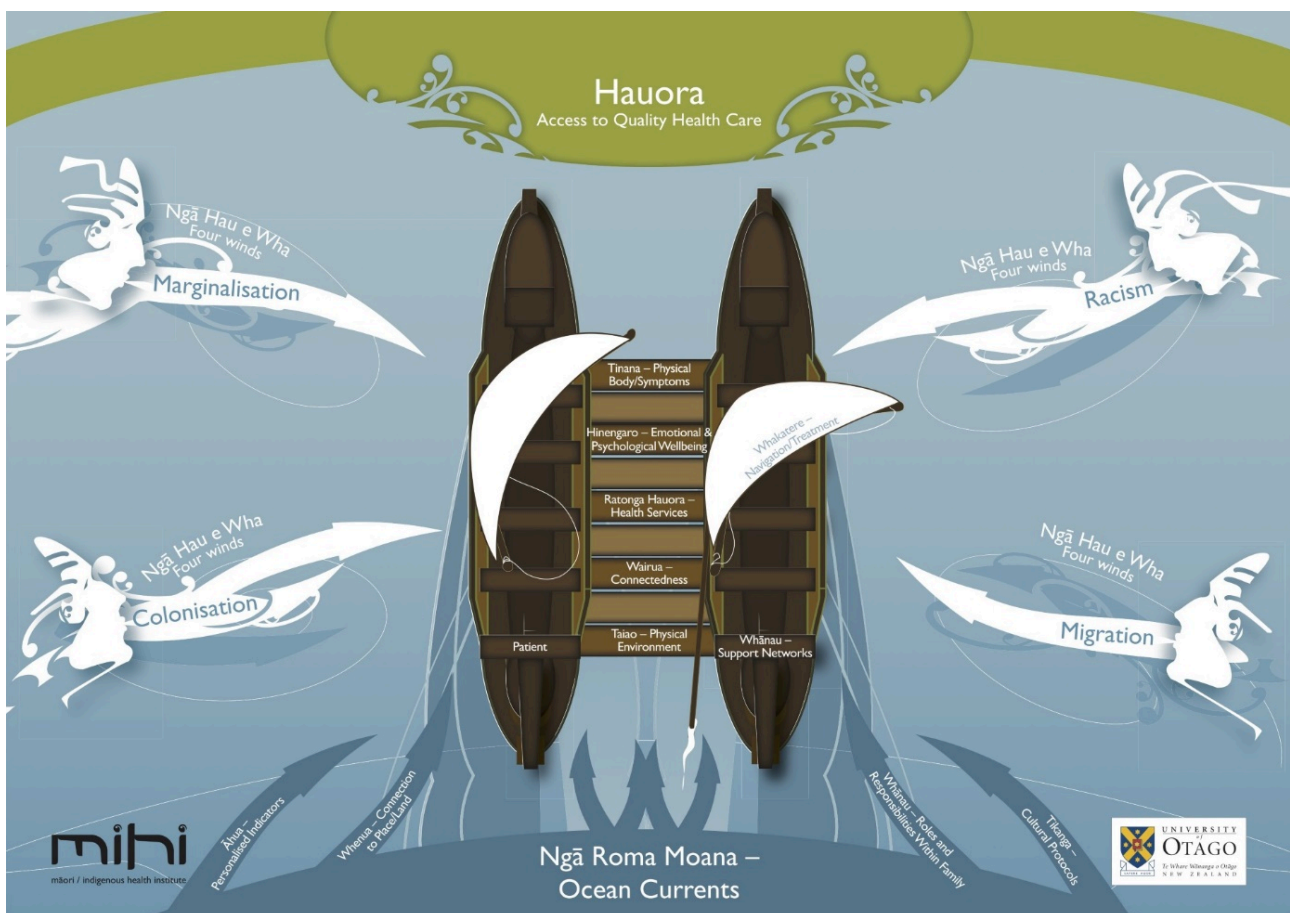


Figure 1.1.2 Meihana Model. (Pitama et. al., 2017. Reproduced with kind permission)

Te Pae Māhutonga

The fourth model we share uses a star constellation and brings together elements of health promotion. **Te Pae Māhutonga** represents charting a course towards Māori health and wellbeing (Durie, 1999). It is a significant constellation in ocean navigation and voyaging, aiding the traditional migrations to **Aotearoa New Zealand** from the Pacific. The constellation consists of four central stars that symbolise the key tasks of health promotion: **mauriora**, reflecting access to **te ao Māori**; **waiora**, representing environmental protection; **toiora**, denoting healthy lifestyles; and **te oranga**, indicating participation in society. There are two additional pointer stars, which are named in the model as **ngā manukura**, referring to leadership, and **te mana whakahaere**, as autonomy. Just as Te Pae Māhutonga as a constellation has served as a guide for successive generations, likewise Te Pae Māhutonga as a model of health promotion provides a map to integrate elements of health promotion as related to Māori health.

How are dimensions of hauora applied?

We use the term “dimensions of **hauora**” to encompass what Māori health models describe as **taha**, domains, tasks, and so on. Although we discuss the dimensions of hauora as distinct concepts, bear in mind the interdependent nature of Māori worldviews. All of these dimensions are connected, fluid, and often overlapping, with no clear lines separating one from another. Linking back to our discussion of historical and socio-political contexts, it is also important to acknowledge the wider contexts that impact on understandings and practices related to the application of Māori knowledges and Māori health models.

Drawing on examples from research and professional practice in psychology, mental health, and broader literature pertaining to **hauora** and Māori wellbeing, we demonstrate the implications of Māori health models and dimensions of hauora for critical health psychology. We begin by discussing the four **taha** within **Te Whare Tapa Whā**, which are mirrored in many Māori health models, and we then explore additional dimensions of hauora that have particular relevance in contemporary settings.

Wairua

We begin with **wairua**, because this is a central to a Māori way of being and therefore foundational to **hauora**. Reverend Māori Marsden, who was a **tohunga** regarded for his expertise on Māori divinity and an ordained Anglican minister, describes wairua as the ultimate reality of existence for Māori (Marsden, 1992). Similarly, from Māori psychological perspectives wairua is described as the fundamental, boundless, and connective aspect of Māori life and ways of being (Valentine, 2009; Valentine et al., 2017). Wairua is a connection to that which is sacred, which is all-encompassing from a Māori standpoint (Brittain, 2022). Therefore wairua can be understood as spirituality, the unseen, divine, connectedness, and is also much more; it permeates Māori views and experiences of the world. Given this, wairua is an essential dimension to hauora for Māori.

Māori spiritual healers' perspectives on healing practices, health, and wellbeing

Mark and Lyons (2010, 2014) highlight the ways Māori spiritual healers conceptualised interconnections between mind, body, and spirit. **Wairua** and spirituality were identified as central to healing processes, and for healers encompassed sensory perception and communication with spiritual sources. The significance of **whānau** and **whenua** to wellbeing was also emphasised. These understandings and research findings support the use of multiple and holistic approaches to improve health for Māori and Indigenous peoples.

Whānau

Whānau is commonly translated as family, although the modern use of whānau to refer to the parent-child family unit is a contemporary development. In **te reo Māori**, when whānau is used as a noun it refers to children of the same parents, a family group, extended family, and can be applied to friends. Whānau can also be a verb, meaning to give birth or to be born. Whānau traditionally were the basic social unit, typically comprising an extended family unit spanning three generations (Walker, 2004). Throughout Māori models of health, whānau and collective wellbeing are prioritised, and working with whānau in health psychology settings can enhance hauora for whānau and individuals alike.

Professional practice exemplars discussed in Te Manu Kai i te Mātauranga: Indigenous psychology in Aotearoa New Zealand (Waitoki & Levy, 2016)

Using a case study format focusing on the story of a Māori woman, Ripeka, and her **whānau**, including her partner, young children, and also her grandparents, this edited book shares insights from several Māori psychologists about how they would engage with Ripeka and her whānau. Drawing on Māori worldviews and **mātauranga**, exemplars of therapeutic and healing approaches are provided for working with **whānau Māori**. These include the use of **pūrākau** and narratives to work toward whānau healing (Cherrington, 2016); addressing and preventing whānau violence (Cooper & Rickard, 2016); and working alongside mothers and infants in a culturally centred way to support whānau wellbeing (Cargo, 2016). Whānau health and wellbeing is foregrounded in Māori approaches. Engaging with an individual who is experiencing distress and difficulties at a minimum necessitates an appreciation for whānau, and ideally entails whānau-centred practice. For example, one approach Cherrington proposes as a path to whānau healing is to retell the pūrākau of **Ranginui** and **Papatūānuku**. She explains, addressing Ripeka and her whānau:

*Why do I want to talk to you about Ranginui and Papatūānuku and all their kids? Because this whānau is a part of our identity as Māori. This whānau was not perfect, but they were known as **atua**, as gods. They had their own problems to deal with. They were a whānau struggling to cope with a separation. Each child had a different reaction. And they were not perfect by any means. All of these family members had strengths and weaknesses.* (Cherrington, 2016, p. 117).

Hinengaro

The next dimension of **hauora** is **hinengaro**. Of interest to psychology in general, hinengaro encompasses the mind, thoughts, emotions, and intellect (Durie, 2001). Rangimarie Pere, who developed Te Wheke and is regarded as a **tohunga**, conceptualises hinengaro as comprising the conscious and subconscious aspects of mind (Pere, 1997). Furthermore, Māori worldviews maintain that thought, awareness, and understanding are not solely activities of the mind, but are deeply connected with bodily or embodied experiences (Marsden, 2003). For example, **ngākau** represents the heart and seat of emotions, and is attuned to hinengaro and **wairua**. Similarly **ate** referring to the liver, and **puku** to the stomach are also regarded as emotional centres within the body (Smith, 2008).

Collaborative approach to mental health practice using Māori healing practices and mainstream psychiatry (NiaNia et al., 2017)

In the book *Collaborative and Indigenous Mental Health Therapy* a series of case narratives are presented detailing the work of Wiremu NiaNia, Māori healing practitioner, and Alistair Bush, psychiatrist. They model a collaborative approach to mental health practice, drawing together Māori healing practices and mainstream psychiatry. In one case narrative, “Into the World of Light” (NiaNia et al., 2017, pp. 103–140), the **pūrākau** of creation is integrated in the therapeutic approach, with a focus on **Hine-tītama** and her transformation to **Hine-nui-te-pō**. **Hinengaro** is symbolic of pain and loss, portrayed as affecting the depths of the mind and emotional experience. As one component of treatment and therapy, the young person in the case narrative, Tangi, who is an artist, is encouraged to connect with this pūrākau in her artwork to shape a narrative that shifts from darkness and obscurity, to light. Tangi describes engaging with art as key to working through her experiences of depression and as a way of relating to **wairua**. She also reflects on her focus on Hine-tītama and Hine-nui-te-pō in her art as symbolising the beginning of her recovery towards wellbeing.

Tinana

Tinana refers to the physical body and as a dimension of **hauora** caring for physical wellbeing can include; regular exercise, eating a balanced and nutritious diet, and healthy sleep habits. Equally it can entail understanding and managing chronic illnesses and health conditions, as well as reducing harms associated with substance use. Physical wellbeing is often framed in terms of individual health behaviours and lifestyle choices. Individuals, particularly Māori, are blamed for making poor choices for their health in ways that disregard context, and instead ethnic or cultural identities are misconstrued as risk factors. Ethnicity is certainly important to consider for physical wellbeing, however, a more constructive perspective is to consider Indigeneity as an indication of exposure to risk factors (Huria et al., 2019).

A widely circulated framing of health connects physical health to lifestyle choices and an individual's responsibility to participate in recognised health behaviours, such as eating a nutritious diet. This individualism disregards the social determinants of health, the circumstances and environment of people's lives that determine their health. Social determinants of health for Māori contribute to severe inequities

across all levels of health (Reid et al., 2019). (For further discussion of dominant discourses that construct health as an individual responsibility, see Riley et al. [Chapter 1.4.](#))

Evidence of Kaupapa Māori health interventions

Rolleston et al. (2019) reviewed **Kaupapa Māori** health interventions used in the prevention or management of a chronic condition. They identified 13 interventions, with the majority focused on lifestyle change and health promotion. Interventions included exercise and lifestyle management for the prevention of cardiovascular disease, health promotion and community education for diabetes prevention, and health literacy resources for gout. Importantly, all of the interventions were reported as successful when assessed against their stated aims. However, a key issue noted was the visibility of evidence for Kaupapa Māori health interventions for the prevention and management of chronic conditions. There is a strong argument for culturally centred health interventions that draw on **mātauranga** and use Kaupapa Māori approaches.

Furthermore, the wellbeing of **tinana** is closely linked with **wairua**, **hinengaro**, and **whānau** health. As we highlighted earlier, the dimensions of **hauora** are interconnected. At times, what may present as a physical or mental illness from a Western medical perspective could have a spiritual basis, or reflect disharmony in whānau circumstances. From a Māori perspective, while issues may manifest physically, explanations may be spiritual or non-physical, therefore necessitating different treatment or healing practices.

The connections between dimensions of hauora

Watch: Professor Sir Mason Durie tells a story of a young girl admitted to hospital with what appeared to Western medicine to be a virus, but a Māori worldview deduced different causes and different solutions.

Ministry of Health – Manatū Hauora. (2014, July 16). *He korowai oranga: Māori health strategy launch – Sir Mason Durie*. [Video]. YouTube. <https://youtu.be/ypKwMUWSUt4?si=MRwFNVlodR5Eb6Zz>



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Culture and te reo Māori

Access to culture and **te reo Māori** is well established as foundational to Māori wellbeing. A positive sense of Māori identity cultivated through cultural and social connection provides a strong base for wellbeing. Māori identity is also considered to be a protective factor for Māori health, as it can be a source of grounding that enables a person respond to challenges in a resilient manner (Durie, 2001).

As discussed earlier, **Te Kōhanga Reo** and **Kura Kaupapa Māori** were established as alternative forms of education for Māori in the 1980s, in the context of revitalisation efforts for **te reo Māori** and recognition of **Te Tiriti**. Te reo Māori education has provided a crucial pathway for Māori to be connected to Māori worldviews and knowledges and through this, to strengthen cultural identities (Durie, 2003). Māori culture and te reo Māori are also embraced and celebrated in **kapa haka**, a form of Māori performing arts that is significant to Māori culture and has become a unique part of national identity in **Aotearoa New Zealand**. Notably, Te Matatini is an acclaimed national Māori performing arts festival held every two years, providing an incentive for individuals and communities to increase their knowledge and understanding of Māori culture and te reo Māori (Durie, 2017).

Ngā hua a Tāne-rore: The benefits of kapa haka (Pihama et al., 2014)

Pihama et al. (2014) assert there are many benefits of **kapa haka** as a gateway to wellbeing for **whānau** and communities.

- Kapa haka facilitates **whanaungatanga**. Through connectedness, shared experiences, and collective support it offers opportunities to strengthen whānau and unite communities.
- It is a vehicle to develop holistic wellbeing. Physical health and fitness are improved collectively, while mental and emotional wellbeing are supported through relationships and experiences of pride.
- **Mātauranga**, Māori traditions and histories, and **te reo Māori** are upheld and revived through kapa haka.
- Kapa haka provides opportunities for Māori who may not be engaged with their **marae**, **hapū**, and **iwi** to access and connect to Māori culture.

There are wide-reaching benefits, from positive health outcomes, to educational opportunities, social cohesion, and also cultural development. Kapa haka has the power to effect wellbeing and to positively transform the lives of whānau, individuals, and communities.

Whenua and te taiao

As a final dimension of **hauora**, **whenua** and **te taiao** are important for hauora in multiple ways. Māori worldviews maintain that people are connected to the natural world and land through **whakapapa**. Connectedness to whenua and te taiao is essential to cultural identity and belonging. This is reflected in key **te reo Māori** terms that depict Māori relationships with the land:

- **Whenua** refers to land and it is also the term for placenta. These dual meanings are similar in reflecting

a source of sustenance.

- **Tangata whenua**, meaning people of the land, is used to describe Māori as Indigenous in Aotearoa New Zealand.
- **Tūrangawaewae** describes a standing place and belonging granted through **whakapapa**. It is usually used to refer to ancestral lands where one has rights of belonging.
- **Ūkaipō** refers to origins or homelands. It also has a dual meaning, describing a mother as a source of sustenance.

Whenua is also closely connected to **wairua** and **whakapapa**, therefore efforts toward **hauora** for Māori must acknowledge relationships with the wider environment (Mark & Lyons, 2010; NiaNia et al., 2017). The significance of **te taiao** is denoted in Māori creation narratives. Māori view the lands, sky, winds, seas, waterways, forests, and the natural environment as **atua** and as **tīpuna**. Given this relationship, a Māori worldview also maintains that Māori have obligations and responsibilities to te taiao. The concept of **kaitiakitanga** encompasses the responsibilities of guardianship and caretaking of the natural environment, to protect and preserve te taiao for future generations (Marsden, 2003). Māori wellbeing across the dimensions of hauora is understood as deeply intertwined with, and dependent upon, the state of te taiao. The impacts of climate change and widespread degradation of the natural environment in the contemporary context therefore pose significant issues for Māori.

Climate change and the impacts for Māori wellbeing

Jones (2019) highlights that climate change is contributing to a disruption of Māori and Indigenous peoples' relationships with lands, through environmental effects such as sea level rise and coastal erosion. Given that **whenua** and **te taiao** are central to **hauora** for Māori, this has drastic potential consequences. Many communities face displacement from their lands, and climate change may exacerbate existing social and health inequities for Māori and Indigenous peoples around the globe. Climate action from a Māori perspective is underpinned by the spiritual and relational significance of whenua and te taiao to Māori lived experiences.

The Ministry of Health (2024) in **Aotearoa New Zealand** recognises the significance of climate change to **hauora** for Māori and adaptation efforts from Māori communities in the *National Health Adaptation Plan 2024-2027*. **Hapū** and **iwi** led responses to the extreme weather during Cyclone Gabrielle in 2023 were critical in the immediate aftermath and recovery efforts. Many **marae** and **whānau** supported the civil defence response by becoming emergency centres, housing displaced people, distributing food and supplies, and coordinating these efforts. Furthermore, whānau, hapū, and iwi in affected areas continue to support communities to recover.

In discussing the dimensions of **hauora** and examples of application we have endeavoured to demonstrate the ways these dimensions and Māori models of health can be translated from conceptual to practical. An expanding body of Māori research and approaches to wellbeing employs knowledges and practices originating in te ao Māori. Across the dimensions of **wairua**, **whānau**, **hinengaro**, **tinana**, culture and **te reo Māori**, as well as **whenua** and **te taiao**, there are many avenues for Māori understandings to enrich health psychology.

In practical terms, appropriate integration of **tikanga**, use of **karakia** and **te reo Māori**, active **whānau**

involvement, use of **whanaungatanga** to develop relationships, and facilitating access to **rongoā** are experienced positively by Māori accessing health services (Pere, 2006; Waitoki et al., 2015). Such efforts underpin models of practice within Māori health services and are means by which the principles of Māori models of health are incorporated to enhance outcomes and **hauora** for Māori.

Conclusion – hauora in a changing world

We conclude by emphasising that contexts influence health experiences and outcomes. **Hauora** for Māori exists in a changing health landscape, with implications for contemporary health psychology. The contexts we live in are constantly evolving, therefore our thinking and practices must also continually develop and adapt. The challenge for critical health psychology in **Aotearoa New Zealand** is to not only be aware of contexts and structures, but to respond constructively, with a commitment to benefitting hauora and Māori communities.

The **critical health psychology pou** have emerged throughout this chapter. The **pou** of valuing theoretical and conceptual thinking was relevant to our discussion of Māori worldviews, knowledges, and understandings of health and wellbeing. In reviewing the historical and socio-political context in **Aotearoa New Zealand** and **Te Tiriti**, the pou of challenging **taken-for-granted understandings** and paying attention to issues of power and equity were important. Māori models of health, dimensions of **hauora**, and links to application and practice offer exemplars of the pou of moving beyond individualistic psychology and considering knowledge as produced in context.

We hope this chapter offers conceptual, historical, and practical foundations to rethink Māori and Indigenous health and wellbeing. Our coverage of Māori knowledges and understandings is intended to ignite thought and reconceptualisation of ideas within health psychology. To this point, Reid et al. (2010) implore Māori and Indigenous peoples alike regarding the importance of creative and critical thought for the future:

Indigenous knowledges are not solely ancient wisdoms but necessarily include processes for the creation of new Indigenous knowledge that have the potential to contribute to well-being of all peoples, our environment and our planet. [...] This Indigenist approach to research and science holds important answers for the critical questions we currently face in collective well-being.

Māori working in health psychology have a significant responsibility, to both draw on existing Māori knowledges and to also create Māori knowledges to contribute to **hauora**. The health and wellbeing of Māori is a pressing issue that must be informed and led by Māori scholars and practitioners, and Māori worldviews and practices. The task for all involved in health psychology in **Aotearoa New Zealand** begins with cultural humility, to be aware of positionality, to be open-minded, and to learn. These issues are equally important for all who study, teach, research, and engage with health psychology in Aotearoa New Zealand. There is abundant potential for Māori knowledges and practices to enrich and expand health psychology, so that hauora for Māori can flourish.

Knowledge Check



An interactive H5P element has been excluded from this version of the text. You can view it online here:

<https://oercollective.caul.edu.au/critical-health-psychology/?p=794#h5p-8>

Want to know more?

Listen: Treaty Talks – RNZ <https://www.rnz.co.nz/video/treaty-talks>

Read: Waitoki, W., & Levy, M. (2016). *Te manu kai i te mātauranga: Indigenous psychology in Aotearoa/New Zealand*. New Zealand Psychological Society.

Watch: Dr Moana Jackson, constitutional lawyer and **Te Tiriti** expert, discuss the meaning and effect of Te Tiriti.

He Tohu. (2017, June 8). *Moana Jackson – He Tohu interview*. [Video]. YouTube. <https://youtu.be/GDM-Ct21N4I?si=t4KZd13rsC68UvR6>



One or more interactive elements has been excluded from this version of the text. You can view them online here: [https://oercollective.caul.edu.au/critical-health-](https://oercollective.caul.edu.au/critical-health-psychology/?p=794#oembed-1)

[psychology/?p=794#oembed-1](https://oercollective.caul.edu.au/critical-health-psychology/?p=794#oembed-1)

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1.2 What do we mean by "people"?

SARAH RILEY; SIOBHÁN HEALY-CULLEN; GARETH TERRY; DON BAKEN; AND AORANGI KORA

Overview

People working in health psychology are involved in a range of research, policy development, and therapeutic practice that aims to support health and wellbeing, or prevent, or treat illness. How they do this work is shaped by the conceptual frameworks they have, including how they conceptualise the person whom they seek to help. This means that it is important for health psychologists to critically reflect on how they conceptualise people. You might be surprised at the variation. This chapter therefore asks the question:

What kind of person are health psychologists thinking of?

Building on the previous chapter, which included a te ao Māori perspective for this question, here, we consider three approaches from Western traditions that offer different ways to conceptualise the person: (1) the biopsychosocial approach and how health psychologists address the “psycho” element with atomised models of universal psychological processes; (2) phenomenologically informed psychology which focuses on individual interpretations of their lived experience; and (3) social constructionist approaches that conceptualise the person as produced through, and thus inseparable from, their context. Throughout we give examples, often using coronary heart disease as a running theme to show the similarities and differences between the approaches when applied to the same health condition. In so doing, we cover the following learning objectives:

Learning objectives

- Understand that there are different ways to conceptualise the person.
- Explain why critical health psychologists are concerned with the individualist orientation in our discipline.
- Reflect on how these different ways to conceptualise the person produce different ways for psychologists to think about, and respond to, health issues.

Introduction

The New Zealand Psychological Society defines psychology as the scientific study of how people behave, learn, think, feel, and respond (New Zealand Psychological Society, 2024). This definition is similar to other professional psychological organisational definitions, such as the American Psychological Association’s description of psychology as the study of the mind and behaviour (American Psychological Association, 2024). These definitions are deliberately broad statements, designed to summarise a whole discipline in an accessible way. But to understand these relatively simple statements, we need a shared understanding of what we mean by “people”.

In Chapter 1.1, Kora and Brittain invited us into te ao Māori, a holistic worldview where people are made sense

of through interconnected relationships across human, physical, and spiritual realms. Te ao Māori offers a unique, culturally grounded framing of people that differs from that usually implied in the definitions used by psychology organisations, the latter drawing on Western ideas of people as individuals **ontologically** separate to, if interacting with, other individuals and their environment.

In Aotearoa New Zealand, one of the opportunities of living in a society where Māori culture is recognised is being primed to understand that there are multiple ways to conceptualise what it means to be a person. This helps us engage with one of the important **pou** in critical health psychology, which is to notice our **taken-for-granted** understandings. We believe that reflecting on our taken-for-granted understandings increases our capacities to think about an issue. Critical reflection is thus the starting point for being able to envisage new, and more enhancing, ways of doing health.

Different frameworks for thinking about what it means to be a person can fundamentally shape how health psychologists think and practice. It is important to recognise that what we know shapes what we do, and what we know is only ever a partial perspective (for further discussion, see Gavey, 2018). The concepts we have about the world therefore represent some aspects of how we might see the world, but not others. This idea is neatly summarised in the expression “the map is not territory”. For example, a geologist’s map can tell you about the types of rock, while a travel map gives information about roads. The both offer different representations of the same land, and depending on context, one may be more, or less, useful to you. But neither of them *are* the territory. This is why another version of the expression is “all models are wrong (but some useful).”¹

In this chapter, we build on the map metaphor to argue that having more than one map is important for expanding our possibilities of thought, and thus practice, in relation to health psychology. We start with **mainstream psychology** and its engagement with the biopsychosocial approach below (also see Morison & Gibson [Chapter 2.1](#) for discussion of the biopsychosocial approach in relation to understanding health and illness).

The biopsychosocial approach

We start with the biopsychosocial approach² because it is foundational for health psychology (Crossley, 2008). This approach to thinking about people’s health can be traced to an article by American psychiatrist George Engel (Engel, 1977). Engel proposed a model of health, within which the range of factors interacting to shape health behaviours and outcomes could be classified into one of three categories related to a person’s biology, psychology, or social context, the latter including social, cultural, and environmental factors. The three elements of the biopsychosocial approach are understood as existing independently from each other, but interacting in complex ways. See text box below using coronary heart disease as an example.

Example of some of the biopsychosocial elements related to coronary heart disease

1. Confusing the map for the territory is attributed to Alfred Korzybski (1933), while all models are wrong is most associated with George Box (1976), but the underlying idea has been historically expressed by various thinkers.

2. Engel (1977) described a biopsychosocial model. However, a model should have explanatory power and a sense of direction regarding causal influences. Since the original biopsychosocial model has neither (as we discuss in this chapter) and has subsequently been used in ways that imply a broader approach or framework for thinking about health, we have used the term biopsychosocial approach.

Cardiovascular diseases, which include coronary heart disease (CHD), are a leading cause of illness and death worldwide (World Health Organization, 2021). A range of factors influence health behaviours and outcomes for CHD (Steptoe & La Marca, 2022). Biological, psychological and social examples include:

Biology: genetic predisposition can account for between 40 – 60% of variance of risk (McPherson & Tybjaerg-Hansen, 2016).

Psychology: people's response to stress impacts CHD. Fun fact: the concept of a Type A personality came from a cardiologist whose patients were wearing away chair upholstery in a pattern that suggested they were agitated while waiting (Friedman & Rosenman, 1974).

Social: racism and childhood trauma are both implicated in the development of CHD through stress-related physiological responses (Almuwaqqat et al., 2021; Javed et al., 2022; Su et al., 2015); while social norms and government policies can reduce smoking (Monson & Arsenaault, 2017; Rey Brandariz et al., 2024).

Interaction: an **epigenetic** study of people who had experienced periods of starvation during World War II in Amsterdam showed that their children experienced genetic changes that predisposed them to develop CHD (Roseboom, 2019).

The biopsychosocial approach helps us think about how our health is produced through intersecting elements (biological, psychological, and social), which in turn, helps health professionals develop efficacious health interventions to support recovery or prevent illness. Continuing our CHD example, breathing techniques to reduce stress responses work on the biological level; providing information on diet addresses the psychological (cognitive) level; and providing collective exercise classes speaks to social issues (e.g., social support). These are all designed to have subsequent positive effects on the biological (e.g., reducing development of disease).

Interventions can also be developed from recognising how different biopsychosocial levels intersect with each other. For example, social isolation and loneliness are psycho-social risk factors for CHD (Kahl et al., 2023). Recognising the dynamic relationships between the biological, psychological, and social also alerts us to how onset of disease (biological) can cause psychological and social outcomes. For example, the experience of illness creates stress (psychological) and affects people socially (e.g., loss of job or isolation) (Barlow et al., 2015).

For health psychology, the advantage of the biopsychosocial approach is that it gives psychology a role alongside the medical profession, and it recognises human health as a complex system. As such, the biopsychosocial approach encourages us to think of illness as having multiple, interacting factors, rather than single causes. This creates richness in our understanding, thus increasing the likelihood of more efficacious interventions.

Problems with the biopsychosocial approach

However, there are concerns from both critical and mainstream health psychologists with how health psychologists and other health practitioners use the biopsychosocial approach. As we discuss below, these problems relate to:

- a. poor theorising and a lack of explanatory power

- b. one element getting priority
- c. an individualist approach.

a) Theorising the biopsychosocial approach

When Engel (1977) coined the term “biopsychosocial”, his primary focus was critiquing **biomedicine** as dehumanising because it was:

- reductionist (reducing complex phenomena to a single primary issue), in this case, the biological
- underpinned by a **mind-body dualism** that gave no role for the mind in disease causation or progress
- imagining the body like a machine, with atomised parts that could be isolated from the whole to be removed or fixed.

Instead, Engel wanted hospital care to include considerations of:

...the person who has the illness, the person's experience of, account of and attitude towards the illness; whether the person or others in fact regard the condition as an illness; care of the patient as a person ... the effect of conditions of living on onset, presentation and course; and finally, the healthcare system itself ... [which] involves social factors such as professionalisation (1977, p. 131–135).

Engel drew all of that together in the pithy term “biopsychosocial”, seeking to encourage a holistic approach to healthcare. But he did not theorise how the bio-psycho-social elements might causally affect each other, nor suggest how to align the psychoanalytic approach of the psychology of the time with the biomedical focus on physiology (Bolton & Gillett, 2019).

Researchers were thus left without direction for how they might operationalise the biopsychosocial model to give it explanatory power (Roberts, 2023). Some ultimately concluding that it was “a slogan too vague to be of any use” (Bolton & Gillett, 2019, p. 6; referencing a critique by Ghaemi, 2009) or that it was never designed to be treated as an explanatory model in the way that people have subsequently—and erroneously—tried to use it (McLaren, 2021). These problems, of (1) explanatory power and (2) untheorised causal relationships, continue to haunt health psychology, with Stam's (2000) critique generally holding, 25 years later:

It is an interesting phenomenon in its own right that such a loose formulation has become the rhetorical mainstay of theory in health psychology ... it appeared almost obligatory to mention the model although very few contemporary textbooks cite papers beyond the original formulations by Engel (1977) or the revision published by Schwartz in 1982. The 'model' has simply been taken for granted and, remarkably, there is absolutely no discussion of what this term could mean other than the 'interplay' or 'interaction' of biological, psychological and social factors (Stam, 2000, p. 24).

b) One element gets priority

Without clearly conceptualising the relationships between the biological, psychological, and social, one element can get emphasised over the others, such as when a dominant conceptual framing shapes researchers' perspective (Roberts, 2023). For example, a biomedical orientation can produce a “bio bio bio” focus, conflating the biopsychosocial model with the **biomedical model** (Mescouto et al., 2022). This can be

seen when mental health problems like psychosis are framed primarily as a (biological) chemical imbalance, which precludes discussion of how psychosis might be understood as a psychological solution to social difficulties (Baboulene, 2020). (See Harper & Cromby (2013) for a similar argument on paranoia).

Conversely, a culturally dominant framing can emphasise psychology, such as when noncommunicable diseases, like coronary heart disease, are framed as “lifestyle diseases” and the outcome of poor decision making. This “psycho psycho psycho” approach undermines and blames patients, negating the biological and social elements of disease causation (Robson et al., 2025). At other times, two, but not three of the elements are considered by researchers professing to use the biopsychosocial model. For example, In their evaluation of how physiotherapist literature on lower back pain enacted the biopsychosocial model, Mescouto et al., (2022, p. 3270) stated that the “social context was rarely mentioned ... and other broader aspects ... such as culture and power dynamics received a little attention.”

c) Aligning the psychosocial to a universalising, atomised and individualist approach

Distancing itself from psychoanalytic theory, mainstream psychology became dominated by the **natural science paradigm**, which aligned more easily with the biomedical approach, since the researcher was understood as being able to observe an external world objectively, and produce generalisable findings that could be applied to a range of populations or contexts. From this, the job of psychologists working in health was to develop the “psycho” and/or “psycho-social” part of the model through empirical research that aimed to identify universal psychological variables implicated in health behaviour.

These variables were conceptualised as interacting, but discrete, atomised components. They also needed to be measurable so that they could be comparable with biomedical measures and included in statistical analysis and modelling (Crossley, 2008). The outcome was a psychological project of substantial and sophisticated analysis focused on developing **socio-cognitive models** comprised of atomised elements with hypothesised relationships, and the quantifying of subjective experience through the development of scales to measure them (Ogden, 2003).

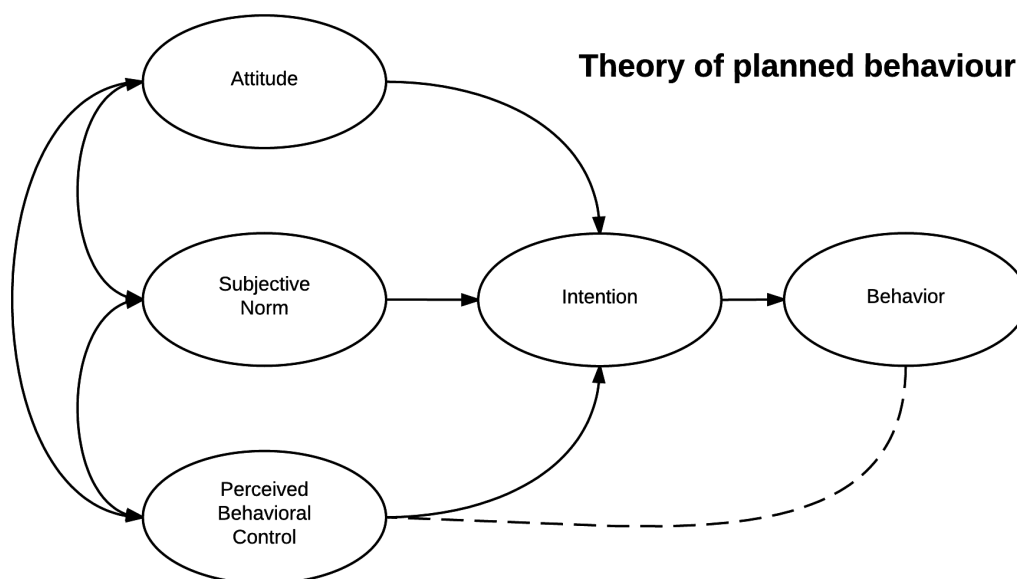


Figure 1.2.1 Theory of Planned Behaviour model. ([Theory of planned behavior](#), by Robert Orzanna via Wikimedia Commons. [CC BY-SA 4.0](#))

An example of a socio-cognitive model is the Theory of Planned Behaviour (TPB). The TPB has three elements (attitude, subjective norm, and perceived behavioural control) that are hypothesised to predict intention to behave, and thus behaviour (Ajzen, 1985; Ajzen & Fishbein, 1972).

TPB is a significant model. A Google Scholar search at time of writing, gives nearly two million results for research articles with “theory of planned behaviour” in the title, and review studies show it is one of the most successful models psychologists have for predicting variance in health behaviours (Mielewczyk & Willig, 2007). The TPB can account for between 4–50% of behaviour variance depending on the health behaviour studied, if TPB was supplemented with additional measured variables, or whether objective measures of behaviour were used in the study (Armitage & Conner, 2001; Mielewczyk & Willig, 2007). Meta-analyses of TPB research suggest “small-to-medium-sized effects, albeit with considerable between-study heterogeneity” (Hagger & Hamilton, 2024, p. 201).

Overall, the evidence suggests that TPB—and relatedly, the Health Belief, Reasoned Action, and Trans Theoretical/Stages of change, to name all four main social cognition models—may be useful tools in health psychology for understanding some health issues, in some contexts. But, overall these models have “poor showing in predicting behaviour” (Stainton-Rogers, 2017, p.46). Returning to our map metaphor, social cognition models, such as TPB, leave a lot of the territory unrepresented. As, Mielewczyk and Willig (2007) argue, “given that TPB routinely leaves around four-fifths unaccounted for ... we need to develop theories which are far more able ... to address the variety and complexity of the influences and processes involved in the performance of health behaviours” (pp. 82, 817).

Of particular interest for us, given the critical health psychology **pou** of moving beyond individualism, and considering knowledge as produced in context, is the limited way in which the social context is conceptualised. These include how TPB, and more broadly the socio cognitive models it is part of:

- fail to include factors that can predict health behaviour without changing intention to behave, such as when nudging (changing the choice architecture) changes people’s health behaviour (Snihotta et al., 2014)
- do not adequately account for the dynamic nature of social contexts, nor includes researchers’ reflection of their own cultural location and context (Ogden, 2015)
- take an individual focus, which has limited effectiveness in practice because this minimises the important role of the social determinants of health (e.g., Theis & White, 2021). For example, in the TPB, all the complexities of wider social, governmental, environmental, and relational contexts in which health related behaviours are practiced are reduced to considerations of perceived subjective norms and perceived behavioural control (both of which are conceptually located in the individual). For further discussion, see Rosin et al., (2024) and the NICE evidence review of behaviour change interventions, which evaluated psychological behaviour change research and recommends developing interventions that “take account of the social, environmental and economic context of behaviours” (2007, p. 56).

In summary, mainstream health psychology is now conceptually aligned with biomedicine through the use of social-cognition models, providing opportunities to have a shared theoretical framework for a biopsychosocial approach. However, many researchers and practitioners have raised concerns that this shared framework is flawed in how it:

- conceptualises people in individualist and universalising ways, and,
- reduces psychology to atomised and measurable parts.

We develop these concerns below in relation to how this overall approach can lead to:

- a. reification – treating concepts as if they are real
- b. oversimplification of complex experiences

- c. epistemic injustice – treating people's realities as wrong
- d. under theorising of power.

a) Reification: As a student, Sarah had an existential crisis when it occurred to her that the model she was experimentally testing was not made of “real” elements, but social constructs being treated as real. It was rather a comfort to find out that a similar crisis had sent Kenneth Gergen on the path to laying the foundations of social constructionism in psychology (Gergen, 1996). Reification occurs when psychologists treat the psychological elements in a model or scale as if they are real, confusing the map with the territory.

b) Oversimplification: The models used in this kind of psychology are atomistic (separating out elements) and universalising (since they seek generalisable, not context-specific knowledge). This can oversimplify the complex dynamics that underpin human (health) behaviour because it misses how health practices are contextualised and relational. For example, depending on context and interpersonal relations, expecting condom use during sex may signify trust in taking care of your partner's sexual health, or a distrust in your partner's monogamy (Willig, 1995).

Indigenous scholars have also problematised atomisation in quantified psychological measures. For example, King et al. (2017) argues that mainstream constructs of atomised, measurable psychological categorisations is a product of European industrialisation, urbanisation, and a particular strand of philosophy that has reduced complex phenomena to measurable categories that fail to recognise the contextualised, interconnectedness, fluidness, and heterogeneity of the self. The authors argue that the outcome for psychology is an “impoverishing psychological knowledge of the self” (King et al., 2017, p.728). Writing from a Māori perspective of studying epistemology in psychology, one of the authors (Pita King) explains,

...one of the first things I ... noticed when studying European philosophy was its eagerness to distinguish, categorize, order, and in general, to break things apart and to pin down their definitions with a high degree of “certainty.” ... For Māori, less importance is placed on atomizing the subject matter under consideration. Atomization is often avoided (King et al., 2017, p. 731).

c) Epistemic injustice: describes when “someone is wronged specifically in their capacity as a knower”, either by having their credibility unfairly undermined due to prejudices, or by underrepresentation of marginalised groups in collective knowledge making (Fricker, 2007, p. 1). It can apply to “**medical gaslighting**”, but we connect it here to the way that psychological measures reduce the complexity of human experience and decision making in ways that feel harmful. Crossley (2008) gives an example when describing how a research participant who she was interviewing, expressed anger at the safe sex messaging of health professionals and the sense of judgement she felt for having unprotected sex with her (HIV positive) partner. The participant explained that she did not care about the risks, not because she did not know them, or was sentimental, emotional, or foolish, but because:

It's so much more than that. I can't really express it. It's just so incredibly important. A kind of moral stance, if you like. To say, look, there are higher values in this world than just 'keeping safe'. To show him how I value him over and above all the trite messages that we're bombarded with (p. 24).

Crossley (2008) reflects that health psychology models might categorise this woman as low in “perceived benefits” of safe sex, but to do so would be to undermine what she had said about complexity. The use of

socio-cognitive models in mainstream psychology can therefore produce epistemic injustice. As Crossley (2008) argues,

...mainstream health psychology seems to have largely bypassed a consideration of many of the complex moral, emotional and ethical issues that lay at the very heart of peoples' experiences of health and illness. It has done this through the use of methods that encourage reductionism and the objectification of experiences into simplistic coding devices that facilitate the testing of particular theories and models (p. 26).

d) Under theorising of power: Power issues tend to be minimised when psychologists think about the 'social' element of the biopsychosocial model. Health psychology textbooks might include issues such as class or ethnicity, for example, but not connect these to exploitative capitalism or structural racism to understand how they come to matter. For example, in a book translating health psychology research into practical guidance for people working with clients, social practices are mentioned, but not racism (Kwasnicka et al., 2021).

Similarly, the Behaviour Change Wheel (Michie et al., 2011) includes social and physical opportunities as elements that can limit health behaviours, but directs focus back onto the individual. This is seen in suggestions of interventions related to education, persuasion, incentivisation, and even coercion, all of which focus on the individual as the site of change (Marks, 2020). This focus on the individual leaves power and social structures under theorised in our models, thus potentially missing important elements that shape people's health experiences. In relation to CHD, such arguments have led critical health psychologists to ask if this is why less than 50% of patients diagnosed with CHD complete cardiac rehabilitation or maintain rehab-taught lifestyle changes to diet and exercise at six-month follow-up (Robson et al., 2024).

Section summary: The biopsychosocial approach aligns psychology with biomedicine by focusing on identifying discrete variables in cause-and-effect relationships. This approach can predict some variance in behaviour, providing directions for how to develop efficacious interventions. However, it fails to deal with the complexity of lived experience, sometimes causing harm through epistemic injustice. For these reasons, some psychologists have put this conceptual map down, and explored the possibilities offered by phenomenology.

Phenomenological health psychology

Much of mainstream health psychology continues to conceptualise its job as identifying discrete, compartmentalised, and measurable elements that are valued if they can predict enough variance of behaviour across large groups of people. This "**nomothetic**" approach stands in contrast to phenomenological psychology, which takes an "**idiographic**" approach that prioritises a deep dive into individual, lived experiences of people as they understand and experience them. As such, phenomenologically informed psychology (herein "phenomenological psychology") speaks to the concerns of oversimplification and epistemic injustice discussed above.

Phenomenology is a branch of philosophy developed in the work of people such as Husserl, Heidegger, Merleau-Ponty, Sartre and Stein. These people were European philosophers writing in the early and mid

20th Century, although they also drew on ideas with a longer history,³ and their ideas were subsequently developed by others (e.g., Ricoeur and Schutz). This means that phenomenology is an umbrella term for a range of ideas, some of which are conflicting.

Conflict also emerges when psychologists use phenomenology, since taking thinking from one discipline and applying it in the service of another inevitably creates translation issues and disagreements. What phenomenological psychologists share, though, is a model of the *person as an interpreter*, who is constantly making sense of their conscious experiences. The word “phenomenon” is derived from the Greek for “show” or “appear”, with “phenomenology” being the study of how things appear to people.

Conceptualising the person as an interpreter is linked to Husserl’s response to Descartes’ famous statement “I think therefore I am”. Husserl argued that, if a person is thinking, they need to be thinking of *something*, therefore when we are conscious, we are conscious of something (Husserl, 1901/1970; cited in Eberle, 2022). This argument gives us the phenomenological concept of “intentionality” of consciousness. Eberle’s (2022) gives a helpful example of perceiving a bird: he is not objectively perceiving a thing external to him, nor a conceptual concept of a bird, but the bird as it is perceived by him in that moment.

Phenomenologists reject the idea that researchers can stand outside of the world to observe it (as in the natural sciences paradigm described above). Instead, they collapse distinctions between the subject (who is studying) and the object (being studied). As Eberle explains, “Husserl argues that the crisis of modern sciences was caused by the fact that they had taken their idealizations and abstractions, their mathematical and geometrical formulae, for bare truth and had forgotten that they originated in the life-world” (2022, p. 110; also see **reification** argument above). From the perspective of phenomenological psychologists, psychologists’ should prioritise understanding that life-world, that is, how a phenomenon is subjectively perceived, experienced, and interpreted by a person (Langridge, 2007).

For these psychologists, phenomenology is the “study of human experience and the way in which things are perceived as they appear to consciousness” (Langridge, 2007, p. 10). It is underpinned by a model of the person as an individual, actively perceiving, experiencing, and interpreting their “lifeworld”. This model of the person is individualised, since people’s thoughts are framed as originating from a relatively coherent self that is the author of their own meaning-making and interpretation of their experience.

Although the focus is on the individual, a person’s interpretation of their lifeworld is understood to be highly contextualised because this model of the person is of “a situated, meaning-making person” (Larkin et al., 2011, p. 318). In this conceptual framework, people cannot stand outside of their world. Instead, interpretation of the present moment is shaped by:

- the interpretive frameworks that people have already developed through past experiences
- the linguistic concepts they have available
- intersubjectivity, as meaning making is generated between people (e.g., awareness of other people’s feelings about an issue can shape interpretations of an experience)
- **embodiment**, since people are conscious of the world through their bodies (Eberle’s experience of a bird is shaped, for example, by the kind of eyes and visual cortex that he has as a human).
- emotions, since these “color” how people experience a phenomenon (Russell, 2006, p. 68).
- **temporality**, since experiences occur in a particular time (and place), in an ongoing way, and experiences of the past can also shape interpretation of the present moment.

3. See for example Phenomenology and Ancient Greek Philosophy: An Introduction (Petropoulos, 2021).

In *Notes from a Heart Attack: A Phenomenology of an Altered Body*, Kevin Aho provides a personal reflection on his experience of suffering a heart attack at 48 years old. He uses phenomenology to explore how such a “world-shattering” (Aho et al., 2019, p. 189) event altered his lived experience of the body, touching on key elements such as embodiment, temporality, spatiality, affect, and intersubjectivity.

Embodiment: Aho describes how his sense of embodiment was radically altered by the heart attack: “The ‘I can’ that opened up my world, that I had effortlessly embodied just a few weeks earlier, had become a debilitating ‘I can’t’” (p. 192). Before the heart attack, he took for granted the possibilities his body afforded him, such as planning long bike rides, overseas travel, and a productive career in academia. After the heart attack, his body became a source of vulnerability and uncertainty, an intimate site of heightened awareness. It also came under the gaze of healthcare professionals as a detached, corporeal object.

Temporality: Aho describes how time became more fragile with his increased consciousness of mortality. His ability to plan or envision long-term goals was hampered by the constant awareness of his body’s vulnerability; what if his implanted defibrillator shocked him while he was travelling? While he had once lived a fast-paced life, he was forced to slow down and reflect on the identity he previously held—the productive, active and dynamic professor—and reshape a new identity, all while navigating a constant feeling of trepidation and uncertainty about the future.

Spatiality: Aho’s describes feeling like his altered, broken body was taking up (too much) space, while simultaneously feeling that his world was contracting: the four yellow footsteps painted on the hospital floor encouraging him to walk as far as the bathroom; the university campus and his neighbourhood became threatening, expansive spaces. The heart attack collapsed his world, reducing it to the confines of “safe” spaces.

Affect: Aho experienced fear, vulnerability, and anxiety, as well as the bodily effects of medication, including fatigue, which impacted his ability to work and socialise. Most frightening to Aho was that the things that used to give him pleasure, such as movies, food, and reading, he now experienced as “affectively empty and flat” (p. 194). These hobbies and activities that held his identity together became meaningless, resulting in a “bleached” life, an inability to feel affected, and a crisis in identity (p. 194).

Intersubjectivity: The heart attack also brought about a new kind of intersubjectivity; Aho became vulnerable, and dependent on the expertise and care of others. His previously held illusion of autonomy and strength was fractured. Aho recalls an altercation with a cardiologist, who flippantly told him, “It may require surgery, but who knows?”, to which he replied, “You should know! You’re the damn doctor” (Aho, 2019, p. 194). Although strained interactions with healthcare professionals were common, the heart attack experience also introduced new dynamics of care, trust, and vulnerability. He experienced gratitude and connection during recovery, with the support of nursing staff and loved ones helping him make sense of his newly altered body and identity. For example, he described being overcome with love and appreciation not just for his family, but also for strangers, in recognition of his, and everybody’s, helplessness and dependence on others.

Applied to research, phenomenological psychology conceptualises both participants and researchers as interpretive beings. Research encounters thus form a “double hermeneutic”, of participants interpreting their experiences, and researchers interpreting that interpretation (Smith, 2007). This opens the possibility for psychologists to analyse beyond what people say or might be aware of. Relatedly, phenomenologists might draw on other theoretical frameworks to help with their interpretation (Langridge, 2007), including psychoanalytic theories (to explore what might be unconsciously driving experience), or social theories (to examine how social structures related to class, gender, sexuality and dis/ability, shape experience).

However, as Guenther, (2020, p. 12) argues, “structures like patriarchy, white supremacy, and heteronormativity ... [are] ... not things to be seen but rather *ways of seeing*, and even ways of *making the world* that go unnoticed without a sustained practice of critical reflection” (their emphasis). The risk for phenomenological psychology, then, is that in focusing on understanding people’s lived experience, people working within this approach have not attended to the social structures that shape experience because neither the participant, nor the psychologist, considered such issues in their interpretation.

A way to address this problem is to take a **critical phenomenological** approach that seeks to connect people’s lived experience to wider social structures. However, this critical orientation is most conceptually aligned with phenomenology when it is done with research participants who include social structures as part of their interpretation. For example, Ahmed’s (2014), phenomenological analysis considered how equal rights activist Audre Lorde experienced being made a racialised subject when treated as vermin as a young Black girl on a New York train: “*Suddenly I realise there is nothing crawling up the seat between us; it is me she doesn’t want her coat to touch ... I will never forget it ... The hate*” (Lorde, 1984, p. 148).

Section summary: Phenomenology offers a theoretically rich approach to studying the complexity of lived experience of health, including how lived experience is contextualised in time, space and embodiment. It is possible to do critical phenomenology in psychology, but few phenomenological psychologists have engaged with political or social structural analysis. Phenomenological psychology therefore remains individualist, offering a limited map for psychologists interested in issues of power. For these reasons, critical health psychologists often prefer a social constructionist approach.

Social constructionism

Although mainstream health psychology (epitomised in the **biopsychosocial** approach) and phenomenological psychology are distinct approaches, both share an individualistic orientation to thinking about the person. Social cognition models, for example, are underpinned by taken-for-granted individualist ideas of the person as a separate being, who then interacts with their world and other people. For example, questions about how concerned people are about meeting social norms in TPB studies imply that people are separate from social norms **ontologically**, even if they rate themselves as caring very much about meeting them.

Thus, while models in mainstream health psychology are often revised, as researchers investigate, debate, and develop them, psychologists rarely question the assumed individualism behind these models. The idea of a separate, rational, coherent, autonomous being who interacts with others, and their environment, therefore remains unchallenged. Relatedly, phenomenology also focuses on the individual, despite blurring distinctions between the subject and the object.

In much of psychology, there is the assumption that the self is coherent and stable enough that, with the right scientific tools and rigour, researchers can identify its real nature. This assumes that the focus of psychological research is the individual, conceptualized as an independent entity, albeit one that develops as they interact with others in society (Riley et al., 2021, p. 286).

In Western thought, individualism is such a taken-for-granted way to understand people that it is often confused with the territory. We gain this insight particularly from cross-cultural analysis, as anthropologist Clifford Geertz (1974, p. 31) infamously stated:

The Western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe; a dynamic center of awareness, emotion, judgment, and action organized into a distinctive whole and set contrastively both against other such wholes and against a social and natural background is, however incorrigible it may seem to us, a rather peculiar idea within the context of the world's cultures.

When Geertz wrote this, the “us” he was referring to were Westerners, grounded in North American and European traditions in thinking. In contrast, as Kora and Brittain (see [Chapter 1.1](#)) have highlighted, those who are steeped in a te ao Māori worldview would argue that the individualism of Western concepts of the self is the peculiar idea.

Leonardo DaVinci's Vitruvian man (see Figure 1.2.2) offers us a representation of this individualism. The image places an individual human at the centre. The person is male, adult, seemingly without dependents, and not currently dependent on others, since he is represented as separate from other people and from his environment. The ideal healthy human represented in this image is thus a separate individual, autonomous, fully formed, and in a stable state of health.

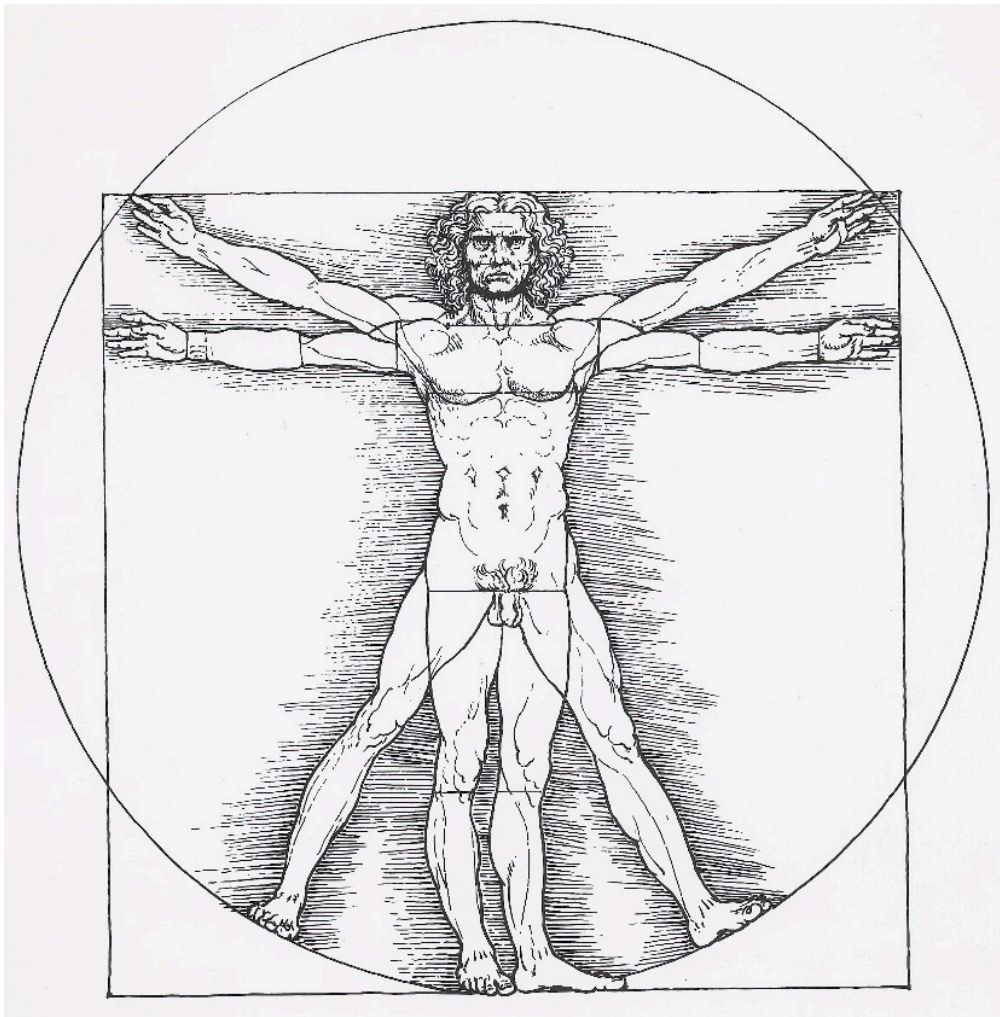


Figure 1.2.2 Image of Leonardo DaVinci's Vitruvian man. ([Vitruvianischer Mann](#), via Wikimedia Commons. Public domain)

There are several concerns with such representation standing in for ideals of health. For example, many people find vitality in experiences that could be described as the opposite of autonomous independence, such as when distinctions between self and other are blurred in intimacy, playing sports, being in an audience, or in spiritual experiences that transcend the self. Pregnancy also creates dynamic and deeply interdependent embodied experiences that contrast with ideals of an autonomous, stable body. Relatedly, the Vitruvian man is male and European, which when represented as an idealised norm, reproduces Eurocentrism, colonialism and the male-as-norm (Coulthard, 2014; Ussher, 2006).

As a figure who stands in for ideal humanity, Vitruvian man represents a cultural norm that is not attainable for most people, since everyone is born dependent, and most of people will experience fluctuating levels of sickness, dis/ability and/or dependency across their lifespan. The Vitruvian man thus reproduces “our collective fantasy that the body is stable, predictable, or controllable” (Garland-Thomson, 2011, p. 603). As critical disability scholars have argued, this “mythical norm” pushes many people outside of constructs of valued humanity, creating and problematising people who “misfit” (Garland-Thomson, 2011). These norms “haunt the human sciences by establishing and re-inscribing norms and outliers, ensuring that some of us are more human than others, and that many of us are excluded from the category” (Rice et al., 2021, p. 98).

Social constructionist theory

Social constructionism shifts analytic focus away from the individual, and onto the shared, social constructs (or ideas) that circulate between people. Social constructionism is an umbrella term covering a range of theories that share the idea that what we consider to be “facts” about the world are, instead, culturally shared agreements about reality. In other words, our truths are shared understandings that are “taken-for-granted” by people in a particular time and place.

This idea is supported by cross cultural and historical analyses that show significant differences in how people make sense of themselves (see Geertz, 1974, quote above). For example, today, English people would usually point to their heart if asked where they feel love. But, in Shakespearean England, the liver elicited passionate feelings (Riva et al., 2011): “Then shall he mourne, if ever love had interest in his liver” (Shakespeare’s *Much Ado About Nothing*, 1600 ca.; cited in Riva et al., 2011, p. 5).

Social constructionists argue that if human understandings were driven by the natural world, they would mirror a shared external reality across both time and cultures and therefore there would be little variation in our sense making (Burr, 2025). To use our example above, people could be heartbroken or liverbroken, but not both. Given that people have been both, it is therefore likely that the ideas humans have to make sense of their world are socially produced and historically bound.⁴

Further, these ideas are communicated and shared through language. To continue our example, Shakespeare grew up in a world where people talked and wrote about emotions as emanating from their liver, providing a conceptual framework for understanding the liver as a source of feelings and emotions. Social constructionists therefore highlight the importance of language because they do not see it as neutrally describing the world, but rather as actively constructing it. Social constructionists would therefore argue that the reason why it is hard for those of us who are English (only) speakers to imagine feeling love in our liver—or even find the idea ludicrous—is because we have not grown up in a linguistic community that makes connections between that organ and our feelings. We do not have a language for it, thus the liver is excluded from our culturally shared agreements and communication about embodied feelings. Also see below for “[How language shapes the way we think](#)” video (Boroditsky, 2017).



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/critical-health-psychology/?p=106#oembed-1>

From a social constructionist perspective, language enables possibilities for thinking because it provides the building blocks for thought. This argument flips a common sense idea that thoughts originate in people’s heads first, and then, if we want to communicate them, we convert them into words or other forms of expression. Instead, social constructionism argues that language has a prior existence before us, offering us a set of concepts from which we can build our individual thoughts. An analogy might help here: two

4. An alternative argument is that we simply know more, and thus better, than our forebears. That argument is often a taken-for-granted understanding and known as the “progressive narrative”. But as the example of feelings in the heart or the liver demonstrates, the progressive narrative cannot account for differences across cultures that show different rather than better understandings. We also note that the progressive narrative has been significantly critiqued by Foucault (2013), who argued that the development of ideas in history is full of ruptures and discontinuities, and does not follow a linear, progressive process.

children playing with Lego could build very different Lego creations, but those creations are produced with block-like shapes, and whatever they make, it will not look like something they made with stickle bricks. As the philosopher Wittgenstein said, “the limits of my language ... mean the limits of my world” (1961, p. 68).

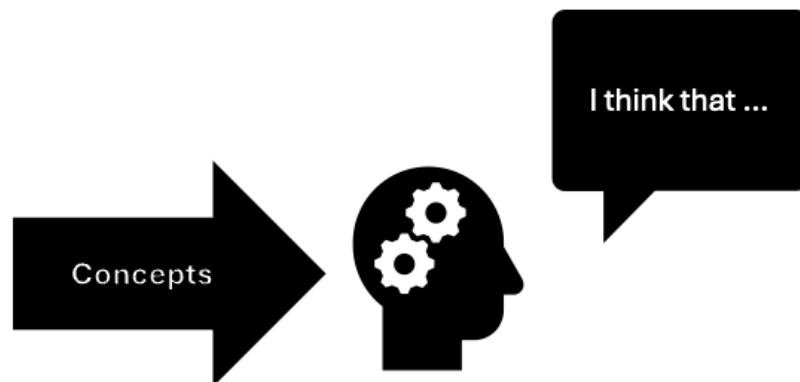


Figure 1.2.3 Visualisation of how linguistic concepts work as building blocks for thinking. (Sarah Riley. [CC BY-NC 4.0](#))

Activity

If people cannot think outside of the concepts they have available to them, then they are “constituted through language”, because language provides the conceptual building blocks for them to make sense of themselves. This argument is often counter to our taken-for-granted understandings, so an activity might help:

Two sites that circulate ideas for thinking about our bodies are social media and sports. For example, social media circulate ideas about a “glow” while sports can talk about “low centre of gravity”. Now think of a concept or phrase that is familiar in your social media or sports world that is used to describe the body, and imagine looking in the mirror:

- How did you think about your body before you knew that concept/phrase?
- Once you were familiar with that concept/phrase, how did you think about your body?
- Even when not looking in the mirror, do you ever use that concept/phrase to think about your body? And, if you do, does it elicit good or bad feelings about your body, or about yourself, or other people?

The above activity is intended to help you understand how concepts – including those we use to make sense of ourselves – circulate outside of ourselves first, and once we become familiar with them, can become concepts we use to think with and take for granted. Once we start to use these ideas to think with, they feel like they *originate* in us, as our own ideas because they are in our personal thoughts. And because we

experience these ideas as our own thoughts and beliefs, it is hard to think differently even when we want to. For example, people critical of media representations of the “thin-ideal” can find it frustrating that they still want to be thin. Further, knowledge and action go together (Burr, 2025; Gergen, 1985), so social constructions shape, not just what people can think, but what they can say, feel or do. (We will unpack relations of power and language further in Riley et al. [Chapter 1.4](#)).

Key takeaways: The social constructionist model of the person

- people are born into a world where concepts for how the world can be understood are already circulating, primarily through language
- as people grow up, they learn to understand the world—including themselves—through these concepts
- these concepts can differ across socio-historic contexts
- people are thus constituted through their social context
- the social constructs available to a person shape what they can say, think, feel or do.

Social constructionism offers a radical alternative to the individualism of mainstream psychology and phenomenological psychology, by shifting focus onto what concepts for meaning making are shared within a particular socio-historic context. Social constructionism thus “de-centres” the subject in psychology, moving focus away from the subject and onto language.

As well as recognising differences in meaning making across socio-historic contexts, social constructionists also argue that there is variation within socio-historic contexts. Thus, in any given socio-historic context, different ways of making sense of an issue circulate, potentially offering multiple ways for people to make sense of themselves (Billig et al., 1988). Social constructionist psychologists are therefore often interested in the different ways people make sense of themselves.

The multiplicity of everyday sense making

Robson et al. (2024) offers a novel approach to explore the perennial problem of why patients do not follow doctors' advice, showing how doctor's expert medical knowledge could be constructed in multiple ways that simultaneously made it valued and devalued. Here is an example from a participant discussing how he feels about his prescribed medication:

...you have to listen to the advice of people who, you know, hopefully know more than you do, you know, and I listen to my GP and I've listened to the consultants, at least I've got from 80 mgs down to 40. Who knows, maybe with diet, now that I've got the stent in, eventually maybe I'll be able to kick them in the head completely

(Eddie, mid 60s, retired public service worker living in Wales, UK; cited in Robson, et al., 2024, p. 11).

We identify three social constructs in Eddie's extract: (1) medical advice to take medication has value; (2) medication-free life is preferable; and (3) a language of addiction where people aspire to be free of drugs ("I'll be able to kick them in the head completely"). Moved through fluidly during a few seconds of speech, these accounts are partially contradictory (e.g., medicine is both valued and devalued), and draw on wider **discourses**, including those that position medical doctors as expert specialists, and the current resurgence towards framing natural as inherently good and medicine as bad (Greenhalgh & Wessely, 2004; Robson et al., 2024).

Within social constructionism, people are therefore not theorised as unified, relatively coherent, bounded individuals as we are used to in Western thinking. Instead, social constructionism:

...replaces the self-contained, pre-social and unitary individual [of individualist psychology] with a fragmented and changing, socially produced phenomenon, who comes into existence and is maintained not inside the skull but in social life (Burr, 2015, p. 122).

The outcome is that people are conceptualised as multiple, contradictory, fluid, and partial, because they are constituted within multiple, contradictory, and partial forms of sense making (Alvesson & Sköldberg, 2017). We expand on these points below:

- **Constituted:** people can only draw on the linguistic concepts that are available to them. Although they may actively use, re-appropriate, resist, or otherwise negotiate these conceptual ideas, they cannot think outside of them. For example, Crossley's participant could push back against safe sex messaging, but she struggled to articulate another way to be understood. Her "I can't explain it" suggests that she was unable to access another way to make sense of her experience.
- **Multiple:** people have access to different ways to make sense of themselves, others, and issues in their world, as in the example of genetics versus lifestyle explanations of disease causation we gave earlier.
- **Contradictory:** given the multiplicity of sense-making circulating at any one time, some social constructs will contradict others. This means people may understand themselves in conflicting ways. Social constructionist approaches do not problematise such contradiction because it is seen as the outcome of people shifting between multiple meanings, rather than a failure to produce a coherent self or to reconcile the accuracy of contradictory information (as individualist approaches might conceptualise it).
- **Fluid:** people may dynamically move through different forms of meaning making, both over the course of their day, and lifetime. A person with coronary heart disease may, for example, shift between understanding themselves as a loving partner, a good patient, and an organised person, as they, respectively, kiss their partner goodbye in the morning, visit their doctor for a check-up, and plan their diary.
- **Partial:** people may only be partially constituted through specific forms of sense-making, because they:
 - draw on concepts in a fleeting way, producing only partially formed thoughts
 - may not be fully aware of the underpinning rationality of these concepts (in the same way that Western psychologists might not notice the individualism underpinning their ideas)

- need another person to confirm that sense-making. For example, Crossley validated her participant by listening to her.

Psychological language

We take psychological language for granted. We use it all the time, such as when we encourage people to have a positive attitude, describe ourselves as “a bit OCD”, or list our strengths and weaknesses for a job application in ways that make even our weaknesses sound good (“my perfectionist tendencies mean I do every job to the highest level”). Often such talk reproduces an understanding of a unique, autonomous self that we can find by looking “inwards”.

It is hard to imagine how we might make sense of ourselves without psychological vocabularies (Rose, 1998). People who are not good at doing so are often problematised, since they are unable to reflect on their thoughts and feelings, and develop better self-awareness (Illouz, 2008).⁵

Psychological language is a taken-for-granted in our current socio-historic moment, so it might be a surprise to know that it is a relatively new phenomenon, and the outcome of multiple social processes, including:

- developments during the European Middle Ages as people imitated new royal court practices of etiquette that required an ability to keep some emotions private/hidden, when previously, emotions were public displays (Elias, 2000)
- later shifts from monarchy to democracies, requiring governments to have self-regulating citizens who would primarily govern themselves within valued constructs of citizenship, rather than as subjects of authoritarian monarchical rule (Foucault, 1977; Gibson, 2016; Miller & Rose, 1990; also see Riley et al. Chapter 1.4 for discussion of [“governmentality”](#))
- 20th Century rise of therapeutic cultures, built on developments in medicine, psychiatry and psychology (Foucault, 1976; Parker, 2015), including psychoanalysis and humanism (Illouz, 2008) and 21st Century self-help cultures (Riley et al., 2019a; Riley et al., 2019b) that require an inward focus to facilitate “fixing” the self
- 20-21st Century expansion of **neoliberal** economics that has required autonomous, rational, flexible, and risk managing citizens to meet the needs of a market-driven economy (Harvey, 2005; see Riley et al. [Chapter 1.4](#) for further discussion on neoliberalism)
- 20-21st Century digital technologies requiring people to participate in significant reflection on how they present themselves to others (Gergen, 1991; Orgad & Gill, 2021).

More-than-human theory

Social constructionism offers a substantial critique and alternative to individualism, locates knowledge in its social context, and opens possibilities to embed theorising power (especially when connected to **poststructuralist** theories of power, which we explain in Riley et al. [Chapter 1.4](#)). Social constructionism

5. Ironically, we need to reflect on the psychological demand for reflexivity.

therefore speaks to several of the **pou** of critical health psychology. However, the focus on social constructions at the expense of material aspects of the physical world, has led some critical health psychologists to turn to “more-than-human theory”.

More-than-human theory is informed by the work of Deleuze and Guattari (e.g., 1987), Braidotti (e.g., 2013), and others, including Barad’s (2007) argument based on quantum physics, that you can study the real, even though the real changes in response to being studied (Barad, 2007). We unpack these arguments further in Riley et al. [Chapter 1.3](#). For now, what is important to know is that more-than-human theory emphasises the mutually co-constitutive processes in which meaning-making and the physical world (“**materiality**”) dynamically interact. That is, the human and nonhuman produce and shape each other in an entangled and unfolding process.

In this approach, the subject of psychology is further decentered. We are not imagining an individual drawing on linguistic concepts circulating within their wider social context, as in social constructionism, but part of an open system of multiple, intersecting (discursive and material) elements that momentarily actualise our object of study, including the person.

An example is clearly going to help here, and we turn to what has become the relatively common place idea that gut bacteria shape our health. When thinking about the relationship between gut bacteria and health, we can conceptualise a unified human body, within which clearly defined gut bacteria reside in multiple numbers (this keeps our sense of a coherent whole intact). Alternatively, we can take a more-than-human approach and imagine an open system, through which multiple elements are in constant flux (e.g., glucose flows across cell membranes, some of which are human and others non-human).

Example of thinking with a more-than-human approach

When critical health researchers take a more-than-human approach, they focus on the flows between the elements in the system they are looking at. To continue with our example of heart disease, a cardioverter-defibrillator (ICD) is a device implanted in people with heart arrhythmias or other conditions. It monitors heart rhythms and maintains regularity by delivering electrical shocks when an abnormal heartbeat is detected. In this sense, the device, and those who programmed it according to biomedical definitions of a “normal” heartbeat, control the patient’s heart. The ICD is thus part of a dynamic network of interacting human and non-human elements that produce a heart beat in a dynamic unfolding process that draws together disease, device, patient, and cardiologist, with life-or-death implications for the patient (Fox, 2017).

More-than-human theory is underpinned by a “**processual**” **philosophy** that focuses on the continual unfolding of an emerging world, directing attention to those forces that shape the emerging world, rather than its separated-out components. A more-than-human approach radically changes how we might think about the object of our study in health psychology, including where the body begins and ends, and distinctions between human and non-human, including animals or other aspects of the natural world (Burr, 2024; Lupton et al., 2023).

These ideas are not, however, radical in Indigenous thought. We return to our earlier quote from Māori scholar, Pita King, that “atomization is often avoided” (King et al., 2017, p. 731). Indeed, the interconnection and unfolding of human and non-human relations, where the human is not the centre of these

relationships, is typically part of Indigenous cosmologies (Hokowhitu, 2020), and may offer important directions for enhancing human relations (Bansal, 2020).

Conclusion

We started this chapter saying that if health psychology is about supporting people towards health and wellbeing, we have to ask, “What kind of person are health psychologists thinking of?” Chapter 1.1 had already started this work with discussion of te ao Māori. In this chapter we built on that discussion by considering four Western approaches to conceptualising of the person. Asking such a fundamental question speaks to the critical health psychology **pou** of challenging taken-for-granted understandings, and thinking critically, and reflexively, about the conceptual frameworks we use. At the end of this chapter, we hope you now have a better understanding of why we asked that question, and also the potential ways you can answer it.

Key takeaways from this chapter

- The biopsychosocial approach, is an example of how mainstream psychology conceptualises the person as an individual separate to the world, who then interacts with it, and whose health practices can be modelled by identifying atomised factors that predict behaviour across contexts. Although there is sophisticated modelling employed in this approach, the underlying principles tend to be under theorised.
- Phenomenological psychology offers a more theoretically developed approach that also focuses on the individual. It conceptualises the person as an interpretative being, whose interpretations of their health experiences are produced through embodiment, temporality, spatiality, affect, intersubjectivity, and personal histories.
- Social constructionism constructs the person as produced through language, and as multiple, contradictory, fluid, and partial because there is always more than one way to understand the world in any linguistic community. Health psychologists employing this theoretical approach tend to focus on how people make sense of their health, and the implications that meaning-making has for what they can say, think, feel, or do.
- More-than-human theories consider how meaning-making and the material, the human and non-human, dynamically interact in an ongoing process that produces experiences of health.

We started this chapter with a map metaphor for thinking about these different approaches. The usefulness of a map depends on the context in which it is being used and its user’s desired outcomes. Thus, while critical health psychologists tend to prefer approaches that are richly theorised and less individualistic, we recognise that all approaches offer potentially useful maps depending on context. So rather than making a case for one being better than the other, we encourage you to think about the possibilities and limitations in all of them.

Further, although there are significant distinctions between approaches, we also note there are important synergies. Social constructionist and more-than-human approaches stand in contrast to individualised

approaches, for example, since they conceptualise people as produced through their social context. Additionally, Kaupapa Māori (discussed in Brittain & Kora [Chapter 1.1](#)), social constructionist, and more-than-human approaches share the idea that our understandings of the world are produced relationally, and that power shapes those understandings.

In the next chapter, we build on what we have discussed so far, helping you develop your familiarity, and thus understanding of these ideas. We do so by considering how different approaches shape the psychological knowledge that we produce and use in health psychology, considering, (1) Kaupapa Māori, (2) mainstream psychology, (3) phenomenological psychology, (4) social constructionist and (5) more-than-human approaches.

Knowledge Check



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Want to know more?

Watch: “The Century of the Self” (Episode One – *Happiness Machines*) (Curtis, 2002). This episode explores some of the ways the self has been understood in the 20th century, and how these ideas have been leveraged to shape people’s identity, desires, and behaviour. (You can find it on various platforms including YouTube and the BBC iPlayer).



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Listen:

“Where’s does the power lie? A critical look at the biopsychosocial model with Karime Mescouto”, on *The Words Matter Podcast* with Oliver Thomson (Thomson, 2021).



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[psychology/?p=106#oembed-3](https://oercollective.caul.edu.au/critical-health-psychology/?p=106#oembed-3)

Read: Chapter 6 “Self, identity, subjectivity” in Gough, B., McFadden, M., & McDonald, M. (2013). *Critical social psychology: An introduction* (2nd ed.). Bloomsbury Publishing.

Also see Morison and Gibson [Chapter 2.1](#) for further discussion of the biomedical and biopsychosocial models.

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1.3 What do we know?

SARAH RILEY; SIOBHÁN HEALY-CULLEN; GARETH TERRY; DON BAKEN; AND AORANGI KORA

Overview

How people working in health psychology support health, or treat illness, is shaped by the conceptual frameworks that underpin their work. Chapter 1.1, for example, discussed Māori health models and the Māori cultural conceptual frameworks underpinning these, including a holistic understanding of people as interconnected with all living things across human, physical, and spiritual realms. In Chapter 1.2, we then turned to Western concepts and considered mainstream psychology, phenomenological, social constructionist, and more-than-human approaches that offer different ways to conceptualise people. Both these chapters showed why it is important for people working in areas related to health psychology to critically reflect on how they conceptualise people. Developing these arguments, we note that in research, policy and therapeutic contexts, people working in health psychology both produce, and act on, knowledge. In this chapter, we therefore ask: **What kind of knowledge do health psychologists produce and use?**

Addressing this question, we consider five traditions that conceptualise knowledge differently: (1) the objectivist science of mainstream psychology, (2) phenomenologically informed psychology, (3) social constructionism, (4) more-than-human theoretical approaches, and (5) Kaupapa Māori research. We engage with each of these systematically, exploring how they conceptualise what we can know, and our methods for knowing it. Using cancer as the health topic that threads through the chapter, each section has a research example to give you a sense of how these ideas are put into practice. We finish each section evaluating how closely these approaches align to the critical health psychology **pou** we use in part one of the book, which are: valuing theoretical/conceptual thinking, challenging taken-for-granted understandings, paying attention to issues of power and equity, moving beyond individualism, and considering knowledge as produced in context. In so doing, we cover the following learning objectives:

Learning objectives

- Compare different approaches to knowledge, and how these shape research in health psychology.
- Evaluate how these approaches connect with our five critical health psychology pou.
- Consider how different ways of conceptualising knowledge shape psychological research, and thus the ways that psychologists can think about, and respond to, health issues.

Introduction

In 2016, wildlife photographer, Greg Armfield, hit the headlines when he was photographed pointing his camera away from two huge mating rhinoceroses just behind him. Looking at this photograph, many people saw a man looking the wrong way, but Armfield tells a different story. From his perspective, there was something else worth looking at beyond the obvious. In [a newspaper article](#) he explained the context:

Rhino-sex takes time (fun fact!) and after a while he turned his camera onto the Kenya Wildlife Service Rangers, seeking to recognise the work they did in protecting endangered animals.



Figure 1.3.1 Image of World Wildlife Fund photographer apparently not noticing the mating rhinoceroses behind him. (Copyright © 2016 Jonathan Caramanus/Green Renaissance / WWF-UK. Reproduced with kind permission)

As a metaphor about knowledge, the image of Armfield helps us to consider the importance of context, perspective, and interpretation. It invites us to think about the perspective of the people who generate knowledge, and the context within which they observe and interpret what they see, as well as how the knowledge they produce is subsequently interpreted by others.

The idea that perspective shapes observation, even when people are trying to be objective, produced a “mic drop” moment in mid-20th Century humanities and social sciences, creating a “crisis of representation” based on the arguments that:

- science is not neutral because it is shaped by the perspectives of the scientists doing it
- the perspectives of scientists are shaped by their social context and social positionalities.

“Social positionalities” refers to how social categories, such as those related to a person’s gender, sexuality, ethnicity, race, class, dis/ability, and so forth, provide people certain vantage points from which to make sense of the world, as well as frameworks from which they might be understood by others. Social positions are also intersecting. For example, Black feminist scholarship has shown how gender is always racialised (Collins, 1998; Collins & Bilge, 2020; Crenshaw, 1989; Hull et al., 1982).

In the crisis of representation, scholars argued that researchers’ abilities to observe and interpret were shaped by their intersecting social positionalities. Turning a research lens onto the researchers, Haraway (1989), for example, demonstrated that studies of psychological research in primatology were profoundly shaped by the perspectives of the mostly White, male, heterosexual researchers.

It can be tempting to locate such problems in history, and imagine ourselves more enlightened. But these arguments are still relevant today, seen, for example, in research suggesting that oncology studies treat the male body as the default human body, despite female and male bodies responding differently to treatments (Florez et al., 2024).¹

Responses to the crisis of representation have been multiple and ongoing, with the outcome that psychologists now have multiple approaches to thinking about, and generating, knowledge. For some, it has meant identifying and correcting bias, such as increasing numbers of female bodies in clinical trials. While this is important, these practices retain the idea that scientists can create objective knowledge. This idea maintains distinctions between the subject (who is studying) and the object (being studied), reducing the likelihood of researchers reflecting on how their cultural frames of reference might shape their studies.

Responses to crisis of representation

- renewed efforts to get better at producing truths, or
- focus on exploring what we understand to be truths.

A different response to the crisis of representation has been to lean-into the idea that knowledge is always produced in context, and from the perspective of the producer. In this response, researchers dissolved the subject-object distinction and developed new methods for working with the idea that researchers—like all people—are embedded within their world, not separate to it.

The idea that subjective knowledge has value underpins the disability activist aphorism “nothing about us without us”; the Kaupapa Māori research principles of “by Māori, with Māori, for Māori” (Wilson et al., 2021); and our critical health psychology **pou** of considering knowledge as produced in context. From this perspective, researchers need to carefully reflect on how their intersecting social positions might shape the research design decisions, observations, and conclusions they make. This **reflexivity** is usually an explicit quality criterion for qualitative research, but often absent in quantitative psychological research, despite arguments for that to change (Jamieson et al., 2003). Reflexivity can be practised in different ways, and at different levels (see text box below).

Reflexivity

When doing reflexivity, a researcher might reflect on how:

1. For a deep dive into this ongoing “male-as-norm” approach in research see, Craido-Perez (2019).

- **their social positions or “positionalities” connect to the topic** (e.g., how a researcher’s own experiences of cancer might shape an oncology project)
- **interactions between researchers and participants are shaped by multiple positionalities** (e.g., when shared positionalities enhance disclosure because of an expectation of understanding)
- **disciplinary orientations shape their questions** (e.g., the individualistic focus in psychology)
- **wider social meaning-making shapes the project** (e.g., positive **feeling rules** might produce research problematising patients who do not “look on the bright side”)
- **institutional norms** (e.g., the way research funding systems support snapshot rather than longitudinal research)
- **their understanding of the nature of reality, and of knowledge, shapes their research.**

As you can see from the final line in the text box above, researchers are expected not just to reflect on their own positionalities, but also on the implications for how they conceptualise knowledge. This means understanding your ‘ologies.

Time out – let’s talk ‘ologies

When psychologists think about the nature of knowledge, they turn to philosophy, because philosophers have been thinking about knowledge for a long time. But, taking thinking from one discipline and applying it to another creates translation issues. Philosophers are also not in agreement (despite all that thinking!). The outcome is that psychological writing about knowledge is diverse, sometimes contradictory, and full of daunting terminology. But all research, implicitly or explicitly, is underpinned by philosophy of knowledge. While psychologists do not need to become philosophers, it is important to have a working knowledge of some key ideas. So, below, we offer a map² through some of this territory, tackling terminology first before discussing our five approaches to knowledge in turn.

Ontology is the branch of philosophy that asks questions about what is real. For example, is there a reality that exists independently of us?³

Epistemology is the branch of philosophy that considers what can be known, and the methods for knowing it. Questions of ontology (what is real?) connect with questions of epistemology (what is knowable, and what are the methods for knowing it?). Broadly, we can think of epistemology on a continuum. On one side, is the understanding that

2. We add a disclaimer: the map that follows is how we see it; there are other interpretations. And in trying to introduce you to complex ideas, we will by default, be oversimplifying in places.

3. This might seem obvious, but we hope that by the end of this chapter you understand why this is a legitimate question.

knowledge about the real world can be accessed and understood through our senses or using the right tools, and tested against other existing knowledge (sometimes called **empiricism**). Knowledge may therefore be “discovered”, “harvested”, or “mined”. On the other side of the continuum is the idea that knowledge is an interpretation of our world, continually being produced and reproduced through how we understand the world (sometimes called **social constructionism**). Here, knowledge is understood to be created, woven, constructed, produced, or co-constituted.

Methodology refers to our theories of the method, and connects the above ‘ologies with research design. Researchers usually prefer coherent designs that have a strong conceptual alignment between their ‘ologies. For example, an ontological position that a real world exists independently of us, would justify an epistemological position that this real world may be knowable, and a methodology that directs our choices towards methods designed to produce objective observations.

Objectivist science of mainstream psychology

The objectivist science approach underpins the kind of work that is predominant in mainstream psychology journals and textbooks. Often the aim of this research is to identify distinct, measurable psychological elements shaping individual behaviour, such as self-efficacy, self-esteem, or perceived norms (see Riley et al. Chapter 1.2’s discussion of the [biopsychosocial approach](#)).

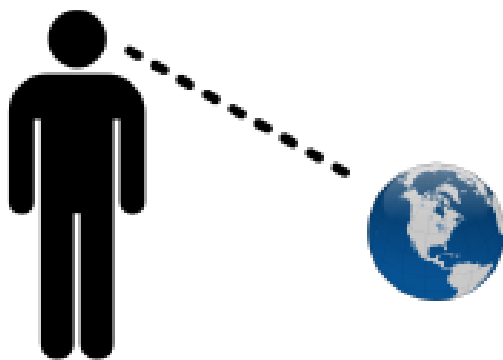


Figure 1.3.2 Representation of the main aim of the objectivist science approach in mainstream psychology to be able to accurately observe reality. (Copyright ©2012 Sarah Riley and Richard Brown. Reproduced with kind permission).

This approach addresses our chapter question about what we can know in the following ways:

What is reality? A realist ontology underpins this approach, in which a real world, or “singular reality”, exists independently of researchers perceiving that world, and which has enough constancy that stable patterns of reality exist to be discovered.

What is the nature of knowledge? We use “objectivist science” as an overarching term to describe a range of related epistemological orientations, including logical positivism, positivism, post-positivism, and neo-positivism. These terms signify variation in how strongly they adhere to the idea that a real world can be accessed unmediated, but what they share is an understanding that good knowledge is knowledge that reflects the real world (as much as possible). Because this epistemology is predominant in mainstream psychology it is often taken for granted, and unreported in publications.

Methodology: Relates to undertaking systematic observation to discover facts about the world. It involves collecting observable data and systematically processing it. Various scientific principles are drawn on, such as understanding that hypotheses are falsified (when predictions fail to materialise) or supported (when predictions are confirmed), but always with the recognition that new information may subsequently falsify a previously supported hypothesis.

Methods: When applied to psychology, objectivist scientific methods often focus on measuring atomised elements (or “variables”) of people’s thinking and behaviour. Treated as real, statistical analysis is performed on these elements to answer questions about cause-and-effect relationships, correlational relationships, or differences between groups.

Quality criteria focus on enhancing researchers’ confidence that their study is accurately describing a real thing, or a thing that can be treated as real since it creates real effects. Examples of quality criteria include:

- Designs – are these set up to minimise researcher bias and/or intervening variables?
- Validity – are researchers measuring what they say they are measuring?
- Reliability – can the researchers reliably produce the same effect?
- Replicability – can other researchers reproduce these findings?
- Triangulation – do different kinds of data point to the same finding, thus maximising researchers’ chances of best approximation to the truth?

An example of an objectivist-scientific cancer study

Laubmeier and Zakowski’s (2004) study on the association between cancer patients’ perceived life threat and their psychological adjustment.

Abridged Abstract	Key points to note
"According to the transactional model of stress ... the individual's perception of a threatening situation is more strongly related to distress than the objective event itself" (p. 425).	Generalised psychological model foregrounded
"Thus, the present study examined whether cancer patients' perceived life threat (PLT) is more strongly associated with psychological adjustment than a more objective index of disease prognosis (i.e., cancer stage)" (p. 425).	Prediction made based on model and applied to a specific context Epistemology absent/assumed
"Patients diagnosed with various types of cancer (N = 97) completed questionnaires assessing PLT, ... distress, and quality of life. ... regression analyses showed that PLT, but not disease stage, was significantly related to psychological distress and quality of life" (p. 425).	An atomised, psychological subjective experience is conceptualised (PLT) and made measurable through the development of a scale
"...these findings suggest that cancer patients' PLT is more strongly related to distress than is cancer stage..." (p. 425).	Different scales are used as measures of latent psychological variables that are treated as real, on which statistical analyses are performed
"Thus, patients who appraise their illness as life threatening may benefit from cognitive interventions aimed at reducing distress ..." (p. 425).	Supported hypothesis, producing an explanation for how people with cancer think (and thus feel) An information processing intervention is recommended

Evaluation:

Science is exciting when it is about endeavouring to understand the world better; as is knowing that new evidence may radically change understanding, but that ultimately people are progressing towards understanding. Feasible interventions aimed at changing individuals can be developed, such as supporting people to develop better information processing. Considered against our five pou, objectivist science in health psychology:

- **values theoretical/conceptual thinking** in relation to developing explanatory models, often related to cognitive processing, but with limited theorising beyond these models.
- **challenges taken-for-granted understandings** in relatively limited ways, as the focus tends to be on meeting established criteria within the system rather than challenging the system of meaning itself
- **rarely pays attention to issues of power and equity** because its individualism directs attention away from structural inequities
- **rarely moves beyond individualism** because the focus is on thought processes happening in an individual that subsequently shape behaviour.
- **considers knowledge as produced in context** in terms of concerns around generalisability, such as noting a predominance of White or well-educated people in a sample. But what is often absent is a deeper consideration of the conditions in which “facts” are produced (despite post-positivist arguments for doing so).⁴ Objectivist scientific research therefore implies that the knowledge it produces represents universal psychological processes despite significant differences across cultures (Danziger, 1997).

For researchers more informed by the crisis of representation, the objectivist science approach in psychology offers only a partial way of looking at the world. Harsh critics might even suggest it directs researchers to look in the wrong direction, and that instead of seeking to produce knowledge that is objective, value free, and generalisable, psychologists are better off focusing on subjective, lived experience, as in phenomenological psychology.

Phenomenological psychology

Phenomenological psychology takes an “**idiographic**” approach, with the aim of understanding various phenomena through the lived experiences of individuals. The aim is not to identify atomised, measurable elements of a psychological model, but to gain understanding of people’s holistic, contextualised interpretation of an experience.

4. This is reinforced through the processes of systematic reviews, often considered the ‘gold standard’ of the evidence-based medicine hierarchy because they are designed to locate consensus within an evidence base. However, they risk proliferating a limited range of findings as ‘real’ evidence due to narrow eligibility criteria, typically unacknowledged postpositivist bias, and privileging of randomised trials that pay little attention to meaning making (Greenhalgh et al., 2018).

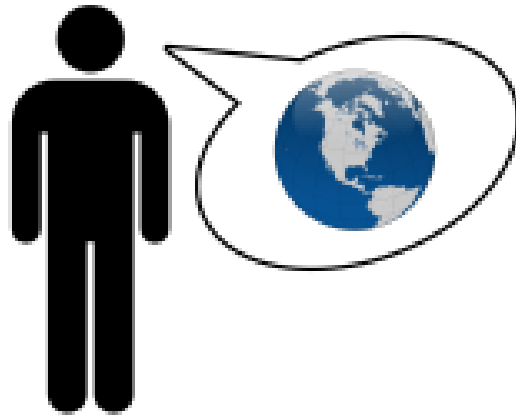


Figure 1.3.3 Representation of the main aim of phenomenological psychology to understand the lived experience of a research participant. (Copyright ©2012 Sarah Riley and Richard Brown. Reproduced with kind permission).

What is reality and the nature of knowledge? Phenomenological psychologists may draw on critical realism, which combines a realist ontology (a real world exists independently of people), with a relativist epistemology (people cannot access the real world directly, because their experience of it is always mediated, though their biology, personal histories, and available social constructs). Human knowledge is thus produced through our interpretations, themselves inseparable from context, and it is these interpretations that are important for psychological research.

Methodology: Phenomenological psychology usually has two methodological aims, namely to:

- reflect participants' lived experiences as accurately as possible (while recognising that researchers can only ever attempt an approximation of this), and
- contribute to the broader understanding of the phenomenon being studied (e.g., a cancer diagnosis).

Those informed by the critical realist philosophy of Roy Bhaskar might also distinguish between three levels of analysis:

- **empirical** level: the phenomena we can observe, e.g., the experiences and sensed perceptions of people as they interpret their conscious world). Using cancer as an example, a person might feel an unexpected lump, and worry.
- **actual** level: objects and events occurring in the real world whether they can be observed or not), e.g., cancerous cells growing that produce the lump or past exposures to carcinogens.
- **"real"** level: entities and structures with powers that interact to produce causal mechanisms shaping the observable phenomena in the empirical level; these operate largely independently from researcher's ideas). This 'real' level is different from positivism because it is not necessarily directly observed, but deduced from research findings (Alvesson & Skoldberg, 2018). One example is the interactions of multiple biological, social, and psychological factors that result in the growth of the cancerous cells.

Methods. The methods phenomenological psychologists use are designed to help people articulate their

holistic, contextualised understanding, and interpretation, of an experience. Often these are individual accounts of their experiences, produced through interviews or other first person research methods such as diaries or counselling recordings. Such data are analysed in terms of re-occurring patterns in individual sense making and interpretation, as well as cross-cutting patterns in accounts from people with similar experiences. To better understand, and contextualise, how people interpret a phenomenon, researchers may focus on specific elements of experience such as **embodiment**, **temporality**, spatiality, relations, and feelings (see for example, Ashworth, 2003; Willig, 2012; also see Riley et al. Chapter 1.2 [Phenomenological health psychology](#) section).

Quality criteria focus on demonstrating that a study's design is theoretically informed by phenomenology, and that it has enabled participants to both articulate their experiences and develop interpretations of their experiences. Rich reflections by researchers on their interpretation of those interpretations are also expected (Langdridge, 2007; Nizza et al., 2021). Examples of quality criteria include:

- analysis that provides a sense of walking in another's shoes, evidencing a "**hermeneutics of empathy**" in seeking to deeply understand participants' experiences, and interpretations, of those experiences
- analysis that is not simply descriptive, but offers detailed, nuanced, contextualised, and interpreted accounts of lived experience
- evidence of close engagement with what participants say, and attention to similarities and differences across participants' experiences
- phenomenological epistemology is claimed and explained
- reflexivity is practised deeply and explicitly, potentially using techniques linked to a specific phenomenological method or approach
- new knowledge is generated that extends existing understanding or produces novel insights.

An example of a phenomenological cancer study

Willig's (2009) phenomenological reflection on waiting for melanoma test results.

Article summary	Key points to note
In this article, Willig considers her experience of wresting meaning from meaninglessness.	Focus on meaning and interpretation
She draws upon personal reflections.	Reflection and reflexivity
Uses her diary.	Uses qualitative data
Focuses the process of being diagnosed with cancer.	Focuses on a particular phenomenon (cancer diagnosis)
In these reflections, she draws on concepts of existentialist philosophy.	Explicitly names the phenomenological philosophy/epistemology
Feeling overwhelmingly frightened, she tries to manage her fears by seeking meaning, but finds this a difficult and embodied experience: “(my) whole body in the struggle against the black hole of meaninglessness” (p. 183).	Close engagement with a first-person account. Description and interpretation of experience, including thoughts and embodied feelings, and how they shape each other. As readers, we ‘feel’ with her.
Later she develops a new perspective and questions the need to find meaning.	Considers how experience, and interpretation of that experience, changes over time.

Evaluation:

The sense of deeply listening to another to understand, and interpret, their lived experience can feel profound for both researchers and participants (see, for example, Padilla, 2003). Considered against our five **pou**, phenomenological psychological research:

- **values theoretical/conceptual thinking** in relation to engaging with phenomenological philosophy
- **challenges taken for granted understandings** when developing new knowledge about human experience, and its **idiographic** approach challenges mainstream psychology’s valuing of **nomothetic** approaches to knowledge. However, because it centres the individual, it often reproduces, rather than challenges, mainstream psychology’s individualistic focus
- **pays attention to issues of power and equity** when providing opportunities for members of marginalised communities to have their voice heard. But care needs to be taken to genuinely amplify marginalised voices, rather than the researcher capitalising on, or consuming, that marginalisation for their own personal gain. The “**idiographic**” approach means that the role of structural inequities in shaping experience is often absent or minimal, unless participants themselves make sense of their experiences through structural critique. Sometimes researchers connect their work to another politicised ideological framework (e.g., feminism, Marxism, critical disabilities, or fat studies), but this happens rarely (cf. Langdridge, 2004, 2007; Riley et al. Chapter 1.2 discussion of [phenomenology](#) for further elaboration)
- **moving beyond individualism** is limited by the focus on individual experience
- **knowledge is contextualised** since experience is understood to be produced within, not separate to,

context including embodiment, intersubjectivity, time and space. But as noted above, how the context is conceptualised may not include social inequities or power structures.

Social constructionist psychology

Social constructionism is an overarching term; it covers a range of approaches sharing the idea that what we consider to be facts about the world are, instead, collective agreements to understand the world in a certain way. Research therefore aims to identify what social constructions we use, and with what effects.

Social constructionists argue that if our understandings were driven by the natural world, there would be little variation in human sense-making because our understandings would mirror a shared external reality. Since there is significant variation, both across cultures and within the same culture across time, the argument is that how we make sense of the world must be socially produced (see Morison & Gibson Chapter 2.1 for further discussion of this [argument](#)).

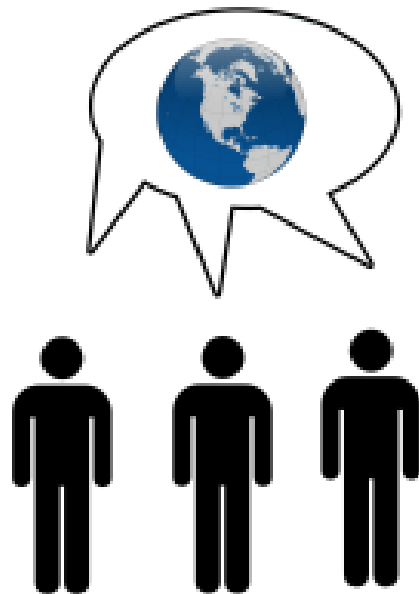


Figure 1.3.4 Representation of social constructionism, where people create their world through social processes in particular communication. (Copyright ©2012 Sarah Riley and Richard Brown. Reproduced with kind permission).

What is reality? Social constructionism has a relativist ontology, there is no singular reality that exists independent of us. For example, bees and humans see different light wavelengths, so when they look at the same flower, they see different realities. Similarly, people's concepts for "seeing" the world shape what is possible for them to experience as reality. For example, it is only in the last hundred years that English speakers have understood motivation as a generalised internal state that we can "have" (and could improve on) (Danziger, 1997), yet it is now a "reality" of human psychology.

What is the nature of knowledge? Because there is no real world that is external to us, a social constructionist epistemology is that the knowledge we have about our world is produced within, and through, social contexts and social processes. Continuing our example, Danziger (1997) described how our current understanding of motivation was produced by U.S. experimental psychologists, competing with psychoanalysts and humanists to address the needs of emerging markets in advertising and education.

Methodology: Since knowledge is always contextual, the aim of psychology is not to search for universal truths (since these do not exist from a social constructionist perspective), but to identify the concepts we have for making sense of ourselves, and examine how these concepts enhance, or limit, our health and wellbeing. For some psychologists, this means emphasising the inseparability (or mutual constitutive-ness) of knowledge and power. This perspective also draws on poststructuralist philosophy, which we unpack in Riley et al. [Chapter 1.4](#)).

Methods involve looking at patterns of sense making occurring in a particular context, and considering their implications for **subjectivity** and **practice**, that is, what people can say, think, feel, and do. Depending on the research questions, and type of social constructionist or poststructuralist analysis being undertaken, methods of analysis may include a focus on:

- **Genealogy:** how ideas develop through history and the institutions involved in supporting these processes.
- **Interpretative repertoires/constructions:** identifying different common-sense ideas available on a topic and considering their implications for subjectivity and practice (e.g., when people talk about “winning” or “losing” a “battle with cancer”, see [Chapter 1.5](#)).
- **Wider social or institutional discourses:** identifying broader forms of sense making that underpin common sense (or “taken for granted”) ideas, such as “healthism” in the Willig (2011) textbox example below.
- **Resistance and dilemmas:** exploring how people may resist discourses or negotiate the dilemmas produced through contradictory discourses that circulate within any given moment.
- **Subject positions:** examining the kinds of subjects (types of people) produced within a discourse, and the vantage points they offer for people located within that subject position.
- **Technologies of self:** considering the work people do on themselves to produce themselves within a subject position.
- **Affect:** considering the relations between feelings, emotions, and discourse, including the socially constructed “**feeling rules**” about appropriate feelings.
- **Rhetorical strategies:** analysing specific patterns in talk or text for their interactive effects, especially in relation to identity claims, use of psychological language, and management of accountability.

Quality criteria vary but are likely to include producing a conceptual analysis that:

- acknowledges the contextual and constructed nature of knowledge
- de-centres the subject by focusing on patterns of meaning making across people (focusing on the patterns of talk, not the individuals, or their internalised beliefs)
- identifies multiple and contradictory discourses (contrasting with psychological research that seeks a single “truth” and the answer to the question, “What did they *really* mean?”)
- employs a “**hermeneutics of suspicion**” by considering how power shapes meaning making
- takes a critical stance towards taken-for-granted knowledge (which also requires **reflexivity**)
- recognises its own analysis is just one reading/interpretation of the text
- offers new insights into the constructions people use to interpret themselves, others, and their world, and the possibilities for subjectivity and practice they enable or limit.
- offers new directions for how we might facilitate better health and wellbeing.

An example of a discourse analysis cancer study informed by social constructionism

Willig's (2011) discourse analysis of dominant constructions of cancer.

Article summary	Key points to note
When people are diagnosed with cancer they must "find meaning in their changed circumstances" (p. 897). A social constructionist approach argues that such meaning is produced from "discursive resources that are available within one's culture" (p. 897).	People draw on available discourses or social constructions (coherent ways of understanding an issue) to make sense of themselves Explicitly names the epistemology
"This paper critically reviews some of the dominant discourses [of] cancer available within English-speaking Western industrialised cultures. It maps out the discursive positions available to those diagnosed with cancer and traces some of their implications for how cancer may be experienced and how it may be lived with" (p. 897).	Knowledge is contextualised Multiplicity of discourses recognised Focus on how available discourses shape subjectivity
Findings: Discourse 1, "This is and does not have to be" friends tell her not to be worried and to stay positive, creating a moral imperative to be positive. This discourse denies her ability to express sadness, fear, or anxiety. Discourse 2, "Moral discourse" friends ask questions that imply her responsibility, such as, how often she went in the sun. This discourse blames her, alleviates her friends' anxieties around their own mortality, and connects to " healthism " a discourse that constructs health outcomes as a product of individual behaviours.	Identifies multiple discourses Uses examples of talk as evidence Examines how these discourses have different implications for subjectivity (e.g., positive feeling rules) and practice (e.g., friends' behaviour) Analysis includes wider discourses (e.g., healthism).

Evaluation:

Social constructionist ideas offer a map to navigate the world that can feel new, exciting, and illuminating. It allows us to embrace complexity, since multiple discourses produce multiple (and sometimes contradictory) sense making. It also enables researchers to challenge taken-for-granted ideas that are framed positively, but which can have negative outcomes. For example, Willig's (2011) experience of a cancer diagnosis was undermined by positive feeling rules and discourses of individual responsibility (see text box above).

Such analysis allows researchers to explore the ideas that dominate now, as a starting point from which to imagine better worlds. It also allows us to look at history differently: the past is not full of failed ideas as we move progressively forward, but full of multiple discourses that have shaped our current moment, while previous moments can give us insights into the constructions we use today.

Social constructionist researchers are often concerned with addressing social justice issues. But developing effective interventions is hard because change is required beyond individual "fixes". Critical researchers are also at risk of critiquing others, without offering meaningful alternatives, and relativism can make it harder to make factual claims that address inequities (which is a problem in a **post-truth world!**).

Social constructionist and poststructuralist ideas also have implications for materiality, since how we understand something shapes our response to it, including, for example, how we design and build healthcare systems, technology, and physical infrastructure. For social constructionists, anything can be

data since discourses can be read in talk, text, image, and even buildings (see for example, Bates, 2019; Gibson et al., 2015; Macdonald, 2016; Parton et al., 2019; Zhang, 2021).

Social constructionists can therefore justify their focus on discourse. But critics argue there has been too much focus on language and representation at the expense of materiality, especially in how the physical body often disappears in an analysis of discourse.

Considered against our five **pou**, social constructionism:

- **values theoretical/conceptual thinking** in relation to social constructionist or poststructuralist philosophy. Researchers also often draw on topic specific theory or concepts, such as, Willig's (2011) discussion of healthism in our example above.
- **challenges taken-for-granted understandings** by reflecting on how we make sense of the world, and treating these understandings as social constructions that can be explored for the vantage points they offer or limit, from which alternatives can also be explored.
- **pays attention to issues of power and equity** when linked to poststructuralism or a social justice agenda, and with analysis that goes beyond "giving voice" by focusing on the social and discursive contexts that produce marginalisation.
- **moves beyond individualism** by de-centring the subject and focusing on meaning making between people (as represented in Figure 1.3.4). Individualism is also critiqued as a problematic discourse within psychology, and in relation to health (see [healthism discussion](#) in Riley et al. Chapter 1.4 for further details).
- **knowledge is produced in context** is a central principle of the social constructionist idea that knowledge is produced within and through people's available discursive contexts, thus the idea of context-free knowledge is an impossibility.

More-than-human theory

We use the term "more-than-human-theory" (herein "MTHT") to describe an eclectic set of interconnected theoretical approaches that are informed by a range of "post" frameworks, including **posthuman**, **post qualitative**, and **new materialism**. MTHT offers novel directions for thinking about issues that concern health psychologists. But as with all new forms of thinking, these ideas might feel difficult at first. If they are new to you, do not expect to understand everything at first; these ideas will become more familiar over time.

MTHT focuses on both discourse and the material world. Materiality includes human bodies, things that are non-human but human-made (e.g., technology), and non-human elements of the natural world. Discursive and material elements are conceptualised as co-produced through dynamically unfolding assemblages.

The term "**assemblage**" is used to conceptualise how a variety of components interact as part of a complex, open, dynamically unfolding, and (often) unpredictable system. Assemblages also interconnect with each other, or may be part of other assemblages (e.g., a hospital policy on patient care in a person's cancer diagnosis assemblage is co-constituted through its own assemblage, including other policy documents, civil servants, secure cloud servers, and so forth).

A health assemblage can include networks of psychological, biological, cultural, and social relations (Fox, 2011). Researchers choose what elements to focus on because, as an open system, the elements of an assemblage can be ever expanding (see text box below).

An abridged list of elements that might constitute a health research assemblage

- bodies and parts of human bodies, e.g., blood, sweat, limbs
- nonhuman animals
- traditional and social media
- documents
- technology (e.g., heart pacemakers) and the communities they enable (e.g., online patient support groups)
- buildings and their content (e.g., waiting room furniture)
- wider environmental elements such as air and sunshine

(from Lupton, 2019, p. 2002).

All the elements of an assemblage have vitality and agency, in the sense they can affect each other. Thus, even inanimate objects have agency, such as the way furniture in a hospital waiting room might illicit feelings of anxiety or comfort (e.g., Fadyl et al., 2020). This understanding of agency means assemblages represent dynamic, mutually co-constitutive processes in an entangled and unfolding process of **“becoming”**.

The term “becoming” is used to emphasise an ongoing, dynamic process. It can be contrasted with the word “being” which implies something finished or static. For example, we may think of a blood test result as a clear, bounded component of a health experience. However, through the lens of MTHT, we see it less as a fixed “thing” and more as a snapshot during its ongoing state of transformation, as blood moves from body to syringe, to chemical reactions in a lab, to digital data on a patient record. (For a discussion of becoming as a way to think about the student experience of work integrated learning see Terry [Chapter 3.2](#)).

Relatedly, the term **“intra-action”** may replace “interaction”, to emphasise how elements of the assemblage are not separate, pre-existing entities that subsequently interact, but are themselves produced through emerging relational entanglements that produce the boundaries of the components we might identify in an assemblage. As Barad (2007) explains, *“to be entangled is not simply to be intertwined with another, as in the joining of separate entities, but to lack an independent, self-contained existence”* (p. ix).



Figure 1.3.5 Representation of MTHT – the human is no longer in the picture, and the focus is on connections made in a process of becoming that are fixed momentarily in this snapshot. (Sarah Riley. [CC BY-NC 4.0](#))

What is reality? MTHT theorises a “relational process” ontology in which reality exists (and which, for some theorists, is all made of the same “stuff”), but it is constantly unfolding into new configurations, which means it is not stable or singular (e.g., Deleuze & Guattari, 1987).

What is the nature of knowledge for MTHT? One concept that can be used to address this question is “agential realism” (Barad, 2007). Agential realism is the argument that although there is a reality out there, we cannot completely observe it because:

1. observations are snapshots of a moving world, and
2. observations change the observed (see for example, the famous particle-wave double slit experiment in quantum physics).⁵

Knowledge produced in psychological research is thus relational, partial, and context specific. This contextualisation includes considerations of the research apparatus assemblage, including the researcher (Barad, 2007; Gibson et al., 2020; Rice et al., 2021).

Methodology: orients to examining meaning, materiality, and capacities for making connections and forming relations as produced through dynamic intra-action. In this myriad work, the focus is often less on specific elements, than on the affective flows between them. In part, this is because these flows create

5. The crisis of representation highlighted how psychologists could not be confident that the work they produced represented objective knowledge, even when they used the methods of natural science; in part, because they were people researching people. As Stainton-Rogers et al., (1995) argued – unlike in the natural science of geology, in psychology, the rock can look back. A separate, but related, challenge to researcher confidence occurs from quantum physics experiments like the particle wave double split experiment, which suggests observation changes outcomes; that in effect, the rock does look back. For further discussion on the implications of these experiments for social scientists, see for example, de Freitas (2016), or for an introduction to the experiment, see <https://youtu.be/DfQH3o6dKss?si=Xe9oYfkMwxZKXL6R>.

the possibilities for **becoming**, and because any element of an assemblage only momentarily takes that form in the ongoing dynamic process of becoming. Health relates to the capacities to form relations in an assemblage (Deleuze, 1988a, 1988b), since making connections increases capacities for action because more things are now possible (imagine a train system, the more train lines between the stations, the more various the journeys passengers can take).

MTHT methodology relates to questions such as:

- What relational connections, affective forces, and agential capacities are generated? (Lupton, 2019, p. 2002)
- How can we produce work that resonates as “intensely real” by disrupting our usual understanding of how things are? (Davies & Gannon, 2012, p. 360)
- What is made to matter, what matters and what is excluded from mattering? (Barad, 2007, p. 235).

Methods are multiple, but can include considering the topic of interest as part of an assemblage, and examining the affective flows associated with that assemblage, often with a particular interest in:

1. feelings, emotions, and bodily sensations, and/or
2. identifying what capacities for action are enabled or reduced.

Creative methods are encouraged, and composite stories/cases or other forms of creative writing may be used. Alternatively, researchers perform a thematic analysis on qualitative data, and then “thinking with theory” (Jackson & Mazzei, 2022), they explore how MTHT theory might provide further insights on those themes.

Quality criteria include:

- creating new insights that can radically shape understanding
- thinking with theory
- reflexivity, including how the research apparatus co-constitutes the findings. Reflexivity needs to be done in line with MTHT, because some ways of conceptualising reflexivity, such as facilitating unbiased analysis, are rejected (e.g., Davies & Gannon 2012)
- recognition that analysis is always partial and contextual.

An example of an MTHT cancer study

Locock et al.'s, (2016) Analysis of a cancer diagnosis assemblage

Article summary	Key points to note
"Diagnosis can be both a 'diagnostic moment', but also a process over time" (p. 85).	Centres a processual orientation
Narrative interviews with people with ovarian cancer were analysed to explore how procedural, spatial and interactional elements occurred before the formal diagnostic moment.	Different elements of an assemblage considered
The authors conceptualise a <i>diagnostic assemblage</i> to capture how individuals connect to, and re-evaluate, signs and events that come to be associated with their bodies.	Concept of assemblage used to think with theory Focus on process and connection
Patients describe being alerted to their diagnosis through interconnected "clues" including: • titles of patient reports (e.g., "pathology") • being moved to "the bad news" room • common sense ideas of how systems work (e.g., no waiting time to see a specialist) • waking with a sudden realisation.	Sensations in the body and non-human actants such as technology, documents, buildings, and norms are considered; these are given agency
Recommendation to consider "the ontological choreography" (p. 91) of complex systems that produces a diagnosis experience to facilitate better health outcomes.	No single element is predictive, and the network of elements and connections are relational Assemblage thinking, rather than focusing on individuals, such as patient-clinician communication

Evaluation:

MHTT offers exciting directions for thinking about the complexity of health, benefitting from centring materiality, including embodiment, as well as discourse. Truly novel insights can be produced, and the recognition of non-human agency can expand our thinking of ethics in relation to human responsibility to the nonhuman (Barad, 2007).

Not having a clear method opens possibilities for creativity, but paradoxically this can produce an orthodoxy as researchers replicate recognised models of success. Sometimes high theory — complex, abstract theoretical frameworks — might seem pretentious or disconnected from real-world issues. In drawing on 20th and 21st Century European/ European Settler philosophers, MHTT theorists have (to date/mostly) failed to engage with Indigenous knowing and scholarship, which have much longer histories of more-than-human thinking (Hokowhitu, 2020; Rosiek et al., 2020).

Considered against our five **pou**, MHTT:

- **values theoretical/conceptual thinking** in relation to an array of complex and contextualised “post” approaches
- **challenges taken for granted understandings** in multiple ways, including locating agency in the nonhuman
- **pays attention to issues of power and equity** in multiple ways, including reflecting on forces that can constrain or enable capacities for action, and highlighting human responsibility for affirmative relations with the natural world through recognising the vitality of all things (which also speaks to climate change)
- **moving beyond individualism** is a central feature of MTHT – the model of a relatively coherent individual is redundant, as there is no single pre-existing unit that has clear boundaries. The focus is not on individual thinking, interpretation, or discourse, as in the approaches discussed above, but on the affective flows within a dynamic assemblage
- **considering knowledge as produced in context** is a core concept because MTHT conceptualises knowledge as contextual and relational.

Kaupapa Māori theory and research

Chapter 1.1 described how Māori worldviews and mātauranga inform Māori understandings of health and wellbeing, and how these then inform Kaupapa Māori approaches to health research. Here, we draw on that discussion to outline Kaupapa Māori theory and research, including a recap on questions of ontology, epistemology, methodology, and the other ‘ologies important for Kaupapa Māori theory – cosmogony and cosmology. This section should be read in conjunction with Brittain and Kora [Chapter 1.1](#).



Figure 1.3.6 Representation of principles of the te ao Māori worldview. (Motu Economic and Public Policy Research Trust on behalf of the Just Transitions Aotearoa Group Copyright © 2023. Reproduced with kind permission)

We start with a discussion of **cosmogony**, that is, beliefs or theories about how the universe or the cosmos began. The Big Bang Theory (that the universe suddenly came into existence) is one cosmogonical theory. Other cosmogonies posit that something caused the universe to be birthed and that this was not spontaneous, but planned or created by a higher being. For Māori, like other Indigenous peoples, rich cosmogonical narratives have provided the conceptual basis for understanding and interpreting reality, and giving meaning and purpose to everyday life (Durie, 1997; Williams & Henare, 2009).

Cosmology is similar to cosmogony, but primarily concerned with the nature of the universe rather than the birth or creation of the universe. Cosmology studies everything to do with the universe from its origins to its end, its nature, its composition, and how these came to be.

What is reality? Māori cosmogony, cosmologies, and ontologies are holistic and relational, recognising our existence as humans as deeply interconnected with the natural and spiritual realms. Our present realities are shaped by that which has come before us, and that which is yet to come. In this way, reality spans across multiple dimensions and across time. As Brittain and Kora (Chapter 1.1) state, "... we recognise our existence as part of a whole, spanning physical and spiritual, across past, present, and future. Existence

does not begin, nor does it end with us.” Notions of spirituality and kin-centricity are foundational to these worldviews.

Epistemology: Knowledge to Māori is informed by the holistic and relational worldviews and values discussed above. Kaupapa Māori research recognises that all knowledge is subjective, according to the world views and value systems researchers prescribe to. Subjectivity in research is not a bad thing. Rather, values are instruments through which researchers (as with all people) can view, interpret, experience, and make sense of the world, and from which they cannot be disconnected (Marsden, 2003).

Knowledge comes in many forms, not just intellectual, and can also be **tapu** (sacred) and encoded to prevent its misuse by those for whom it is not intended. Knowledge is values-based, concerned with the “ultimate why”. Knowledge must be useful, a person’s knowledge (or data) is not ontologically separate to them.

Māori have lived in synchrony with the natural environment, observing and recording patterns in the environment over time and adjusting practices accordingly. “Observation” or “coming to know” for Māori is not limited to conventional Western senses like seeing, hearing, smelling, and tasting. The term rongo (sensing) is holistic and relational and means “to know or get to know through, not only by hearing but also, touching, feeling, intuition, or any other means” (Smith, 2000, p. 55). Being so attuned to the spiritual and natural realms, intuitive, participatory, and experiential ways of knowing are central to Indigenous Māori perspectives and understandings (Tassell-Matamua et al., 2021). For example, the puku (stomach) is where people feel intuition and instinct. People’s ability to understand and perceive tohu (signs, omens, indications) requires being attuned to what is happening in the environment, in those around us, or in our own bodies, and not rely solely on the mind for guidance (Beverland, 2023). Discussing the role of ngākau (the heart that feels) as an example of Māori senses, Takirangi Smith explains:

“Western knowledge systems are often premised upon the assumption that events occur and are conveyed by the senses to the brain where they are rationalized in the mind and stored. For Māori knowledge systems and other Pacific cultures with the same epistemological origins, memory and rational thought are perceived as occurring within the ngākau ... The ngākau is where thought is centralized and stored as memory” (2008, p. 266-267).

Methodology: Draws on understanding of knowledge based on aspects of a Māori worldview; under the maxim by Māori, with Māori, and for Māori.

Methods: A range of methods are used. Depending on the aims of project, these are informed by tikanga Māori (protocols and practices), often focusing on kia āta-kōrero (discussion) of practical, ethical, and spiritual dimensions, sometimes combined with participatory research or culturally valued practices of meaning making (e.g., story, song, weaving) (Pihama, et al., 2015). Research methods related to systematic observation and statistical analysis are also used (e.g., using health statistics to identify the impact of inequity). Data storage methods recognise Māori sovereignty over their data.

Quality criteria: Graham Hingangaroa Smith’s (2017) five tests of veracity for Kaupapa Māori research include:

- positionality: researchers locate themselves in time and space, explaining where one speaks from, and why one speaks
- criticality: Māori political, historical, and ongoing colonising contexts needs to be critically understood, to create a space for Māori language, knowledge, interests, and successful interventions. This includes taking a strengths based approach (e.g., Hawaiiiki et al., 2024)
- structural and cultural considerations: that include ways of changing people, but also the structural

impediments to Māori wellbeing

- “praxicality”: bringing theory and practice together, to create transforming praxis that is grounded in action and produced through ongoing cycles of action and reflection that tests theory against practical enactments
- transformability: positive outcomes for Māori need to be embedded within the research so that meaningful, impactful outcomes are produced, including enhancing self-determination.

An example of a Kaupapa Māori cancer study

Kidd et al.'s, (2021) Kaupapa Māori approach to lung cancer research.

Summarised Abstract:	Key points to note
“Community engagement is a key premise of co-design and is also particularly vital when carrying out Kaupapa Māori research. Kaupapa Māori describes a ‘by Māori, for Māori’ approach to research in Aotearoa/New Zealand” (p. 192).	Importance of collective collaboration By Māori, with Māori, and for Māori approach
“This article discusses the research process of Hā Ora: a co-design project underpinned by a Kaupapa Māori approach” (p. 192)(and the researchers undertaking it).	Explicit Kaupapa Māori approach Participatory method Researchers’ positionality
“The objective was to explore the barriers to early presentation and diagnosis of lung cancer, barriers identified by Māori” (p. 192).	Māori centred as source of knowledge
“The team worked with four rural Māori communities, with whom we aimed to co-design local interventions that would promote earlier diagnosis of lung cancer” (p. 192).	Collaboration and local contextualisation = meaningful knowledge Seeking to enhance Māori wellbeing/transformability thus enacting praxicality
Examples of findings: • Different communities had different ways of interacting with the researchers. • Context of mistrust of research due to history of racism. • Need to know tikanga (e.g., how to introduce themselves in te reo (Māori language) and build relationships (e.g., holding more than one hui (meeting).	Knowledge and practice occur at a local level, recognising the heterogeneity of Māori Structural considerations Cultural considerations
How research funding protocols are incompatible with relationship building or respectful relationships (e.g., providing supermarket vouchers as reciprocity/ thank you (koha) but being asked by the funders/university to restrict the ability to use them for alcohol).	Critical reflection on how wider institutions reduce ability for doing culturally appropriate work and reduce Māori sovereignty.

Evaluation:

Kaupapa Māori research offers a strengths-based approach to research with Māori that aligns both with Māori knowledge and practices and with Te Tiriti o Waitangi, a treaty between rangatira Māori (tribal chiefs) and British settlers and the founding constitutional document of Aotearoa New Zealand (see Brittain & Kora [Chapter 1.1](#)) which includes discussion of Māori rights to **rangatiratanga** (self-determination). Kaupapa Māori research is used to enhance Māori wellbeing and create novel solutions in health research. It is part of an exciting revival of Māori culture, a grounding force that enables Māori to bounce back from adversity better, as well as navigate the challenges of contemporary society more resiliently (Durie, 2001, 2011; Tassell-

Matamua et al., 2021). It is, however, hard to do within institutional settings that do not recognise or value te ao Māori and ongoing impacts of colonialism. As Smith has argued,

For most Māori and other Indigenous communities, we survive in contexts where our colonisation persists. That is, within unequal power relations between dominant others and subordinated indigenous populations. In Aotearoa, colonisation has not been overthrown, nor has it gone away. It not only remains ever-present, it is also resilient, continually changing into new forms. Indigenous communities need to remain in a state of preparedness to resist these shifting forces (Smith, 2017, p. 79).

Considered against our five **pou**, Kaupapa Māori research:

- **values theoretical/conceptual thinking** in relation to the complex and contextualised cosmologies and ontologies that are underpinned by mātauranga Māori.
- **challenges taken for granted understandings** through kia āta-kōrero (discussion), a characteristic feature of Kaupapa Māori research. In the light of colonisation, a further challenge to taken-for-granted understandings occurs when, as Moewaka-Barnes (2015, p. 31) explains, “Kaupapa Māori researchers ask, ‘whose truth?’ and ask ‘how it constructed’”.
- **pays attention to issues of power and equity** in the way Kaupapa Māori researchers recognise that power flows through relationships. Kaupapa Māori health research is especially critical of the legacy of colonialism in maintaining health inequities, and emphasises the need for Māori to determine and own the knowledge and power to make sense of themselves, which includes control over all aspects of Kaupapa Māori research.
- **moves beyond individualism** with a holistic and relatedness approach to knowledge, both because Māori are collectivist people, with multiple levels of social relations such as **whānau**, **hapu**, and **iwi**, and because **Kaupapa Māori** research considers the wider physical, social, cultural, political, historical, and spiritual contexts within which people are embedded (Durie, 2001).
- **considers knowledge as produced in context**. This is a defining feature for **Kaupapa Māori** research because knowledge is understood as relational and contextual, produced in, and through, the local physical and social environment. For example, different **iwi** may celebrate Matariki (the Māori new year) at different times, in part because of geographical regional differences in when the star cluster appears over the horizon, signalling a new cycle (see text box below).

Want to know more?

Living with star knowledge: An example of how knowledge is contextual for Māori

Read: Matamua, N. (2024). *Te-ia-o-te-Rangi: Exploring Tūhoe astronomical knowledge in relation to the localised environmental management of water*: A thesis presented in partial fulfilment of the requirements for the degree of Masters of Arts in Psychology at Massey University, Manawātū, Aotearoa New Zealand. Available at: <https://mro.massey.ac.nz/items/e3b9e0c7-2dcd-488e-824b-06a05bc9a71f>

Watch: Professor Rangi Matamua's YouTube channel, "[Living by the stars](#)"

Conclusion

We have discussed five approaches to the nature of knowledge, and, specifically, their implications for the kind of knowledge that can be generated in the service of health psychology.

Summary of our five approaches to the nature of knowledge and their associated methods

An objectivist scientific approach understands psychological factors related to health as located in the individual, discoverable through systematic observation designed to produce objective, value free, generalisable knowledge.

Phenomenology foregrounds the nature of psychological health knowledge in terms of the subjective, contextualised interpretation of health experience by the individual, accessed through in-depth qualitative methods that facilitate articulation, and interpretation, of experience.

Social constructionism and poststructuralism decentre the subject, conceptualising health as constructed through discourse. Methods are designed to identify the multiple discourses constructing health in a given social context, and their implications for **subjectivity** and practice.

More-than-human theories further decentre the subject, conceptualising health as produced through increasing capacities for the human and nonhuman to make connections within an unfolding discursive and material assemblage, with methods orienting to the study of affective flows shaping assemblages.

Kaupapa Māori approaches understand knowledge as holistic, and produced relationally through connections between the spiritual, physical, psychological, relations with others, and relations with the land – creating health as a vitality. Methods draw on a te ao Māori worldviews and are enacted in the service of Māori wellbeing.

Returning to our Chapter 1.2 discussion of the expression “the map is not the territory”, we note that these approaches to knowledge act like maps, offering different (and differently useful) perspectives for how to navigate the landscape of health psychology.

We can develop this metaphor by considering what kind of glasses we might wear to read a map. Just as different glasses (e.g., 3D, coloured, bifocal, etc.) shape perception, so too can applying different theoretical lenses to the epistemological maps that we have outlined above, including queer theory, critical race theory, crip and disability scholarship, fat studies, and so forth. Other traditions of thinking not covered here, such as Asian philosophies (Liu, 2017), add further potential lenses for health researchers.

When people use a map repeatedly, they can widen some paths, while abandoning others to become overgrown. In shaping practice, maps can therefore shape the landscape. Applied to health psychology, we

note that different epistemologies can fundamentally shape the ways that psychologists “produce” health. Valuing multiple ways of knowing widens our capacities for thinking—for taking different paths—as does experimenting with developing new ways of knowing (see text box below).

Epistemological innovations

New epistemological perspectives: Parker et al. (2023), for example, adopt and extend a trans epistemology to centre the voices and experiences of trans people in research about their own lives. Applied in a study of perinatal care services, their research challenged conventional knowledge structures that reproduce cis normativity, showing how it harmed trans people’s wellbeing. Further, considering the problematisation of fat maternal bodies in perinatal healthcare, Parker (2022) considers the range of complex interlocking oppressive social systems of power that shape fat people’s experiences of pregnancy, reimagining how “a counter story of pregnancy fatness informed by the framework of sexual and reproductive justice could draw on a holistic and arguably non-Western epistemological view of pregnancy health that takes account of the social, political, and cultural context of health, body weight, and parenting. It could draw on the knowledges afforded by a mātauranga Māori epistemology of reproduction and other Indigenous and cultural frameworks of reproduction (Le Grice 2014; Le Grice and Braun 2016; Parker, Pausé, and Le Grice 2019)” (p. 133). Such an epistemological shift positions fat pregnant people as valued, respected, with their pregnancies understood as socially and culturally located rather than inevitably problematic, as they are typically constructed in Western biomedical discourse.

Dual methodology: Researchers have taken the same data, conducted separate, parallel differently informed epistemological analyses, and then considered what can be learnt from the different vantage points these analyses offer. For example, phenomenology to explore lived experience, and social constructionism to consider the discourses that might have shaped these experiences (see for example, Baboulene, 2020; Black, 2023; Del Busso & Reavey, 2013; Willig, 2017).

Combining epistemologies to create novel approaches: “Post-phenomenology”, for example, shifts attention away from the individual as the originating site for interpretation, and onto the social structures that scaffold individual experience and interpretation. The “phenomenon known as ‘human consciousness’ does not take place ‘in’ the bodies of the human but ‘with’ the dense scaffolding of things that enables and shapes human thought” (Ash & Simpson, 2016, p. 62). However, this work is currently underdeveloped in psychology (for a notable exception, see Riley & Paskova, 2022).

Focus on ethics: Ethics and epistemology mutually shape one another, since epistemological questions such as “What counts as knowledge?” connect with ethical questions such as “Is this knowledge consistent with our notion of justice?”. For instance, **epistemic injustice** emphasises how certain individuals or groups can be unfairly discredited in their capacity as knowers, perpetuating marginalisation of certain voices, and affecting what knowledge and experiences are valued (Fricker, 2017). Epistemology thus shapes what we consider to be ethical practice, regardless of what approach we take. Some approaches explicitly connect ethics and epistemology (Barad, 2007), or argue that we should put ethics before epistemology (Hopner & Liu, 2021).

As the text box above shows, epistemologies are not fixed, objective, natural truths – new theories of knowledge develop, which, as the crisis of representation showed, often come from the positionalities of

researchers who offer new perspectives (Bell, 2018). So although a mark of quality research is that it is conceptually strong, which usually translates as conceptual coherence between ontology, epistemology, methodology, and methods, this should not stifle innovation.⁶

Knowledge Check



An interactive H5P element has been excluded from this version of the text. You can view it online here:

<https://oercollective.caul.edu.au/critical-health-psychology/?p=351#h5p-3>

Want to know more?

Watch:

Crenshaw, K. (2016, October). *The urgency of intersectionality* [Video]. TED Conferences.

<https://youtu.be/akOe5-UsQ2o>

Listen:

“Power”: In this episode of The Operative Word, an ISCHP podcast, Associate Professor Brett Scholz reflects on the power that we hold in conducting health psychology research and he encourages us to consider the role we, as researchers, can play as allies in partnering with community members. This episode also briefly mentions some work done by Dr Britta Wigginton and Dr Jenny Setchell on researchers’ positions as insiders/outside (ers) (<https://doi.org/10.1080/14780887.2016.1183065>).

“Psychology’s-Eugenics”: In this episode of The Operative Word, an ISCHP podcast, Dr Glen Jankowski challenges the discipline of psychology, to consider the ways in which discrimination and racism continue to be perpetuated by how we practise and conduct research. He argues for a focus on the effects of such discrimination for the health and wellbeing of people from BME (Black Minoritised Ethnic) groups. You can also visit his and his colleagues’ website: <https://bmepsychology.com/> for more information and resources.

Read: Tuhiwai Smith, L. (1999). *Decolonizing methodologies: Research and indigenous peoples*. Zed Books.

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6. Also see Chamberlain et al.’s (2011) discussion of how using multiple methods forces careful consideration of epistemology.

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1.4 Equity and power

SARAH RILEY; SIOBHÁN HEALY-CULLEN; SONJA ELLIS; GARETH TERRY; AND AORANGI KORA

Overview

In this chapter, we focus on issues of equity and power, as they intersect with how we conceptualise health. In so doing, we continue our critical reflection on the concepts we use by asking: **How do our concepts of health shape possibilities for in/equitable health outcomes?**

To address the above question, we start with the distinction between equity and equality. We then introduce a poststructuralist approach for thinking about relationships between power, meaning making, psychology, and health. From this, we consider “**healthism**”, a term used to describe an individualist orientation to health that makes it a personal responsibility. As a framework for understanding health, we discuss how healthism contributes to a culture of risk and blame, which can make health inequities appear fair or justified. We finish with ways we might work with, challenge, or destabilise this individualist orientation to health. Within each section, we thread through examples relating to health and weight—since weight is often treated as a proxy for health. In so doing, we cover the following learning objectives:

Learning objectives

1. Understand why equity issues are important for psychological work seeking to enhance health.
2. Critically reflect on how modern power works through psychology.
3. Evaluate healthism as a discourse of health.

Introduction

During New Zealand’s 2020 electoral campaign, electoral candidate Judith Collins described weight as a personal responsibility. When challenged, she argued that healthy eating was not “that hard” and that “we can all take personal responsibility” (1News, 2020). These comments were made in response to population statistics showing that Aotearoa New Zealand had the third highest adult obesity rate in the OECD (34% of the population, OECD, 2023), with Māori and Pacific peoples having higher rates than the national average (Ministry of Health, 2015). These statistics, and the politician’s response to them, can be contextualised within an entrenched “obesity epidemic” discourse circulating globally in health and public spheres. This discourse constructs fatness¹ as a significant population health issue, and the outcome of people making

1. We use the term “fat” instead of “overweight” or “obese”, to discuss these issues in the least stigmatising way we can (Cooper, 2010; Pausé & Taylor, 2021). As Calogero et al. (2019, p. 23), explain, “We use fat to describe a person, much as we would use tall, short, and thin... if we shun the use of the word fat, we validate and perpetuate the stigma this term evokes”.

poor choices that can be addressed through lifestyle change (Gailey, 2022; Gard, 2010). Collins was therefore simply reproducing normative discourses. Yet push back quickly followed.

The response that caught the public attention came from a social media post by Isoa Kavakimotu, a Pacific man who grew up in Auckland, whose photograph, along with his post showed him as visibly fat (see Figure 1.4.1).

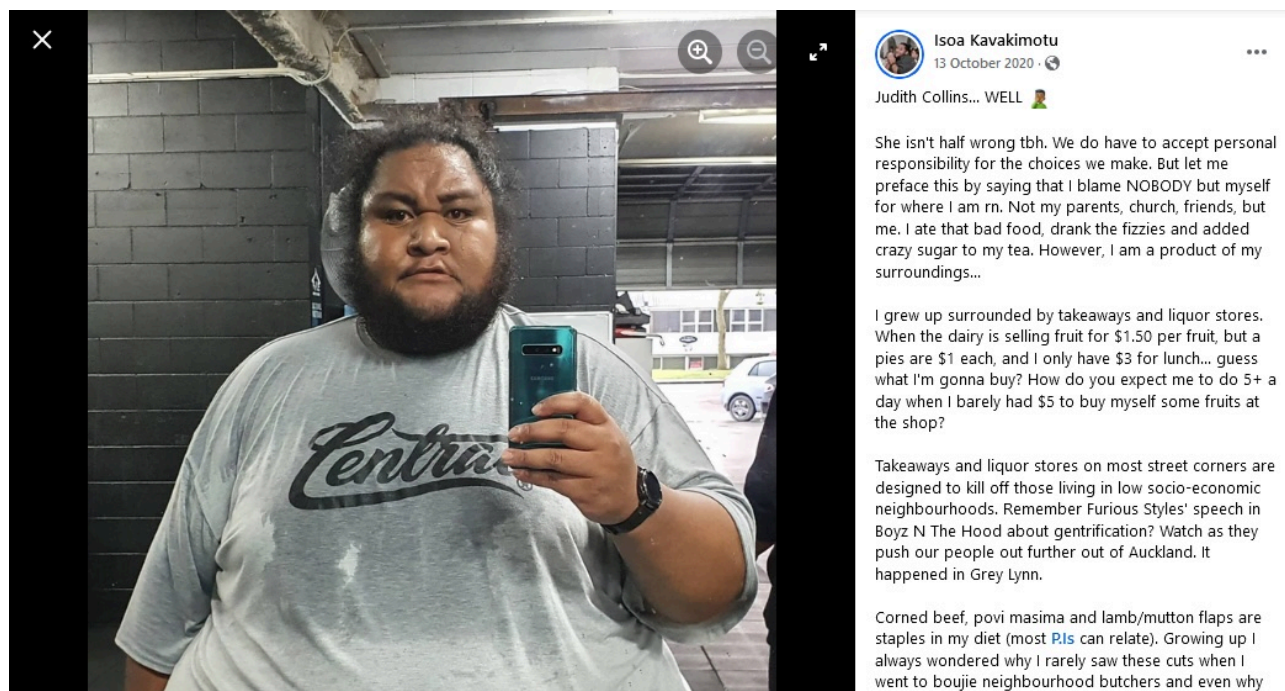


Figure 1.4.1 Isoa Kavakimotu's Facebook post responding to Judith Collin's comment that healthy eating was a personal responsibility. (Copyright © 2020 Isoa Kavakimotu on Facebook. Reproduced with kind permission).

While acknowledging the personal responsibility discourse, Kavakimotu highlighted social issues, such as the kinds of food, and the price differentials of healthy and unhealthy food that were sold in his neighbourhood, as well as how historic trade systems shaped the diet of Pacific Islanders.² See text box below for an abridged version of his post.

Excerpt from Isoa Kavakimotu's social media post

I grew up surrounded by takeaways and liquor stores. When the dairy is selling fruit for \$1.50 per

2. This issue continues today. Consider Samoa's attempt to ban the import of fatty cuts of "turkey tails" from the U.S.A. The ban was never implemented because of wider trade agreements, reducing Samoa's ability to implement policies designed to enhance population health (Thow et al., 2017).

fruit, but pies are \$1 each, and I only have \$3 for lunch... guess what I'm gonna buy? How do you expect me to do 5+ a day when I barely had \$5 to buy myself some fruits at the shop? [...] Judith Collins shouldn't be so dismissive because I'm out here trying to change my own relationship with food and taking responsibility for what got me here. But for her to say "don't blame the system" is bullshit because this was/is the system in play to enable the fattiest cuts of meat become staples of our diet, and be surrounded by heart attack food

You can read his [full post](#) on Facebook, and more posts from Isoa Kavakimotu, see [his Facebook page](#) and [his Instagram profile](#).

Kavakimotu's social media post received significant media coverage and a variety of positive responses (to date, receiving 27,000 thumbs up/heart responses on Facebook). Multiple expert and public voices followed suit, with social justice and equity arguments against the personal responsibility discourse. This Collins-Kavakimotu moment makes visible the multiple, and competing, constructs of health in our time. In this chapter, we consider these ideas in depth, starting with an examination of what we mean by equity.

Equality, equity and social justice

Equality is often treated as a taken-for-granted good thing, defined as treating people the same. In this logic, treating people differently becomes a taken-for-granted bad thing, since it is a practice of inequality. These ideas assume an equal starting point. But since people often do not have the same starting point, treating everyone the same often produces inequitable outcomes, which is why it is useful to make a distinction between equality and equity.

We understand this distinction in relation to physical issues. For example, we do not call it "equality" to expect a person who uses a wheelchair to take the stairs. But it can be harder to see how treating people the same in health contexts can reproduce existing privilege and marginalisation.³ To address that difficulty, the image in Figure 1.4.2 was designed to visually represent distinctions between equality and equity.

3. As Breheny (2020) argued, privilege is akin to a cyclist with the wind on their back, who attributes the extra momentum it gives them to their personal fitness.

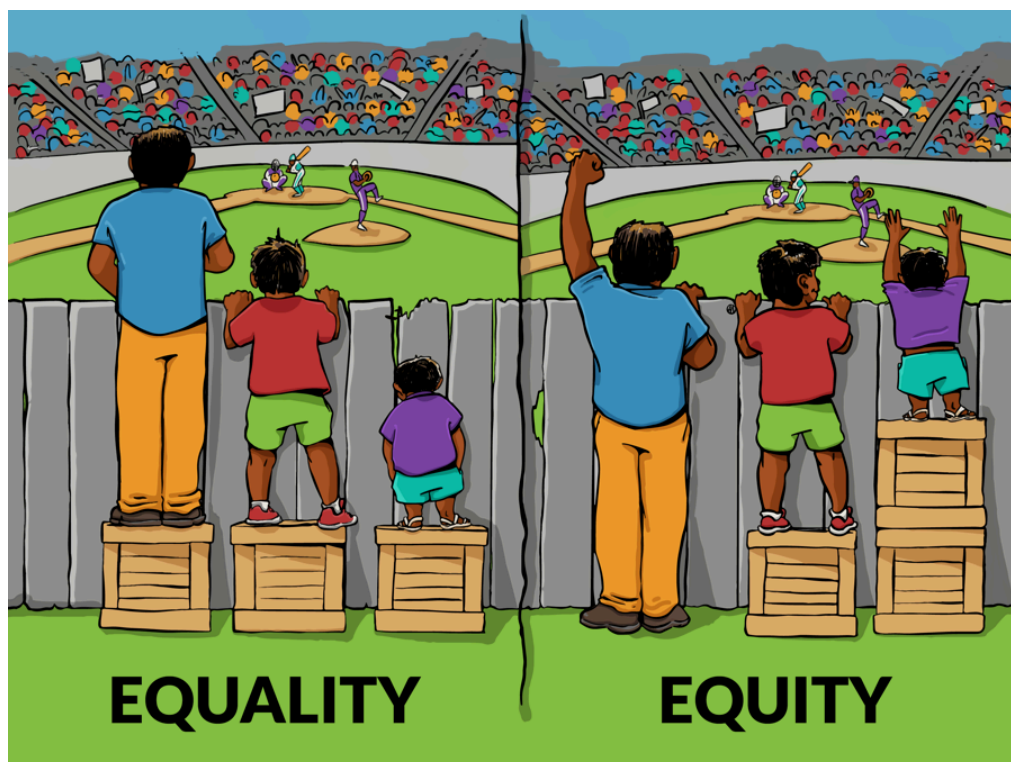


Figure 1.4.2 Image representing equality versus equity. ([Equality vs equity](#), Angus Maguire, Interaction Institute for Social Change. [CC-BY-SA 4.0](#))

It is therefore often useful to make distinctions between equality, defined as distributing resources equally, and equity, defined as distributing resources in relation to needs and outcomes. As the World Health Organization (2018) states:

Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. Health inequities are unfair and could be reduced by the right mix of government policies.

The COVID-19 vaccination rollout in Aotearoa New Zealand offers us a good example of such distinctions between equality and equity. In 2021, Manatū Hauora Ministry of Health rolled out a phased approach to Covid-19 vaccinations, similar to strategies used internationally. This approach prioritised vaccination for older people according to age brackets because they were at higher risk of severe illness if they contracted COVID-19 (The New Zealand Government, 2021). However, the focus on age, meant that the rollout overlooked intersecting ethnic differences in health needs. For example, in contrast to the majority **Pākehā**, Māori have higher mortality rates and manage more health conditions – disparities that are rooted in longstanding health inequities. Māori are thus less likely to be in the older age brackets, and when younger, are more at risk for developing severe illness if they contract COVID-19 (Hunt & Bradwell-Pollak, 2022).

The COVID-19 vaccination rollout example demonstrates why it is important to evaluate health policies, and practice, in relation to their risk of producing health *inequities*. We can expand the remit of critical health work further when connecting it to a **social justice** agenda, which includes dismantling entrenched social values and meaning making that perpetuate marginalisation (e.g., Bailey et al., 2024; Goodman et al., 2004).

To do this work demands strong critical evaluation skills. Figure 1.4.2 above, for example, is a highly circulated (and thus socially valued) image used to represent equity issues. But critical analysis highlights how it also reproduces the male norm (since the figures are male-presenting), White supremacy (the people who need help are brown), and a deficit orientation to the person who needs “help”, since there is no sense that the shorter person has strengths that could be leveraged (Ann Milne Education, 2021; Mind Reader, 2018).

Accordingly, people have experimented with creating images to represent these distinctions, such as how different size and shaped bodies can ride better on different types of bicycles. Others have focused on showing how fixing the system to enable equal access to opportunities is preferable to adding props to the system (like the boxes to stand on).

Activity: Thinking critically about equality, equity and social justice

Put the search terms “equality and equity meme” in an internet browser image search to explore the variations of these images – consider, which one do you prefer, and why?

Critical reflection is an important part of health psychology because it allows us to identify, challenge, or avoid practices that may seem fair to those managing resources, but which perpetuate marginalisation. Critical reflection also helps identify alternative solutions. It is therefore important that we have the tools for doing critical reflection on power.

The power of discourse

To be able to critically evaluate the way we frame health, we need to think deeply about discourse and power. For this task, the philosophical work of Michel Foucault⁴ is invaluable. Although many of his ideas had taken some form in prior feminist writing (Gavey, 2018), and were further developed by subsequent theorising, Foucault’s conceptualising of power as operating through discourse, and being productive, diffuse, and disciplinary, offers an important foundational framework for critical health psychology, as we outline below.

Discourse

In previous chapters, we have used the term “discourse” to describe broad forms of shared cultural sense making that construct an object, or issue, in a relatively coherent way. When doing so, we were drawing on

4. Hearing of Foucault’s alleged sexual abuse with children in Tunisia in the 1960s, we discussed whether to continue to use his work. We have taken our lead from Tunisian academic Haythem Guesmi (2021), who argued, “I am not calling for Foucault to be “cancelled” or the reports of his child sexual abuse to be used to attack his scholarly work and academia in general. But it is important to acknowledge that Foucault’s monstrosity had permanently changed the lives of many faceless and nameless Tunisian children and caused rippling traumatic effects in their lives.”

Foucault (e.g., 1977, 1978), who defined discourse as practices that systematically form the object of which we speak. From this perspective, health discourses do not neutrally describe what health is, but actively construct our idea of it:

“Discourses are thus relatively coherent ways of making sense of an issue, they govern how that issue can meaningfully be thought and talked about, which in turn, shapes what people might feel or do. Crucially, discourses are not neutral descriptions of the issue but bring it into being” (Riley, Forthcoming)

Productive power

Foucault distinguished between coercive and productive power. Coercive power is enacted when a person explicitly wields power over the other. Using a contemporary example, coercive power operates when a person cannot access healthcare until they lose weight.

In contrast, productive power operates when some ideas about the world, and the people in it, accrue greater cultural acceptance than others – we can think of this as power that produces particular understandings. Returning to our weight example, productive power occurs when **body mass index** (BMI) serves as a widely recognised, proxy measure for health (despite evidence challenging this simple notion; e.g., Bacon & Aphramor, 2011; Tomiyama et al., 2013, 2016).

Productive power renders issues (such as health) “knowable”, providing us with ways to make sense of them (e.g., related to weight) and suggesting ways to respond based on such sense making (e.g., weighing people). So, while productive power is not coercive, it is directive in the sense that it shapes how people see and operate in the world.

Applied to how we understand people, productive power is evident in “**subject positions**”, a term used to describe how discourses produce types of persons or roles that have associated ways of speaking and acting (Davies & Harré, 1990). When people occupy a subject position, they have a particular vantage point from which to understand themselves, or be understood by others. People categorised as “obese”, for example, report finding it hard to have their healthcare professionals consider any symptoms they report as not related to their weight (Pausé, 2014).

Power as diffuse

Foucault also argued that multiple agents circulate similar ideas, which makes power “diffuse”, that is, pervasive and dispersed. Diffuse power can be contrasted with top-down flows of power, such as directives from a singular identifiable source in an **autocracy**. Associations between health and weight, for example, are familiar to many because they are reproduced in multiple places, and by multiple people, including those in formal institutions related to health, government, or education; as well as in everyday interactions, health and lifestyle publications, social media, and technology (such as when upmarket electronic scales measure adiposity as well as weight).

Disciplinary power

Foucault used the term “disciplinary power” to describe how discourses provide the building blocks for

people's thinking, shaping their internal life (see the [Social constructionism](#) section in Riley et al. Chapter 1.2 on people being constituted through language).

Foucault used the panopticon prison design as a metaphor for disciplinary power (Foucault, 1977). With a central guard tower surrounded by well-lit prison cells (see Figure 1.4.3 below), the panopticon prison was imagined as one where there was always potential for a guard to be looking at a prisoner. Never sure if they were being looked at, the prisoners would thus act *as if* the guard was looking, in effect becoming their own guard.

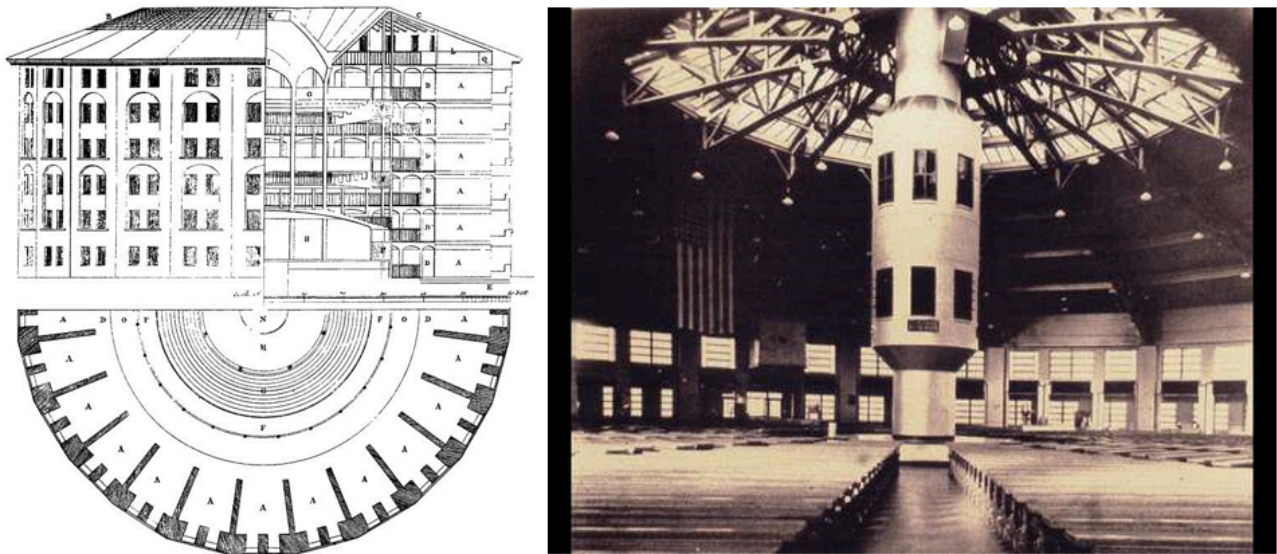


Figure 1.4.3 Two images of the panopticon – a plan and a realisation in Stateville. ([Plan of the Panopticon](#), Jeremy Bentham, Wikimedia Commons. Public domain (left); [Stateville Panopticon dining room, 1940s](#), Unknown author, Wikimedia Commons. Public domain (right))

Through the process of managing themselves within the norms set by the guard, prisoners in a panopticon would use these norms to think with. These norms were thus shaping their inner most thoughts and feelings, with a prisoner:

“...interiorising to the point that he is his [sic] own overseer, each individual thus exercising this surveillance over, and against himself. A superb formula: power exercised continuously and for what turns out to be a minimal cost (Foucault, 1980, p. 155)

Using the panopticon metaphor, disciplinary power describes how people manage themselves in line with dominant societal constructs, while often feeling like this is driven by their own desires. Norms, surveillance, and examination play an important part of this process:

- norms set expectations
- surveillance measures people against these norms
- examination identifies any need for intervention.

BMI health apps offer an example. Disciplinary power occurs when people download a BMI calculating app, and input their height and weight for the app to calculate their BMI. The app then examines them against

programmed norms regarding valued and problematised weight categories (e.g., underweight, healthy weight, overweight, or obese). If the app user's weight falls outside the “desired” range, the app offers a recommendation, and implied expectation, to change category status (e.g., by providing opportunities to “track your progress”). Such health apps add features to encourage motivation, such as celebration animations when people hit particular targets. Some apps may also put people in groups to hold each other to account. This technological architecture creates affordances related to practices of self-surveillance and examination against the (desired) norm of a “healthy” weight.

Desires for self-transformation

Such practices of self-surveillance, examination, and transformation highlight how people work on themselves to produce themselves into the image of their desires (Foucault, 1988). But people's desires for who they want to be are shaped by socially-shared meanings, especially those about what it means to be a “good” person or live a “good” life. Discourses and norms thus work “on and through desire” (Zabrodska et al., 2011, p. 710), directing us to understand that certain things, such as a BMI between 18-25, will bring us health and happiness. In our contemporary moment, **“good life” discourses** are often linked to self-transformation, creating an imperative to be continually working on oneself:

The transformation imperative is enabled by the idea that the body is malleable, and therefore can be transformed, if with the application of effort, money, skill and appropriate use of technologies and expertise (Riley et al., 2023, p. 50).

The transformation imperative has a hopeful, optimistic affective register, it connects with Foucault's idea of technologies of self, that is, things people do, “so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality” (Foucault, 1988, p. 18). However, these hopes can produce a form of “cruel optimism” when good life discourses direct people's desires towards things that may be unattainable or harmful (Berlant, 2011). One example is when restrictive or obsessive dietary and exercise practices are understood as “just healthy eating” (Lewthwaite & LaMarre, 2022, p. 1).

These ideas, about hope and cruel optimism, highlight the role of feelings and emotions in shaping our desires towards, and experiences of, understanding ourselves within a discourse. For example, discourses that associate health, weight, and “goodness” mean that people may feel joy, pride, anxiety, shame, fear, or distress when looking at their BMI calculator apps. These feelings occur, in part, because they understand their BMI as representing something important to them, and about them.

Discourses *about* feelings and emotions also have disciplinary power because they create “feeling rules”, that is, culturally prescribed norms and expectations about emotional expression (Hochschild, 1979; Wetherell, 2013). Feeling rules are often gendered, and as **intersectionality theory** argues, gender is always racialised (e.g., Collins & Bilge, 2020; Crenshaw, 1991). For example, women are valued for expressing positivity, which reduces their ability to express anger or other “problematic” feelings (e.g., Calder-Dawe et al., 2021; Orgad & Gill, 2021). For Black women, positive feeling rules can translate into desires to be seen as a “strong Black woman” who can face any challenge thrown at her, and be a source of support for others. The “strong Black woman” is an affirmative **subject position**, but it also individualises difficulties in Black women's lives, even when they are related to wider issues such as sexism, racism, cost of living, or existential fears like climate change. Expectations for emotional strength also deny legitimacy to difficult feelings (e.g., anger or vulnerability) and may reduce help seeking (Edeh et al., 2022; Graham & Clarke, 2021; Woods-Giscombé, 2010).

Key takeaways

So far, we have shown how Foucauldian theorising offers a conceptual framework for thinking about power as:

- productive, through discourses that construct how an object, issue, or person can be understood
- diffuse, when discourses circulate across a range of actors and media, and
- disciplinary, because discourses shape people's thoughts, and thus feelings and desires.

Possibilities for resistance

Agency and resistance can be enacted when people actively shift from one discourse to another. For example, rejecting a weight focused discourse for a weight inclusive one (Calogero, et al., 2019). (For further discussion on how people shift across discourses, see Chapter 1.2 section on [Social constructionist models of the person](#)).

But, often it is hard to resist entrenched discourses, and the norms they produce, because to understand oneself within a valued norm is to be able to recognise oneself as “a viable being” (Davies, 2013, p. 24). Think back, for example, to the potential for a person to feel pride when looking at the outcome of their BMI calculator app. It would be hard for them to say that this number does not matter, and if it really did not matter to them, they would have lost the possibility of understanding themselves in a culturally valued way.

Governmentality

In a variety of ways, organisations render people *knowable*, such as when they categorise people as requiring social support, eligible for healthcare, and so forth. People can draw on these organisational ways of knowing to understand themselves, shaping their desires towards wanting to be known within valued categories. This process of government-produced disciplinary power is known as “governmentality”.

Governmentality can occur as an outcome of administration. For example, census data designed for government planning creates—as a byproduct —different kinds of more, and less, valued categories of people (Miller & Rose, 1997). But, disciplinary power can also be *deliberately leveraged* to shape people's thinking and thus behaviour, so that to the people concerned, it feels like they are enacting their own free will:

What makes power hold good, what makes it accepted, is simply the fact it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression (Foucault, 1980, p. 119).

In the extract above, Foucault contrasts coercive power (*"a force that says no ... whose function is repression"*) to diffuse, productive power that connects to identity and desire (*"it traverses and produces pleasure, forms knowledge"*). For Foucault, modern power works by inviting people to understand themselves in particular ways, from which they will govern themselves. Governmentality thus refers to how organisations manage people through their psychology.

Government funded BMI calculator apps are an example of governmentality. These apps enact productive power (since they (re)produce the idea that BMI is a proxy for health), and they act as a form of governmentality, since they are made available to people to *choose* to download and use. Users thus participate in self-surveillance and understand it as empowerment.

We are not criticising people who find such tools empowering. The implication of Foucauldian approaches to power, is not so much that we should identify good or bad discourses, but to examine what capacities for action are enabled or restricted when discourses operate within particular contexts. Returning to our map analogy of Chapter 1.3, poststructuralist theories of power help sensitise us to the maps/discourses we are using to make sense of ourselves. They also lay the foundational work for thinking about the most entrenched map we have for thinking about health in our current moment, the map that was invoked by Judith Collins when she said weight is a personal responsibility, and the topic of our next section.

Healthism

The term 'healthism' is attributed to Robert Crawford (1980), a political scientist who outlined a range of interacting factors that produced our contemporary idea of health as personal responsibility and a product of lifestyle choice. Within healthism, health is constructed as a risk, which can be mitigated when people understand that their health is their responsibility and subsequently engage in on-going health-maintaining practices.

Developments in the 1970s in the USA were pivotal in producing the antecedents for healthism. Crawford (1980, 2006) highlighted how this era was characterised, in part, by an anti-establishment attitude, including feminist concerns of how patriarchal medicine ignored women's lived experience of their bodies. Antiestablishmentarianism was often linked to a highly individualist approach, as seen in the countercultural movements of the time, which sought self-actualisation through radical individualism (Curtis, 2011), and the rise of therapeutic cultures that directed attention to individual psychology (Illouz, 2007). The wellness industry capitalised on these cultural shifts, all of which intersected with the extension of medical issues into everyday life (**medicalisation**) and secularity, with its associated focus on the here and now (see Turrini, 2015, for more details).

The context outlined above was also shaped by neoliberal economics. Neoliberal economic policies focus on **deregulating industry** and allowing markets to determine flows of capital, with view to generating a self-adjusting economy and monetary growth. These policies radically shaped 1980s government policies across the globe, including Thatcher's Britain, Reagan's USA, Pinochet's Chilean dictatorship, and the "Rogernomics" of Aotearoa New Zealand. Now, neoliberal policies are pervasive and often taken for granted (Harvey, 2005).

Want to know more about neoliberalism in Aotearoa New Zealand?

Watch: Barry, A. (Director) (2015, April 15). *Someone Else's Country* documentary [Video recording].



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/critical-health-psychology/?p=262#oembed-1>

Listen: Juggernaut: The Story of the Fourth Labour Government, episode 2 "[The nation is at risk](#)".

[Embodied neoliberalism](#). Professor Antonia Lyons recounts some of the key points from the keynote address she delivered at the last ISCHP conference. Informed by her research programme on young adults' drinking cultures, she reflects on a broad range of issues including gender, social media identity curation, marginalised groups, and neoliberalism.

Read: Groot, S., van Ommen, C., Masters-Awatere, B., & Tassell-Matamua, N. (Eds.) (2017). *Precarity: Uncertain, insecure and unequal lives in Aotearoa New Zealand*. Massey University Press.

Important for our discussion on psychology, is that neoliberal economies need a particular kind of person, someone who:

- understands themselves to be responsible for their own destiny, who is not reliant on state welfare/ services, nor determined by social structures, such as class (Giddens, 1991)
- is risk-managing and self-monitoring and thus able to recognise fluctuations in the market and flexibly adjust accordingly (e.g., by re-skilling for an emerging market or being willing to move to areas of higher employment) (Beck, 1992; Kelly, 2006)
- who understands themselves as a project, and consumption as a route through which they can create themselves (thus meeting the needs of a consumer economy) (Giddens, 1991; Rose, 1998).

Neoliberal citizens are valued for their ability to live productive lives, when productive lives are linked to consumption, economic participation, and not being a cost on the state. Failure to do so represents individual failure.

Neoliberalism and health

When neoliberal logic is applied to health, as in healthism, people are **interpellated** (i.e., called on) to understand their health:

- as a personal responsibility

- as produced through their lifestyle and consumption practices
- as a risk to be managed through continuous self-monitoring
- as part of their project of self and a measure of whether they are a good person
- as part of their responsibility, as citizens, to live a productive life and avoid being a cost-risk to the state through ill health.

The power of healthism

Healthism has an optimistic tone. It constructs health as an achievable, stable state (if one works hard enough and consumes appropriately). By being linked to morality and citizenship, healthism offers the opportunity to understand oneself as a good person living a good life, and to be understood by others as so doing:

...in a health-valuing culture, people come to define themselves in part by how well they succeed or fail in adopting healthy practices (Crawford, 2006, p. 403).

But, seen through the lens of governmentality, healthism can be read as an enactment of power more closely linked to **cruel optimism**, as we discuss below.

Health becomes hard work, risky, and expensive

Within healthism, health is not a given, but a risk to be managed. This is for everyone, regardless of health status, since even when one feels healthy, there may be hidden problems potentially developing! The optimistic tone of healthism thus shifts towards anxiety. Healthism is also connected to a transformation imperative, and associated consumer practices to effect that transformation (e.g., expensive blenders and fruit to go in them) that require resources in time, money, and skills, and moving health out of reach for people without these resources.

Health is also hard work because it requires significant knowledge, “**responsibilising**” people to gain and keep up with medical knowledge related to health. This can feel hard in a complex health environment, with many experts and contradictory advice shared across traditional and social media, and a proliferation of practices people feel expected to do. This complexity means that alongside the importance of getting it right, there is difficulty in getting it right.

Ill health is stigmatised within a logic of blame

If a person does not look “healthy” (when health is read as a slim athletic body), or if a person is ill, then the implication within healthism is that they made poor choices, creating a logic of blame. For example, when psychologist Carla Willig had a potential melanoma, her friends asked questions that implied her responsibility (“Did you use a sunbed?”) (Willig, 2011).

Within healthism, ill health becomes read as a moral failure. This stigmatises ill health, reproduces the

mythical norm (discussed in [Chapter 1.2](#)), and casts any deviation from the “ideal”—including disability—as “a diminished state of being human” (Bailey et al., 2024, p. 348, citing Campbell, 2008, p. 44). This sense making therefore also produces an “eradication” discourse, where non-normative bodies are positioned as needing fixing, changing, or eradicating (Gillon & Pausé, 2021). It is through noting such eradication discourses that critical scholars consider healthism to be part of a continuation of the eugenics movement (Bailey et al., 2024; Klein, 2023).

The logic of blame can cause distress when people become ill (e.g., Robson et al., 2023), when those they care for become ill, or when they are too ill to care for their dependents (e.g., Parton et al., 2019). Furthermore, it can limit people’s engagement with health care when it connects to shame or stigma (Kashkari & LaMarre, 2024; Singh et al., 2012).

Relatedly, healthism underpins public health campaigns that place responsibility on individuals for their health behaviours, which can lead to stigmatisation, guilt, and shame (Lupton, 2014, 2016). See Figure 1.4.4 below. Such campaigns ignore the well-established links between health/wellbeing and broader economic, social, and cultural factors that shape health, masking the structural inequities that influence health behaviours, especially among marginalised populations (Sumibcay, 2024).



Figure 1.4.4 Image of graffitied public health poster campaign. (Accessed at [Cancer Research faces ‘fat-shaming’ backlash over obesity campaign](#). Campaign images reproduced with kind permission of Cancer Research UK)

Subjectivity

When health becomes an identity, people’s sense of self is shaped by how much they understand

themselves as adopting healthy practices, or being read by others as adopting them. An advantage of this, is that people might participate in health practices more, such as doing an extra walk, motivated by the sense of “doing health” or enjoying the subject position of a “healthy person”.

But when health is defined in terms of lifestyle choices that can be visibly read on the body, people’s sense of self can become wrapped up in appearance and self-scrutiny (Graham et al., 2017; Kristensen et al., 2016; Riley et al., 2019; Tischner & Malson, 2012). This opens possibilities for negative psychological outcomes or health practices, such as appearance-related anxiety, dietary restriction, and excessive exercising.

Practices of self-scrutiny can also be applied to others, producing a surveillance culture in which people scrutinise themselves and others, and watch themselves being scrutinised by other people (Riley et al., 2016; Robson et al., 2023). This, in turn, further heightens an internalised awareness in people of their own performance of a healthy body (Rysst, 2010).

Such dynamic, critical looking can also harm people’s relationships. Robson et al. (2023), for example, showed how couples applied health surveillance to their partners as well as themselves, as a form of “**relational healthism**”. Their work showed that healthism’s emphasis on surveillance, control, and discipline contravened relationship norms of support, acceptance, and respect for the other’s autonomy, creating contradictory demands for people when enacting loving relationships.

These subjective and relational effects are intensified when healthism intersects with gender, in particular, with postfeminism, a term that describes a dominant framing of femininity that:

renders the intense surveillance of women’s bodies normal or even desirable, that calls forth endless work on the self and that centres notions of empowerment and choice while enrolling women in ever more intense regimes of ‘the perfect’ (Gill, 2017, p. 609).

Postfeminism intersects with healthism, blurring the boundaries between health and appearance, and **interpellating** a range of feminine-identified people to understand that working on their bodies to meet normative constructs of feminine health/appearance is empowering. The outcome is a “**postfeminist healthism**”, a term that describes how work on the body and mind to meet cultural norms of feminine health and beauty, is understood as the route to living a good life, and being recognised as doing so by others (Riley et al., 2019, 2023). For example, aesthetic procedures are increasingly framed as not just a personal choice, but an act of self-care and an expression of self-worth, “because you’re worth it” (Pussetti, 2021; Riley et al., 2019, 2023). Relatedly, appearance concerns and diet cultures, which had become subject to public concerns regarding body image, got an affirmative rebrand through their connection to health (Cairns & Johnston, 2015), as seen the proliferation of images of women joyfully eating salad (see Figure 1.4.5 below).



Figure 1.4.5 A White, slim woman smiling while eating healthily. (Photo by [Pablo Merchán Montes](#), via Unsplash. [Unsplash licence](#))

Postfeminist healthism also shapes practices of health associated with masculinity, especially when binary concepts of gender intersect with a “masculinity in crisis” discourse that serves to distance men from feminised practices. This can include encouraging men to avoid salads, to participate in exercise regimes designed to enhance muscularity rather than (slender) flexibility, and even the public shaming of men with eating disorders more commonly associated with women (Riley et al., 2023).

Limited solutions

In the context of postfeminist healthism, solutions become individualised and individuals responsibilised. For example, in an article about healthy lifestyle in menopause (Mishra & Mishra, 2011), the nine-sentence abstract contained eight instances of modal verbs, such as “should”, “should not”, “must”, as well as the term “imperative”.

Individualised solutions, such as listing exercises people should do, rarely considers the social contexts within which people try to enact health. This is despite substantial evidence that the social determinants of health (see Table 1.4.1 below) have greater impact on health than individual lifestyle change (Barnett & Bagshaw, 2020; Hodgetts & Stolte, 2017; Wilkinson & Marmot, 2003).

The social context includes whether it is safe, or possible, to exercise; as well as social norms, such as how women often bear disproportionate responsibility for providing and preparing food for the family, further reducing their time for other activities (Fielding-Singh & Dmowska, 2022; Tischner, 2012). Research on the social context of people’s health practices also shows the many cost-benefit assessments that low-income families must make, which lead to them buying cheaper foods that are higher in fat, sugar, and salt. Such assessments are absent in the “individual choice” argument (Arlinghaus & Laska, 2021; Daniel, 2020;

Ward et al., 2013). Relatedly, Warin et al.'s, (2015) ethnographic study of Australians in a low socioeconomic neighbourhood targeted with a public health intervention on healthy eating, showed how a discourse of future risk of ill health mitigated by current lifestyle change required an orientation to the future that was not possible when people were living day to day.

Individual solutions also cause other issues when they intersect with culture. Greenhalgh and Wessely (2004), for example, describe how healthism has produced a middle class subculture⁵ of health recognisable in doctors' surgeries in the UK. This is linked to inappropriate requests or expectations that undermine the doctor patient relationship, including rejection of medical expertise for alternative medicine solutions and requests for referrals or treatments in the privatised sector that the doctor does not recommend.

Individual solutions cause different difficulties for more collectivist communities, since individual solutions go against cultural norms and practices, as shown in Kashkari and LaMarre's (2024) analysis of South Asian Muslim individuals' experiences of type 2 diabetes healthcare in Aotearoa New Zealand. Relatedly, notions of "personal responsibility" and "individual success" that underpin a healthism approach are antithetical to Māori perspectives on health. Further, when health is defined in narrow terms, disabled, fat, and racialised bodies, especially, are positioned as outside of health and undesirable, making places of self-improvement feel unwelcoming:

the fitness and leisure sector tends to capacitate bodies already imagined as able or capable and to debilitate or ignore those deemed unwanted, disposable, and non-vital (Bailey et al., 2023, 2024, pp. 351–352; also see Rinaldi et al., 2021).

Affect

Within healthism, health is hard work, exclusionary, complicated, and difficult, yet also a measure of a person and a valued identity. As an ongoing project of the self, even those who have "achieved" health can never be confident of sustaining this position. Such a context produces the conditions of possibility for a range of feelings, including, joy, pride, shame, anxiety, distress, dissatisfaction, and fear.

These feelings can tie people closer to the norms of healthism, in line with our discussion of disciplinary power above. Conversely, in the context of so many demands and practices, people, feeling exhausted or anxious can turn away from health (Crawford, 2006). These various feelings can also shape relations with others. For example, fat and skinny women report people commenting on their body in ways that make them feel uncomfortable or distressed, and the source of other people's envy or hatred⁶ (Riley et al., 2023).

Commercial solutions for health

An individualised lifestyle orientation to health that aligns with consumerism, will logically position consumer culture, and the associated commercial sector, as offering solutions to health. This logic puts commercial vested interests at the centre of health practices and interventions (Dutta, 2016), as when governments partner with companies like Weight Watchers (Cobiack et al., 2010; Mahase, 2020), or Coca-

5. The authors argue that culture includes "what people say they do, what they are actually observed to do, and the underlying (and often unconscious) belief systems that drive their behaviour" (p. 199).

6. We recognise that skinny and fat shaming are not equivalent because of the intense fat phobia shaping our societies. For further discussion, see the chapter "Shame" in Postfeminism and body image (Riley et al., 2023).

Cola sponsors anti-obesity initiatives in schools (Powell & Gard, 2015). The concern is that such public-private partnerships may:

- prioritise profit over public or individual health goals
- direct attention onto individual solutions for social problems
- promote products or services that are not necessarily beneficial to health, or are unhealthy
- connect health to products that may be unaffordable or unrelated to health
- shape discourses of health, and a healthy life, towards vested commercial interests
- elicit continuous desire for product rather than sating it with lasting solutions (thus feeding consumers back into cycles of consumption that meet the needs of capitalist profit generating systems).

Surveillance in health insurance policies

The integration of tracking apps with health insurance policies exemplifies Foucauldian ideas of power as operating through surveillance, norms, and examination. In Aotearoa New Zealand the public health system (Te Whatu Ora – Health New Zealand) provides only some services at no cost. Others are low cost through subsidies, and others still are paid fully by patients. In this context, many people have additional private health insurance to cover these gaps (Blumberg, 2006).

Some insurers collect data from wearable devices and apps on physical activity, sleep, and self-care (e.g., meditation), linking specific behaviours to rewards within insurance plans, and offering, for example:

... a science-backed health and wellbeing programme that gives you more out of life so you can start thriving. It shows you how healthy you are now, provides you with tools you need and offers rewards and discounts to keep you motivated along your journey (AIA Insurance, www.aia.co.nz, retrieved December 11, 2024).

This language frames health as an aspirational, quantifiable state of optimal functioning (“thriving”). By offering rewards and discounts to “keep you motivated”, the programme reinforces the idea that health is a personal (endless) journey tied to consumer choices. The programme also normalises specific health metrics (e.g., gym visits) as markers of a “healthy” life, measuring insurees against these norms, with incentives like discounts and rewards serving as a mechanism of power to encourage compliance.

Amongst joyful images of youthful, slim healthiness, the promise of “thriving” becomes a moral imperative. This can result in a range of affective responses (shame, guilt, anxiety) since the language used by the health provider frames those who cannot/decide not to participate as neglectful of their own wellbeing, or as choosing not to “thrive”. Siobhán experienced this tension firsthand when choosing health insurance. The external rewards were appealing, as was motivation to participate in healthy activities, even while she was concerned about how insurers were embedding surveillance into health policies, and the way these policies widen inequities by excluding those who cannot afford or access such technologies (Martani et al., 2019; Presset & Ohl, 2023).

Different kinds of solutions

Above, we have outlined problems with individualised health solutions. In this section we consider some directions for thinking about health, equity, and power that more strongly align with the **pou** of critical health psychology. These are:

- critically evaluating discursive constructions
- producing alternative discourses
- foregrounding the social determinants of health
- employing holistic constructs of health.

Critically evaluating discursive constructions

Above we have highlighted the problems of individualism in health, especially the personal responsibility discourse. And so, we start this section by suggesting caution about its use. As illustrated by the supportive response to Kavakimotu's post, people are pushing back against the personal responsibility discourse that dominates discussions about health. Relatedly, popular culture also offers a site for critical, and humorous, responses to dominant constructions, such as the “women laughing alone with salad” memes that parody postfeminist healthism (see Figure 1.4.6 below).



Figure 1.4.6: Examples of the “women laughing with salad” meme (Meme creator unknown, [When your salad keeps making jokes](#))

We note that Foucauldian theories of power emphasise how all discourses open some possibilities while closing others. The complexity of the discursive space means the consequences of discourses in shaping capacities are unpredictable (Hook, 2001). Aligning with our critical health psychology **pou** of knowledge in social context, the implication of what we have discussed is that we need to identify and critically evaluate the discourses we use when working in health psychology. Further—in an ongoing way—we need to assess them for their potential to enable health or perpetuate marginalisation, stigma, pathologisation, and othering. See text box on “nudge” below for such a discussion.

What is nudge? By Paulina Bondaronek

Nudging involves interventions that change people's behaviour in predictable ways by modifying how choices are presented (choice architecture) to encourage healthier or more favourable decisions while preserving freedom of choice. For example, placing fruit at eye level in a supermarket is a nudge, but banning junk food in hospitals is not. As Thaler and Sunstein (2009), who coined the term, state: “To count as a mere nudge, the intervention must be easy and cheap to avoid” (p. 6).

Nudge theory has attracted significant interest among policymakers and is grounded in dual processing theories. These theories, popularised by Daniel Kahneman's (2011) book *Thinking, Fast and Slow*, distinguish between automatic, fast processing (System 1 – based on feelings, habits, instinctive responses) and controlled, slow processing (System 2- reflective, logical, problem-solving and planning). Nudges target System 1 by simplifying decisions, making healthier choices more intuitive and less effortful.

Practical applications of nudge theory in public health

Examples of nudge interventions include using traffic light labels to highlight healthy choices. Signs encouraging stair use, visible bike racks, offering smaller glass sizes for wine, prominently placing non-alcoholic drinks, implementing graphic warning labels on cigarette packaging to deter smoking, and making organ donation opt-out are other strategies (Arno & Thomas, 2016; Landais et al., 2020). With attention to context, these interventions can have an impact on physical activity and diet.

Criticisms and ethical concerns

Nudging can undermine autonomy by subtly influencing choices without individuals' awareness, raising concerns about manipulation of the decision-maker. Additionally, covert nudges can lead to decisions made without informed consent, potentially causing regret and distrust. Furthermore, the predictability of nudges is not always guaranteed; they may backfire, causing reactance or other unintended negative outcomes, which complicates their ethical application. For example, if a cafeteria prominently labels certain items as “healthy” while implicitly labelling others as “unhealthy”, this can lead to reactance, where people deliberately choose the less healthy options as a form of resistance against the perceived control (Kuyer & Gordijn, 2023; Sunstein, 2015).

Consideration of ethical concerns also needs to be contextualised within our wider capitalist context, where commercial interests already structure choice architecture. We are constantly “nudged” but who is nudging most effectively? Nudge interventions therefore do not occur in a truly “neutral” environment. In this context, do we need stricter regulation of commercial practices that exploit our automatic responses (System 1) before we nudge?

Equity and power in the context of nudging

As indicated above, promoting healthy behaviours through nudging is challenging when commercial interests shape choice architecture, exploiting System 1 to create desires for unhealthy options in the first place. This can lead to interventions that fail to address underlying inequities, such as the broader socioeconomic context that relates to access to resources and health literacy. For example, unhealthy food outlets are more common in poorer neighbourhoods (“food deserts”). As discussed earlier in the chapter, not only does this undermine efforts to increase healthy eating through nudging, but it can facilitate a logic of blame where poor people are framed as making poor choices.

A critical health psychology approach might therefore accept that nudging can be a useful tool for health psychology, but only in the context of careful reflection, which includes (1) who is doing the nudging, (2) the ethical values underpinning the intervention (e.g., if eliciting shame is considered appropriate), and (3) the power relations creating the context for the need to nudge in the first place, and if these should be addressed instead or as well.

Discussion point

Thinking of a health issue that you would like to change, reflect on:

- the choice architecture it is embedded in
- the System 1 and 2 elements that are involved in this architecture.

With this knowledge, what sort of intervention would you design?

Producing alternative discursive constructions

Paying attention to discourse involves not just challenging taken-for-granted discourses about body/minds, but exploring alternatives. Fat studies scholars have, for example, rejected seeking to define what health “is” (which tends to stigmatise fat people), and instead, ask affirmative questions around “How can we promote health for fat people”? (Burgard, 2009).

Another example of reframing comes from Warin et al.’s, (2015) ethnographic study of Australians in a low socioeconomic neighbourhood targeted by a public health intervention on healthy eating (discussed above). The researchers challenged the dominant narrative that such people were failing to focus on the risk of future ill health. Instead they highlighted poor people’s innovative strategies for survival in the present, and the responsibility of public health interventions to recognise the socioeconomic and material contexts within which people make decisions, and tailor interventions accordingly.

People participating in online health cultures can also resist healthism through role modelling of alternative, relational care practices that recognise a collective vulnerability and centre responsibility for care of others (Toffoletti, et al., 2025). Participatory research, and collaboration, is another way to shift the discourse, since it enables the people targeted by health policies and practices to contribute to the services designed to support them (NICE, 2007; Szaflarski & Vaughn, 2015; Taylor & Hanefeld, 2021).

Decolonisation also involves opposing taken-for-granted discourses by illuminating, and challenging, the ongoing implications of colonialism on health and wellbeing (Hawaiiiki et al., 2024). Decolonising psychology involves kōrero (conversations), listening, and unlearning ingrained beliefs and practices. Listening requires non-Indigenous people to hear perspectives that may be new or different, and which may be difficult to hear at first, especially if they challenge taken-for-granted knowledge (see [Introduction Part One](#) for distinctions between lovely and difficult knowledge). By “unlearning”, we mean the active identification

and resistance of internalised colonial logics that position Indigenous knowledge and peoples as inferior or deficit, and simultaneous engagement with Indigenous thinking that can widen the discursive framing of health issues. For example, in their article exploring Kaupapa Māori perspectives of fatness and health, Gillon and Pausé (2022) discussed how words in te reo Māori (Māori language) that are associated with fatness widen discursive possibilities for value and pleasure. For example:

“mōmona”, which is often used for the word fat, however it also means in good condition, rich, fertile, nourished. Also, to “whakamōmona” is to make something fat, to enrich it, to nourish it (Gillon & Pausé, 2022, p. 13).

Re*vision projects that shift the discourse

Re*vision, Centre for Art and Social Justice (<https://revisioncentre.ca>), has undertaken a range of projects seeking to widen possibilities for thinking about fat, Indigenous, and disabled ‘crip’ bodies that challenge harmful weight stigma discourses. Examples of projects include:

1. *“Through thick and thin: investigating body image and body management amongst queer women in Southern Ontario”*. The project included a video story *“My Mi’kmaw body”* by a participant whose statement “I have a proud survivor’s body”, explains how her weight represents the strength of the Indigenous Mi’kmaw people to survive extreme (social and environmental) conditions because they could store fat well.
2. *“ReVisioning Fitness”* also made short videos centring the lived experiences of trans, non-binary, queer, Black, radicalised, disabled, and fat/thick/thick/curvy people’s fitness-related experiences and inventiveness. Their aim was to reimagine fitness spaces that could centre and celebrate difference and unsettle “white supremacy in fitness” (p. 353). As one participant explained:

My intention was as a Black and plus sized woman, to let people know, who are like me, that they are not alone. And for [white, thin, able-bodied] people who dominate the gym space to realize what they are doing. Sometimes they might not realize what that does to someone. And my video doesn’t just target Black plus sized women, but everyone who feels uncomfortable in the gym (Bailey et al., 2024, p. 358).

3. *Worlding Difference* is an open access online platform filled with counter hegemonic knowledge about bodymind difference, built by, for, and with difference. It invites visitors to imagine new accessible worlds and ways of being together, offering an entry into crip culture, desiring neurodiversity, aging vitalities, and counter-culture making as resistance. It contains contributions from 200 artists, academics, and community members.

Foregrounding the social determinants of health

An important way people can challenge taken-for-granted discourses that individualise health is to focus their work and interventions on the social determinants of health (see textbox below).

List of the social determinants of health as outlined by WHO (2024)

Income and social protection
Education
Employment and job security
Safe and fair working conditions
Food security
Housing, basic amenities, and a safe living environment
Support for early childhood development
Social inclusion, equity, and non-discrimination
Peaceful and cooperative societies/nations
Access to affordable health services of decent quality.

A social determinants of health approach often means promoting health widening capacities and capabilities of people by focusing on the social and environmental levels. One example is ensuring safe environments for physical activity by addressing adequate lighting and footpath infrastructure (Stephens and Breheny, 2018). Acknowledging colonisation as a social determinant of Indigenous peoples' health, including Māori, also recognises the long-lasting impacts of historical events and offers broader understandings of health status.

Racism's impact on pregnancy outcomes

This excerpt from [When the Bough Breaks](#) explores the impact of racism on pregnancy outcomes. It illustrates how a lifetime of exposures to racism can literally get inside the body and affect the health of new-borns. Those from lower socioeconomic groups are also at greater risk of poor health due to factors such as poor-quality housing, hazardous work conditions, and other risk imposing environments that no amount of investment in self-improvement technologies will mitigate.

The social determinants of health approach highlights how people on low incomes may be more likely to eat highly processed, (often) cheap food as a matter of necessity rather than choice, when healthy diets including fresh fruit, vegetables, wholegrains, and lean meat are unaffordable and unavailable (Bowen,

et al., 2019). These **obesogenic environment** arguments have gained traction in recent years and offer important directions for social and policy interventions (O'Dea et al., 2007; Sushil et al., 2017).

However, care should be taken about the idea that people will make “good” consumer choices when facilitated to do so (i.e., when healthy food is affordable and available), since this argument ignores psychosocial and affective aspects of eating. For example, people often enjoy eating sugary/fatty foods. This pleasure can relate to the sensation of taste, but in the context of poverty, it may be one of few pleasures available (Ngawhika, 2020; Warin et al., 2015). Sweet/fatty foods are also often part of valued cultural practices and markers of identity, developed when calories were hard to access, but made risky when traditional ways of eating intersect with industrialised food supply systems (Thow et al., 2010).

Within the social determinants of health, therefore, we also need to consider the commercial determinants of health. The “commercial determinants of health” refers to the influence exerted by commercial actors, such as industries involved in the production and marketing of goods and services related to health, as well as those providing solutions to health problems.

Examples include the alcohol and food industries, whose marketing practices, product formulations, and lobbying efforts can profoundly shape public health outcomes. For instance, the promotion of unhealthy food and beverages contributes to rising rates of obesity and diet-related diseases (Kickbusch et al., 2016; Stuckler et al., 2012; also see the “Commercial solutions for health” section above and the Podcast with Antonia Lyons in the “Want to know more about neoliberalism in Aotearoa New Zealand?” section above.

The digital determinants of health

In this mix, we also highlight the importance of challenging the individual choice discourses embedded in the roll out of digital health technologies. As digital health technologies—such as health tracking apps and wearable devices—become increasingly integrated, already underserved populations may be further marginalised through inequitable access to these technologies. For example, those with low incomes may not be able to afford the technology, or the data required to use them, reducing their ability to participate in “the digital health ecosystem” (Lupton, 2017, p. 2; Lupton, 2022).

Jahnel et al. (2022) describe this phenomenon as the “digital rainbow”, whereby interlocking factors such as socioeconomic status, housing, healthcare services, and so forth, come to bear on people’s use of digital health resources, shaping health outcomes. They offer an example of the German COVID-19 warning app (Corona-Warn-App, CWA). Usage analyses of the app highlighted significant social stratification, partly because the languages of major immigrant communities, who were overrepresented in high-exposure public-facing jobs, were not available on the app, exemplifying how digital determinants can deepen health inequities.

Others highlight how the dominance of Western sensibilities in digital health technology means that consideration of Indigenous peoples’ cultural needs is rarely incorporated into the designs. For Indigenous people, this increases the risk of digital exclusion, inadequate care, and loss of sovereignty over their health data (Choukou et al., 2021; Cordes et al., 2024; Naderbagi et al., 2023).

Holistic constructs of health

Holistic constructs of health also offer alternatives to the individualistic focus of healthism. Māori models, such as the Meihana Model (Pitama et al., 2007, 2017), for example, highlight how health is produced through multiple, interconnected elements. These include the four described in Te Whare Tapa Whā model (Durie, 1985), namely aha wairua (spiritual wellbeing), taha tinana (physical wellbeing), taha hinengaro (psychological/mental wellbeing), and taha whānau (family wellbeing), but also other elements, such as

those that account for the historical and social context of Aotearoa New Zealand, including the ongoing impact of colonisation, migration, marginalisation, and racism for **whānau** (see Brittain & Kora [Chapter 1.1](#) for further discussion of these models⁷). Holistic models emphasise how health is contingent on all these elements and the dynamic interactions between them; and that what impacts one element, impacts all the others. For example, strong connections to **whānau**, **whenua**, and **whakapapa** can be spiritually, mentally, and emotionally healing while dis-connection from those same dimensions can have the opposite effect. Relatedly, Gillon and Pausé explain:

Evident in te reo Māori, the Māori language, is the complexity of health. “Hauora” is a Māori word often used for health and wellness. Hauora also means to be fit, well, healthy, vigorous, in good spirits. The word “hau” is understood as vitality, vital essence, and “ora” is understood as well, safe, cured, to be alive, to recover, to be healthy; ora is vitality and ora is life ... This highlights the ways in which health for Māori centers not only around cultural and holistic interpretations, but also, anti-oppressive notions of wellness, for example, ensuring Māori live sovereign lives, exercising agency and self-determination (2021, p. 11).

In this quote, we see not just the interconnectedness of multiple factors shaping health, but an extension of what these factors might be, which goes far beyond individual lifestyle choices, and towards explicit considerations of power. An important contribution to these debates is offered by Warbrick et al. (2016, p.394), whose article showed the harm that an individual, weight-centred orientation to health can do to Māori, and which offered, instead “a new epistemology for Māori health” that included how Māori would recognise the significance of the land supporting the house in the Te Whare Tapa Whā model, and the importance of centring land and culture in health interventions. Describing the approach taken by Ihirangi Heke in his work to improve health in sedentary and “overweight” Māori communities, the authors explained:

Heke’s focus was not to ‘help’ people lose weight, but to connect these individuals, all of whom were Māori, to ancestral lands; their mountains, rivers, and forests. In the process, individuals and families came to know these culturally significant locations, which are an inseparable part of cultural identity and health, more intimately. The actual physical activity and subsequent changes in health and weight achieved in the process of ‘reconnecting’ became secondary to a far more meaningful and arguably healthier focus. Presenting physical activity as a means to enhance cultural identity or conversely, cultural identity as a means to enhance physical activity and linkages to significant aspects of ones environment by running up culturally-significant maunga (mountains), and swimming in genealogically relevant awa (rivers) has led to enhanced health and well-being, without focusing individual efforts on weight and weight loss (Warbrick et al., 2015, p. 14).

Conclusion

In this chapter, we have centred the **critical health psychology pou** of power and equity. We started

7. We also note that to fully engaged with these holistic constructs, we need to be mindful of Hokowhitu’s (2014) critique of how Māori health models are problematically assimilated in Western discursive frameworks when we are not cognisant of the complex, unique cultural meanings represented in these words. For example, he is critical of how wairua becomes translated as spirituality, missing its quality as a “a sub-atomic global essence that pervades all things, both living and inanimate” (p. 53).

by discussing distinctions between equality, equity, and social justice, from which, we emphasised the importance of critical reflection on health practice and policy to avoid reproducing inequities and injustice. We then presented important tools for critical reflection from Foucauldian poststructuralist theories, which understand power through the concepts of:

- discourse (relatively coherent ways of understanding an issue, which produce the concept rather than describing something already in existence),
- power as productive, diffuse, and disciplinary,
- power as operating on and through psychology by shaping subjectivity, desire and affect,
- governmentality, in which disciplinary power is leveraged in order to have citizens manage their own behaviour in ways that meet the needs of the state.

Having set up this foundational theoretical framework (and addressing our **pou** of valuing theoretical/conceptual thinking), we applied it to health, identifying “healthism” as a language of governmentality that:

- produces a narrow construct of health (often related to being slim, White, young or young looking, able bodied, and in full health),
- individualises health as a personal responsibility,
- connects health to consumerism, neoliberal citizenship, and expectations for continuous self-transformation as part of living a good life.

Addressing our **pou** of challenging taken-for-granted knowledge, our subsequent critique of healthism as a dominant construct of health addressed the question we posed at the beginning of this chapter, namely, “How do our concepts of health shape possibilities for in/equitable health outcomes?”. We did this by showing how healthism makes health hard work, expensive, and risky. It produces a space of anxiety for those who can achieve it, while being out of reach for people with non-normative bodies, including fat and disabled bodies. The optimistic tone of healthism thus easily collapses into a form of cruel optimism, within which shame, anxiety, fear, and stigma circulate.

Having highlighted the limitations of healthism as an individualised construct of health, crystallised in the “personal responsibility” discourse, we finished the chapter through addressing our **pou** of moving beyond individualism, by considering the importance of:

- critically evaluating discursive constructions, and how they are used in context, for the possibilities they enable and limit
- foregrounding the social, commercial, and digital determinants of health
- holistic constructs of health in Indigenous world views.

Throughout we have addressed our **pou** of considering knowledge as produced in context, for example, showing how healthism developed into a dominant discourse through multiple intersecting factors, including the responsibilising of citizens within neoliberal economies. This chapter completes our review of foundational thinking in critical health psychology. We have taken you through a lot of ideas, some of which may feel exciting, some may feel overwhelming (maybe both at the same time!).

In the next two chapters we hope to move you fully into an exciting space, as we apply the **five pou of critical psychology**, and all the associated theoretical work that we have done so far, to understanding how people experience illness (Chapter 1.5) and experience treatment (Chapter 1.6). We also note how the foundational concepts we have covered here will be picked up and developed in [Part Two \(Approaches to understanding health and illness\)](#), and [Part Three \(Doing critical health psychology\)](#).

Knowledge Check



An interactive H5P element has been excluded from this version of the text. You can view it online here:

<https://oercollective.caul.edu.au/critical-health-psychology/?p=262#h5p-4>

Want to know more?

Watch:

- Leiden University – Faculty of Humanities (Director). (2017, October 19). *Chapter 2.5: Michel Foucault, power* [Video recording]. <https://www.youtube.com/watch?v=keLnKbmrW5g>
- Curtis, A. (Director). (2011). *All Watched Over by Machines of Loving Grace* [Video recording]. BBC. <https://www.bbc.co.uk/programmes/b011lvb9> (also available to watch: <https://watchdocumentaries.com/all-watched-over-by-machines-of-loving-grace/>)
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Listen:

- West, S. (2018). Michel Foucault. *Philosophize This!* [Broadcast]. Retrieved December 11, 2024, from <https://www.philosophizethis.org/search?q=foucault>
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Read:

- Chapter 2 “Weight”, in Riley, S., Evans, A., & Robson, M. (2019). *Postfeminism and health: Critical psychology and media perspectives*. Routledge. Available open access at: <https://library.oapen.org/handle/20.500.12657/77181>
- The Routledge *critical approaches to health* book series is produced in association with the International Society for Critical Health Psychology (ISCHP) and covers a range of topics, several of these books are also open access. See the book series website for further details: <https://www.routledge.com/Critical-Approaches-to-Health/book-series/CRITHEA>

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1.5 Experiencing illness

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Overview

In this chapter, we address the question: **How do people experience illness?** We start by considering how we make sense of illness and the elements that shape this highlighting the importance of the social context. This discussion also provides foundational understanding for [Part Two](#) of this book, which focuses on illness and diagnosis. We then introduce the concept of “illness narratives” to show how stories provide a resource for people to make sense of illness, as well as shaping possibilities for that experience. We follow this with a discussion on “biographical disruption”, a term that describes how the onset of illness can profoundly interrupt a person’s sense of self and relations with others, requiring them to craft new stories about themselves. We finish with the limits to biographical disruption as a concept by discussing how social and economic factors shape illness expectations. In so doing, we cover three learning objectives:

Learning objectives

1. Understand the importance of the social context in how people experience illness.
2. Explore how illness impacts people’s sense of self and the narratives that they can tell about themselves.
3. Critically reflect on the social contexts that shape those narratives.

Introduction: making sense of illness and the elements that shape it

Illness is a subjective experience, related to feeling unwell, being ill, or having symptoms considered a medical issue. As Amzat and Razum (2014, p. 29) explain, “illness is the lived-experience of a diseased condition”. Illness is therefore a holistic experience, and is likely to encompass:

- **embodied sensations** (e.g., pain or physical discomfort) that brings the body into consciousness
- **identity issues** (such as a challenge to one’s sense of self as healthy or independent)
- **social aspects** (e.g., greater dependence on others, isolation, or becoming the recipient of different responses from others, such as, greater care, sympathy, judgment, or pity)
- **economic aspects** (if it effects a person’s income).

Typically, illness reduces the functional capacities of a person, which, in turn, can be experienced as traumatic. For example, Swartzman et al.’s (2016) meta-analysis (of mostly Global North studies) showed that post traumatic stress disorder is more common in survivors of cancer than it is in the general population. But people can also report growth in response to life threatening illnesses (e.g., Sawyer et al., 2010). We gained insight into this complexity in Riley et al Chapter 1.2 from [Kevin Aho’s \(2019\) phenomenological](#)

[account](#) of his experiences of suffering a heart attack, which, while “world-shattering” (p. 189), also created new feelings of love and appreciation of others.

Distinctions between illness, disease, disability, and injury

Illness, disease, disability, and injury are different, but overlapping, concepts. While there is no absolute consensus on these definitions, here we consolidate some of the ways that health scholars make these distinctions.

Illness refers to the subjective experience of feeling unwell and having symptoms that are interpreted as illness or a medical issue. Illness encompasses the personal and social aspects of feeling ill or unwell. It is also typically associated with reduced functionality, since we can do less things when feeling ill. For example, it can be harder to get out of bed or concentrate.

Disease is a pathological condition characterised by symptomatology and diagnosed by medical experts. If illness is the subjective experience of a condition that limits functional capacity, disease is the medical diagnosis.

Disability refers to a physical or mental condition that significantly limits a person's movements, senses, or activities. The social model of disability emphasises the role of societal barriers in creating disability, rather than just the individual's condition. For example, people who use wheelchairs are dis-abled by buildings that can only be accessed by stairs, rather than a ramp.

Injury is physical harm or damage to the body resulting from an external force, such as accidents or violence.

As we discuss in this chapter, the lived experience of illness is shaped by specific disease symptoms, personal histories, and the wider discursive and material contexts. It is important to recognise these multiple elements because they bring our attention to how illness is complex, socially shaped, and embedded in power relations. We consider this complexity below in our discussion of the different elements that can shape the intelligibility of illnesses, seeking to offer some foundational concepts such as distinctions between acute and chronic disease. We also unpack those elements, such as spirituality and **temporality**, which we consider important but often overlooked in health psychology textbooks.

Acute / chronic distinctions

Diseases can be categorised as acute or chronic; these distinctions provide insights into the kind of illness experience they generate. Acute diseases tend to have a rapid onset of symptoms that get resolved in a relatively short period of time, potentially without treatment. Acute diseases are usually communicable, spreading from person to person through air, water, or bodily fluids, and may range from mild to life-threatening. Examples of acute illnesses include cholera, chickenpox, and influenza.

In contrast to acute diseases, chronic diseases tend to have a slower onset of symptoms, which are then

more prolonged in duration. These symptoms rarely resolve themselves, and often require long-term management, which is why the term “**chronic health condition**” may be used, in recognition that people are managing an ongoing health issue.

Chronic health conditions may be treatable, but not curable, and they can get worse over time. They are typically noncommunicable, meaning they are not spread from person to person. Common examples include cardiovascular disease, asthma, and diabetes. Cancer may also be considered a chronic health condition since it usually does not have a rapid onset, and people can live with it for a long time, either because curative-intent therapy requires ongoing treatments, or because treatments for incurable cancer may enable people to live with it for many years (Pituskin, 2022). Approximately a third of the adult population, globally, manages at least one chronic health condition (Clur & Barnard, 2024).

While chronic diseases are usually noncommunicable, there are exceptions, such as Long COVID, a chronic condition resulting from the communicable COVID-19 virus. And as the efficacy of medical treatments increases, there can be more non-communicable acute diseases. For example the significant improvements in breast cancer prognosis mean that the five-year survival rate of early cancers exceeds 99% in some countries (Cancer Research UK, 2016, cited in Greenhalgh, 2017). These examples highlight how categorical distinctions of diseases are complex and variable. Offering these broad distinctions—acute versus chronic, communicable versus noncommunicable—remains useful however, for highlighting that the disease symptomology and associated treatments will shape how illness is experienced. We also note that the experience of illness is further complicated when patients’ physical symptoms are medically unexplained, and thus unclassified (Kornelsen et al., 2016).

Social meanings related to disease-specific symptoms:

Disease-specific symptoms shape the experience of illness in interaction with wider **discourses** and social norms. For example, people with irritable bowel syndrome (IBS) experience bloating and diarrhoea. These symptoms are unpleasant in themselves, but they also reduce a sufferer’s ability to understand themselves in culturally valued ways, since bloated stomachs are the opposite of flat stomach body ideals and diarrhoea elicits disgust (e.g., Björkman et al., 2014). These symptoms position the sufferer in socially undesirable ways that impact on their experience of managing IBS beyond the physiological challenges.

Personal histories and associated interpretations of illness

People’s personal histories shape their interpretations of illness. For example, in Greenhalgh’s (2017) autoethnography of her experience of breast cancer, she used her knowledge as a medical doctor to interpret her illness and options for treatment.

Other people’s personal histories can also shape our experience of illness. For example, people might draw on family stories, or anecdotes from others, to help them interpret their own illness (Driessnack, 2017; Jaramillo et al., 2019; Line et al., 2024). Sometimes people report feeling another person’s illness, blurring the boundaries often understood to exist between people, especially in Western cultures. For example, Ahmed (2014) challenged the notion that pain is solely an individual experience, underscoring the interconnectedness of human experiences, particularly within a familial context:

I would say that my main experiences of living with pain relate to living with my mother’s pain... You might note that I said ‘living with’ my mother’s pain. You might question this. It is my mother who has pain. She has to live with it. Yet, the experience of living with my mother was an experiencing of living with her pain (p. 29).

Spirituality

Part of a person's personal history includes how important spirituality is to them. Spirituality underpins ways of being for many people, yet it is often overlooked in health psychology textbooks, or relegated to considerations of end of life care. For many Indigenous peoples, spirituality is based on a sense of connectedness and respect for the Earth, ancestors, family, and a peaceful existence (e.g., Brittain & Kora, [Chapter 1.1](#) ; Cram et al., 2003; Dudgeon, et al., 2020; Valentine et al., 2017; Warbrick et al., 2023). For example, Māori health models, such as Te Whare Tapa Whā (Durie, 1985; Ministry of Health New Zealand, 2023) position te taha **wairua** (spiritual wellbeing¹) as one of the key dimensions of health and wellbeing, alongside physical, mental, and family wellbeing (see Brittain & Kora [Chapter 1.1](#) for further discussion of this and other Māori health models). These ideas of spirituality shape how illness is intelligible, for example, in conceptions of illness as an imbalance between these key dimensions of health (Valentine et al., 2017).

Spirituality also shapes illness experience for many non-Indigenous people. Whether linked to a religion, or to a broader sense of higher purpose or life force, spirituality may enhance meaning in adversity and/or shape health outcomes by shaping behaviour, physiology, and social practices (Aspinwall & Tedeschi, 2010²; Shattuck & Muehlenbein, 2020). Conversely, spiritual responses to illness may require people to create strategies for managing unanswered prayers and the emotional pain associated with disappointment (Dein & Brown, 2024).

Temporality

Like spirituality, people's sense of location in time is not always foregrounded in health psychology textbooks, but it does shape illness experience in multiple ways. For example, the onset of illness can disrupt a person's sense of where they are in their life's time frame (Crossley, 2003).

Temporality is also evident when we consider disease progression, which may involve a steady improvement or decline, or conversely, produce cyclical experiences as a person moves in and out of remission or cycles through multiple challenges that can occur during an ongoing illness. In these moments, people need to mobilise different skills, knowledge, social, and economic resources. Illness is thus characterised by ongoing demands on resources at a time when people's resources are often depleted because of their illness.

Onset of illness as an example of how illness makes different demands of people at different times during disease progression

The onset of a significant illness often requires people to simultaneously employ a range of resources to manage new demands related to:

- bodily functioning, such as dealing with pain, discomfort or incapacity

1. We are mindful of Hokowhitu's (2014) critique of how wairua becomes translated as spirituality, missing, for example, its quality as a "a sub-atomic global essence that pervades all things, both living and inanimate" (p. 53).

2. Aspinwall and Tedeschi (2010) advance the value of positive psychology while cautioning against the promotion of positive thinking as a cure for cancer or other diseases.

- relations with other people (including healthcare professionals, friends, family, and work colleagues)
- distressing feelings and emotions
- new everyday practices (such as knowing where to park in a hospital or to how to use medical equipment)
- institutional requirements, including medical, occupational, and financial (e.g., welfare, pensions, sick leave, or insurance).

People can also have complex experiences of time, such as when past experiences and future fears are felt in the present. As Robson et al. (2025, n.p.) note in their discussion of temporality in people's experiences of having coronary heart disease, "fear of future illness or hope of future health ... are ways in which different futures are embodied in the present". One example comes from a [reproductive health project](#) conducted by Sarah and Siobhan (two authors of this chapter), when a research participant described how she refused contraception with potential side effects related to the eyes because she had previously experienced a severe eye condition and was fearful of suffering a similar experience again. When telling her story, the past fear of losing her sight was not just relegated to the person she once was, but re-imagined in the present body. In so doing, she also brought a dis-preferred future self—one marked by illness—closer to her present moment.

Māori understandings of time are also intertwined with the past and future, but may have a more extended reach into the past and future than for people embedded in Western cultures. For example, present experiences of illness may be shaped by the experiences (positive and negative) of earlier generations within ones **whānau**, or by potential impacts on future generations. As Durie explains:

Future generations are often referred to as 'us', a reminder that through a process of inter-generational transfers, endurance transcends personal longevity to embrace the life span of the tribe. Time-frames become longer and time itself is measured more by seasons – or even by generations – than by a timepiece (2001, p. 77).

Critical disability scholars also question Western normative expectations of time. Their concept of "crip time" challenges cultural values related to a productive and controllable body:

Crip time is flex time not just expanded but exploded; it requires reimagining our notions of what can and should happen on time, recognising how expectations of "how long things take" are based on very particular minds and bodies ... Rather than bend disabled bodies and minds to meet the clock, crip time bends the clock to meet disabled bodies and minds (Kafer, 2013, p. 27; cited in White, 2023, p. 1263).

These arguments represent a form of resistance to working practices within capitalism, and its associations of disciplining bodies to maximise productivity. Such scholarship highlights how socially sanctioned schedules create disabling temporal rhythms for a wide range of people, producing a form of misfitting—where the disabled person cannot fit in with the socio-material structures organising the wider

world (Garland-Thomson, 2011; White, 2023). For instance, individuals with chronic health conditions, such as multiple sclerosis or fibromyalgia, often experience fluctuating symptoms that can make it difficult to adhere to rigid work schedules. The misalignment between social systems and bodily needs is also evident when considering temporary acute health conditions. For example, an individual recovering from major surgery, or severe influenza, might require a period of extended rest and gradual return to normal activities, but these needs are often undermined by expectations for quick recovery and return to productivity.

Place

As well as being temporally situated, illness experience is shaped by space and place. In Chapter 1.3, for example, we discussed [Locock et al.'s \(2016\) analysis of a cancer diagnosis assemblage](#), which included the size and décor of hospital waiting rooms.

We extend our discussion of space and place in the materiality of illness and treatment in Riley et al. [Chapter 1.6](#). Here we highlight the importance of where people live. Living in areas with social and economic deprivation creates a persistent environment of stress and uncertainty that impacts on illness (Hodgetts & Stolte, 2017). These neighbourhoods often have negative reputations or media representations, and coming from such a stigmatised place can shape illness through internalised stigma, lower self-esteem, anger, or shame (Halliday, et al., 2021). Social and economic deprivation occurs in both rural and urban locations, but rural living can have additional problems such as reduced access to services. In Aotearoa New Zealand, for example, those living in rural areas have higher mortality rates from preventable causes (Nixon et al., 2023; Whitehead et al., 2023).

Technologies

Digital and physical technologies are also important when understanding illness because they shape how people think and feel about an illness. Examples include when technologies:

- provide information (aka “Dr Google”)
- offer peer support (e.g., social media platforms or websites like <https://healthtalk.org/> that share patient stories)
- act as public pedagogies (i.e., teaching people how to understand an illness)
- shape behaviour (e.g., through product links and advertising, or recommendations to see a doctor)
- provide ways to “know” the body and thus interpret illness (e.g., when scans visualise illness progression within the body, or tracking apps show patterns in symptoms).



Figure 1.5.1 Meme: *I googled your symptoms. You have one week to live.* (Meme creator unknown. [Paging Dr Google](#))

Technologies can also shape illness by reducing the impact of chronic health conditions on everyday living. For example, real-time biosensors monitoring blood sugar levels in people with diabetes are designed to reduce the burden of self-monitoring (Lawton et al., 2018). However, such positive impacts on illness cannot be guaranteed, since technologies designed to manage illness can create other dispreferred experiences (Lupton, 2018; see Riley et al. [Chapter 1.6](#) for discussion of the experience of treatment).

Social support

Social support is the perception that one is cared for, and part of a mutually supportive social network. There is a robust literature mapping benefits of social support on illness, in part, because social support mediates stress responses that suppress the immune system (Taylor, 2011). But this broad pattern belies significant complexity. For example, people might receive differing levels of support depending on how many resources they need and for how long, while not all support that is given is desired or experienced positively. These issues point to the importance of understanding the context within which social support occurs.

One consideration of the context of social support is where it comes from. Winkler (2017), for example, highlighted a range of people involved in supporting her participants to manage their illness, which required home parenteral nutrition (when nutrition is delivered intravenously). These people included friends, family, and healthcare professionals. Importantly, her participants described how the ability to find “others just like me” (p. 1756) provided vital relationships with other people who understood what they were experiencing. Although these patients had used Internet searches to identify organisations that provided support or peer networking, Winkler encouraged healthcare professionals to make these connections to help patients access these resources.

For Māori in Aotearoa New Zealand, social support it occurs within an elaborate and interconnected social support network of **whānau**, **hapu**, and **iwi**. Whānau support, for example, can involve practical day-to-day assistance, as well as emotional, spiritual, and cultural support. In this context, it is perhaps unsurprising

that Jones et al. (2023) showed that Māori cancer patients received most of their care needs from whānau. The wellbeing of the ill person is often interconnected with the wellbeing of the entire whānau, meaning wider support systems to maintain whānau wellbeing are also important for a person's experience of illness. This social support may also include helping whānau navigate illness within a Western healthcare system, especially when there are concerns that healthcare providers do not know Māori culture (Kidd et al., 2013). Additional social support may then be provided by external organisations, to facilitate the interconnected wellbeing of the ill person and their entire whānau.

The wider discursive context

In Riley et al. [Chapter 1.4](#), we drew on the poststructuralist work of Michel Foucault to theorise how power is integral to people's understanding of themselves (e.g., Foucault, 1980). There, we discussed how discourses, defined as relatively coherent ways to make sense of an issue, produce understandings, norms, expectations, and **subject positions**, including those related to illness. Discourses provide recognisable ways of explaining or storying the world, with the outcome that people make sense of themselves in line with these concepts. For example, healthism is a discourse that constructs health as a measure of a person's value, morality, and citizenship, a logic that produces illness as a kind of individual failure that may elicit shame in an ill person. The discourses available to an ill person therefore shape the intelligibility of their illness.

"Positivity" is an example of a wider discourse that intersects with healthism, in which thinking positively becomes constructed as an essential response to illness – and thus a moral duty if one wants to return to health. When these ideas become popular:

...the general public may come to believe that one can conquer cancer by thinking positively and that if one is not getting a good response, one is not thinking positively enough, not laughing enough, or not being spiritual enough. Indeed, the explicit blame of people with serious illness for their failure to cure themselves in best-selling popular treatments of positive thinking is shocking and reprehensible (Aspinwall & Tedeschi, 2010, pp. 115-116).

Such positivity imperatives reduce ill people's ability to express "negative" feelings, like fear, anxiety, and anger. For example, in their analysis of people's blogs describing life after meningitis, Balint et al., (2024) reported the post:

I'm very silent when talking about meningitis to my family because I feel if I did talk about it I would just be told to grow up and to carry on thinking that I was lucky to have the outcome I had, and I know that.

Multiple actors produced and circulate discourses, within which, institutions play an important role (Foucault 2020). Medicine for example, legitimises some illness claims and not others. But, discourses also produces their own resistance, and both doctors and patients can push back with alternative discourses to medical consensus in an unfolding—if often unequal—dynamic of knowledge/power (Foucault, 1978; Suijker, 2023). Tracking the multiple discourses circulating around breast cancer, Greenhalgh (2017), for example, described three ways of framing this cancer:

- the tragedy genre, which focuses on individual women's inexorable progression of disfigurement,

compromised sexuality, and terminal illness, positioning women as victims and doctors as heroes in the battle with cancer

- feminist counter discourses, which highlight the sometimes brutalising experience of breast surgery, challenge the feminised “pink washing” of contemporary breast cancer activism, and “queers” cancer through “bald pride, rejection of reconstructive surgery and energising power of women’s support network networks” (p. 341)
- her own discourse that accounted for medical developments – of good prognosis but at a substantial price, paid in biographical disruption, a stigmatised cancer patient identity, and the material and lived-body strangeness produced by aggressive chemotherapy treatment that makes people profoundly sick in order to make them well.

Long COVID as an example of a contested illness whose intelligibility has changed overtime

In the history of contested illnesses that subsequently become medically recognised, Long COVID (LC) is perhaps the first to be connected to the **affordances of social media**. Social media platforms allow huge numbers of people, on a global scale, to share experiences, which in the context of LC was of persistent symptoms long after recovery was expected. With medical consensus denying the existence of such ongoing symptoms, patients—both lay and medical—found their experiences discounted, creating a form of **epistemic injustice** (aka “medical gaslighting”). Through their collective sharing of experiences, and self-advocacy across multiple media, LC sufferers were able to push back and shape public, government, and medical discourse, ultimately achieving recognition for LC (Callard & Perego, 2021).

Patient voices were thus central to constructing the concept of LC and changing medical consensus. But once this contested illness was recognised, patient voices were marginalised as medical expertise took over public discourses around the disease. To date, patients with LC report ongoing experiences of discrimination, stigma, and a lack of social and structural support that impacts on their psychological wellbeing (e.g., Samper-Pardo et al., 2023). Some researchers continue to deny its existence beyond a form of mass hysteria, reproducing a historically long pattern of epistemic injustice, particularly for illnesses that women are more likely to report (Moretti & Barker, 2024).

Interested in contested illnesses? See [Part Two](#) for a deeper dive into how understandings and recognition of illnesses are negotiated in society.

Institutions play an important role in the production, and circulation of discourses that shape illness experience. These discourses also impact on aspects of the material world that shape illness. For example, public health discourses that shape retail outlets and local councils decisions to provide accessible clean toilets, mean people who manage urinary conditions can more fully participate in public life (Nielsen, 2024).

Institutions also shape the experience of illness because they control material resources, such as healthcare or financial aid. The material resources managed by, for example, government agencies and commercial health insurance companies, impact on a range of illness experiences, from how an illness might be treated, to a person’s vulnerability to poverty and further ill health. See, for example, McAllister et al.’s, (2013)

discussion of how government/insurance categories of illness versus injury impact on health outcomes in Aotearoa New Zealand).

Section summary: Elements shaping illness experience

We have discussed multiple elements shaping the experience of illness beyond only disease symptoms. This range of elements includes:

- disease distinctions such as acute versus chronic
- social meanings related to disease specific symptoms
- personal histories and associated interpretations of illness
- spirituality
- temporality
- place
- digital and physical technologies
- social support
- the wider discursive context
- institutions that shape both discourse and material outcomes.

The list above is not exhaustive. Rather it is used to highlight how multiple elements shape illness, and the complex relational and situatedness of people's experience of illness. Separately, and in interaction, these elements shape people's intelligibility of themselves and their condition in ways that ultimately delimits what they can say, think, feel, or do in relation to their illness. Considering this broad range of elements is important because, be it at work, or in our personal lives, having this broad perspective enhances our ability to understand and support people who are ill. Considering these multiple elements also connects with the **critical health psychology pou** in relation to taking an approach that goes beyond individualism, and instead, understanding illness as embedded within a person's social context and produced within relations of power and equity.

The elements we have discussed suggest significant levels of complexity, especially when we consider they dynamically interact with each other. This complexity might leave us asking how to engage with so many interconnecting issues without finding it overwhelming? One answer to this question is stories.

Illness narratives

Stories offer an important vehicle through which people make sense of illness. They have several useful qualities for doing so. Stories can package complex information, like knowledge, values, identities, and expectations, into an accessible form. They may also incorporate **temporality**, such as when they explicitly or implicitly describe a past that has led to the current situation and/or orient to a future imagined outcome. The stories people tell about themselves, their families, or their ancestors can also shape their sense of identity and evoke strong feelings. As such, stories offer psychologists an important entry point into making sense of the complexities of illness experience (Crossley, 2000; Llewellyn-Beardsley, et al., 2019; Riessman, 2008).

Stories shape how we make sense of and understand ourselves – stories therefore have agency in the production of our selves. As Greenhalgh (2017, p. 351) explains, it is a myth is “that the self writes the story. In reality, the story writes the self”. Psychologists can leverage the power of stories to support people experiencing illness. Bibliotherapy, for example, involves people reading fictional or non-fictional work that can give them insights into how other people negotiated similar challenges to their own.

However, because stories often reflect contemporary norms, the readings chosen for therapeutic purposes can reproduce dominant discourses and relations of power, including individualism and ideas of what constitutes living a good life (Nair et al., 2023). For example, gendered norms are reproduced in self-help stories when women are exhorted to stay positive (Riley, et al., 2019a; Riley, et al., 2019b) and men invited to imagine their bodies as a machine (Sparkes, 2014). Critical scholars have sought to illuminate and challenge these dominant norms. For example, in relation to virtual reality games designed to support people managing health conditions, Perram and Ensslin (2022) suggested designers need to:

...move away from binary notions of ‘healthy’ versus ‘ill’ and instead re-envision VR narrative creation as a political tool for individuals whose identities and embodiments are pathologized (disability, gendered illness, fat bodies, pain, etc. [...]) the therapeutic aspect is found not in imagining a ‘healthy’ self but in reimagining an inclusive world (Perram & Ensslin, 2022, p. 137).

Critical scholars have also created stories for bibliotherapy that explore health challenges from an individual's perspective, while locating these experiences within their wider social, material, discursive, and political contexts. “[Voices](https://crissxross.net/works/voices/)” (<https://crissxross.net/works/voices/>) (Wilks, 2024), for example, is a digital, interactive story/game with a protagonist struggling with embodied distress against a backdrop of fear of redundancy and concerns around climate change.

Biographical disruption

A central concept in scholarship on narratives of illness is “biographical disruption”, which describes how illness disrupts the expected life story of a person. Bury (1982) coined this term when describing the experiences of participants in a study on being diagnosed with rheumatoid arthritis. Since then, many studies have shown how illness can challenge people's existing self-narratives, creating existential anxiety, and questions such as “Why me?”, “Why now?”, “Whats going to happen to me?” – and even “Who am I?”. As one of Winkler's (2022) participants with a long-term health condition explained, “in the beginning I felt like I had been dropped off in the middle of nowhere with no direction on how to get back home” (p. 1753).

Biographical disruption often forces individuals to fundamentally reevaluate their identity and capabilities. In Riley et al. [Chapter 1.3](#), Carla Willig provided an example of biographical disruption when she described facing cancer as “a situation which seems to make no sense at all, which doesn't seem to fit with the rest of our lives and over which we have little or no control” (Willig, 2009, p. 182).

As a concept, biographical disruption recognises that multiple elements of a person's experience of themselves are disrupted simultaneously, including their body, life trajectory, and relations with others.

- **The body:** The human mind tends to conserve energy by ignoring things that feel normal or unproblematic (Spray, 2022). This creates a paradoxical experience: although everything we do is mediated through our body, we usually do not notice it when it functions well. Leder (1990, p.4) described this state as a "presence-absence". In contrast, he argued, illness forces the body into awareness, intruding on a person's sense of self by becoming an unwanted presence. Illness thus disrupts a person's sense of embodiment and embodied self, with potential to create an "uncanny body experience and an unhomelike being-in-the world" (Madeira, et al., 2020).
- **Life trajectory:** The onset of illness can disrupt a person's expectations for how their life will progress. Illness may reduce people's ability to live in ways they have previously valued, and create an uncertain, unexpected, and/or undesired imagined future.
- **Relations with others:** Illness can impinge on a range of relationships. Illness often changes relationships with loved ones (e.g., by increasing dependency), reduces social interactions, and requires people to form relationships with medical staff.

There is a body of work evidencing biographical disruption as a robust concept for describing illness experience (e.g., Anderson & Bury, 2024; Dew et al., 2024; Locock et al., forthcoming; Raap et al., 2024). These studies show that biographical disruption is:

- **evident across a range of illnesses** related to acute, chronic, terminal, and curable diseases, as well as injuries and age-related frailty
- **also useful for understanding experiences of parents and carers of children** and young adults diagnosed with life limiting illnesses, or
- **applicable to those who have the reverse experience**, that is, people who are told they have life limiting illnesses but later find out it was either a misdiagnosis or who live longer than clinically expected.

Managing biographical disruption

The interruption of an expected life trajectory means ill people need to craft new narratives about who they are. These narratives can allow a person to make sense of themselves within their social context, drawing together ideas of who they were, their changing present, and their uncertain future. Pearce et al. (2020) connect our earlier discussion of the multiplicity of time to biographical disruption, explaining:

...[there is a] relationship between individual biography and its social context as the past is brought

into line with a changing present, scaffolding an emergent future. Narrative is central to this process, operating as a hinge between multiple futures and a reinterpretable past (p. 378).

An influential figure in understanding narratives of illness, is sociologist Arthur Frank. Drawing on his own illness experience and subsequent scholarship, Frank argued that, in illness, people “lose their sense of what story they are part of” (2007, p. 390) and thus need new stories to make their situation intelligible, give meaning to their suffering, and psychologically care for them. The stories we tell are constrained by what is culturally intelligible, and from his late 20th Century North American location, Frank identified three narrative templates people could use in response to illness, which he called “restitution”, “quest” and “chaos” (e.g., Frank, 2007, 2008, 2013).

Restitution narratives construct illness as a temporary issue and focus on restoring people back to their original life before illness. In this narrative, the person is constructed as having lived a full or normative life, which is interrupted by an illness that is treated, restoring their previous life. Illness is thus a temporary problem that does not substantially change the sense of self.

Quest narratives construct illness as a loss, but also as having some benefit, such as an insight, or new ways of thinking or being. These narratives involve “the heroic epic of call, descent, suffering, return, and at the end, some reward for suffering, either a material reward or a spiritual one” (Frank, 2008, p. 86).

An example of a quest narrative

Quest narratives help individuals navigate the present by enabling them to construct a new sense of self, even if there is not a positive resolution to the illness. Returning to our reproductive health study mentioned earlier, one participant described how she made sense of the suffering she experienced with PMDD (premenstrual dysphoric disorder), by considering how the moon affects the tide. This allowed her to forge a new identity for herself as “tidal”:

I kind of ended up with this phrase, a bit like a mantra, that I would try to remember and come back to, which was to say that “I am tidal”... there was this constant conflict in my life around this trying to accept the fact that I’m tidal, you know, I cannot escape that. And after a while I got more aware of that, and it almost became like my central organising principle (Celeste, cis woman, 45-55 years old).

Chaos narratives are “anti-narrative”, since events do not flow from one to another, ending with a sense of resolution. In the chaos narrative, the sense of suffering is not given a purpose, the future is unpredictable, and there is no happy ending. Instead, chaos reigns: “one thing happens after another, but nothing leads to anything else; there is no ordering of events, and that is what is chaotic” (Frank, 2008, p. 85).

Within these three narrative frameworks of restitution, quest, chaos, Frank argued that something is at risk, and that conflicting forces need to be addressed, creating a series of “dramas” that need to play out.

Frank's (e.g. 2007) five dramas in illness narratives

- genesis (illness start/cause)
- emotions
- faith and desire
- fear and loss
- the self.

(1) Genesis dramas focus on what caused the illness. For example, the dominance of **healthism** means people with a noncommunicable disease might narrate the genesis of their illness in terms of self-blame, creating additional distress. In Robson et al.'s (forthcoming) study of Welsh people managing a diagnosis of coronary heart disease, for example, "Louise" described how her nurse relieved her genesis drama associated with this logic of blame by offering an alternative, fatalistic, narrative that constructed illness as cyclical, natural, and uncontrollable:

I started to cry the other day when I was with [nurse] and I said, "what did I do wrong?" She says, "you didn't do anything wrong" she says "Louise if this is genetics you did nothing, it just happened, just like it's you know, trees get leaves trees, lose leaves, trees get leaves, trees lose leaves, one branch might grow bigger than the other branch, it's part of the tree". And it's the same thing with me, and as long as I can stay on top of that thought I'm okay (Louise, cis woman, late 60s, self-employed professional, in Robson et al., forthcoming, p. 11).

(2) Emotion dramas are the emotional displays that are socially required or prohibited. In the restitution and quest narratives the ill person is restored to health or finds meaning in illness. As such, these narratives have an affirmative, hopeful orientation.

But "looking on the bright side" can also be experienced as an obligation (e.g., Wilkinson & Kitzinger, 2000), creating social pressures on ill people towards telling quest and resolution narratives while avoiding chaos stories (Donnelly, 2024; Frank, 2008). Emotional dramas can therefore occur when others enforce quest or resolution narratives as a strategy for the sick person to manage their illness, or to mediate their own fears of illness (Frank, 2008). Willig (2009), for example, described how her friends rejected the strategies she had carefully developed for managing her existential angst because they were not positive enough.

Restitution narratives in eating disorder recovery

In the context of questions about defining eating disorder recovery, LaMarre and colleagues (e.g., De Vos et al., 2017; LaMarre et al., 2023; LaMarre & Rice, 2021) have challenged dominant binary constructions of recovery that position a person as either recovered or not recovered. Instead, they argue that recovery encapsulates a range of fluid and nuanced experiences, and that positioning restitution as the only narrative of recovery may be harming and a form of **epistemic injustice**.

In contrast to the culturally valued quest and resolution narratives, chaos stories are often resisted as “too transgressive, frightening, and difficult for the listener to hear” (Sparkes, 2014, p. 38). Individuals trying to tell chaos narratives may thus be prevented from telling their story when people explicitly silence them, withdraw from them, or unhelpfully offer solutions as if their ongoing challenges are easy to fix (Donnelly, 2024; Frank, 2008). Raap et al. (2024), for example, described how, in their UK based study, parents felt socially policed from describing their ongoing challenges related to caring for their disabled children. As one participant explained, “It feels a bit like: ‘oh, there she is again’ (bored tone)” (p. 9).

Being listened to is a form of recognition because it validates the speaker, and their claims for who they are, and what is happening to them. Thus, for a narrative to be meaningful and “take care” of a person, it needs to be listened to (Frank, 2008). This means that people are dependent on others to hear their story.

The painful experience of having one's narrative denied

In our reproductive health project discussed earlier, one of our participants, “Ashley”, had a combination of long-term health conditions, including a neurological condition that could lead to seizures. These experiences had no easy resolution and left Ashley full of feelings they wanted to express. However, the **positive feeling rules** of their friends denied Ashley this, causing additional distress and a sense of adulthood being an isolated and lonely experience. As Ashley passionately explained:

*Can't talk to my friends cause cause all of them, all of them are the kind of people who can't hold space for you and your energy. That they need to convert it into “Yeah, but”. I f****g, I f****g hate those. Just let me have my feeling and don't tell me “you gotta look on the bright side” and just listen to me. That's that's how I feel about that. “Just let me f****g complain. You can't fix this. I can't fix this. I just need a f****g complain” [...] So yeah, I just, I know I haven't got a support network of like my close friends, my, my genuine friends who I love intensely. They're not the people I can speak to (Ashley, they/them, non-binary menstruator, 45-54 years old).*

(3) Faith and desire dramas relate to how “humans have the particular capacity to interpret suffering with an awareness of some purpose or dimension that transcends the self” (Frank, 2008, p. 91). This purpose may be explicitly religious, secular, or even mundane, but gives people a sense of something beyond themselves.

Examples include a greater recognition of the beauty of life and the belief that everything happens for a purpose.

(4) Loss and fear dramas refer to the potential for illness to create multiple losses related to body functioning, relationships, capacity to work, future expectations, and life. In a context of uncertainty, fear of these losses can feel so terrifying as to be unspeakable, trapping the ill person in their own horror story. Relatedly, Crossley (2003) argued that when patients are encouraged to place faith in treatment as a strategy for dealing with the existential crisis brought on by serious illness, they are left with anxiety provoking “‘unspoken narratives’ of uncertainty, fear and skepticism in relation to the power of medicine” (p. 439). According to Frank (2007), moving out of this drama requires a person to express their fear fully so that it can evolve into a new story.

(5) Self and identity dramas relate to creating a new sense of self when previous stories no longer hold meaning: “part of managing the experience of illness is to find stories that ... teach people how to be who they find themselves having to be” (Frank, 2007, p. 391).

Dramas of self are shaped by individual psychology and life histories, but these are interconnected with cultural norms. Gender, ethnicity, class, sexuality, age, and so forth—as they intersect with illness—thus shape the possible dramas of self (see text box below). For example, in their study of identity work people do in response to chronic disease, Clur and Barnard (2024, p. 6), reported how “Fiona” described the loss of her hair in the following terms:

Hair is seen through the ages as a symbol of femininity, sensuality, and beauty but more than that, it gives you an identity. My whole life, my hair was my joy, and I can honestly say that I never had a bad hair day ... A deep pain lodged in my body and, believe me, for a long time, I could not look at myself in the mirror without experiencing pain ... I felt naked. It was the start of a long mourning process (Fiona, cis woman with chronic disease for over 14 years, living and working in South Africa, Afrikaans speaker, aged between 40–62).

Clur and Barnard (2024) also tracked how Fiona developed new narratives for herself, first by finding a different cultural ideal to identify with, in this case related to being strong-willed and adaptable. And then, unable to bridge the gap between her sick body and cultural ideals, Fiona shifted to a narrative focused on meaningfulness, which for her related to being creative through art.

How gender norms shape experience of medically induced menopause

Studies of cis women who experience early menopause as a result of cancer treatment show how gender norms related to femininity shape this experience. For example, Parton et al. (2017) showed that the experience of medically induced early menopause intersected with gender norms that connected femininity to fertility. This added further challenges to how these women could manage their cancer as an illness, since it created a sense of being an “incomplete woman” (p. 1109). Adding

further contextualisation, Johnston-Ataata et al. (2020) showed how this affective experience of medically induced early menopause was mediated by the extent to which these people, and those around them, identified with the gender norms.

Although we have described Frank's narratives and dramas separately above, they are often experienced as entangled and fluid. People can shift between narratives, use combinations, or only use some elements. Different dramas also operate within these narratives depending on how the person, and the people around them, respond to the illness.

Venus Williams as an illustration of the fluidity of illness narratives

After professional tennis player, Venus Williams, was diagnosed with the autoimmune disease Sjögren's syndrome, her career was interrupted by debilitating symptoms. Williams subsequently returned to professional tennis, adjusting her lifestyle and training to accommodate her condition. Williams' experience highlights the complexity and fluidity of illness narratives and demonstrates how individuals navigate the intertwined dramas in their journey with illness. Reading her story – as presented in her YouTube video "[My Life with Chronic Illness](#)" – against Frank's narratives, we identify elements of the:

- **chaos** narrative in dealing with a delay in diagnosis and changing symptoms
- **restitution** narrative in her efforts to manage the disease and regain her form
- **quest** narrative in finding new purpose in advocacy for autoimmune diseases.

In these narratives were the:

- **genesis drama** involving the origin and onset of her symptoms, raising questions about what caused the illness (Sjögren's syndrome is challenging to diagnose)
- **emotions drama** encompassing the emotional turmoil of coping with a chronic condition, including feelings of frustration, hope, and resilience
- **faith and desire drama** relating to her belief in her ability to manage her symptoms and her desire to continue competing at the professional level
- **fear and loss drama**, such as, the fear of not being able to return to her previous form and the potential loss of her career
- **self drama** that revolved around her identity as an elite athlete and how she redefines herself in light of her illness.

People can also get stuck in a narrative that stops dramas from being resolved. Sparkes (2014) offers an example in an elite sportsman, who he calls "David", who was part of a life history study (Sparkes et al., 2012). Throughout his cancer journey, David focused on the restitution narrative, connecting it to his sporting identity, which he associated with valued notions of mental toughness and courage that mapped onto

his successful sporting career. In so doing, David sought to “win” his battle with cancer, by applying the narratives that had given his life meaning before his illness.

But, by only drawing on the restitution narrative, Sparkes et al. (2012) sees David missing opportunities to frame his illness as part of a quest for different kinds of knowledge, or to connect with the other cancer patients who represented dispreferred frailty to David. These lost opportunities are particularly poignant given that David died. In the battle narrative, David loses. This construction was not only shared by David, but, Sparkes et al. (2012) argued, reproduced in public discourse by national newspapers, which had made much of David’s early “battle” with cancer but offered little coverage of his death.

As Frank (2007) argues, “not all stories do an equally good job of taking care of people” (p. 383). Sparkes’ (2014) analysis highlighted how people can get stuck in a narrative that limits their capacities to respond to illness, especially narratives that have greater value or intelligibility within the wider culture. Through David’s example, the analysis showed the importance of people being able to flexibly develop narratives that provide comfort or meaning as their illness progresses. Sparkes sees this ability to flexibly develop narratives as a collective responsibility, since it requires others to listen to ill people when their stories are difficult to hear, and public platforms to circulate stories about ongoing struggles that are not easily resolved.

Activity

Think of an illness that either you or someone you know has had.

- What stories did you tell yourself about that illness?
- Did that story do a good job of taking care of you?
- Did it align with culturally valued narratives or discourses about how people should be?
- What alternative narratives might you have used, and how would this have shaped your sense of self or interactions with others?

Limitations to biographical disruption

We have discussed how illness can create a profound shock to a person’s sense of self, body, and relations with others, requiring people to navigate biographical disruption and develop new narratives about themselves. We have also noted there is a substantial body of work demonstrating biographical disruption in a variety of illness experiences. But despite the robustness of biographical disruption as an explanatory framework for illness experience, there are limitations and critiques of the concept. As we outline below, these critiques challenge the normativity of health implicit in biographical disruption and recognise the continuum of health experiences where health norms are not uniformly established or disrupted.

Other cultural stories

Frank’s narratives resonate with many people because these stories have long histories. For example, the quest narrative maps onto the “hero’s journey” story, which can be found in most cultures’ mythic traditions, and is ubiquitous in popular culture (e.g., movies) (Campbell, 1949, 2008). But the supporting research for his narratives often comes from researchers located within North America and Europe, increasing the

chances of missing other cultural narratives that can shape illness experience. For example, in Aotearoa New Zealand, Diana and Mark Kopua use Māori stories as a form of healing for neurodiverse children who can find understanding or acceptance through Māori creation stories. These include those of Whiro who embodies negativity in thought, emotion and action, or Uepoto, who is full of mischief (Duff, 2018; Rangihuna et al., 2018). Further, Brittain (2022) showed how elements of chaos, quest and enlightenment narratives were differently configured within te ao Māori as part of the cycle of **te kore** (chaos/potentiality), **te pō** (night/darkness), **te ao mārama** (light/day) in Māori stories of mental distress.

Illness specific considerations

While biographical disruption occurs across various illnesses, focusing on this broader concept can overlook how the unique symptoms, and progression, of specific illnesses shape individual experiences. For example, asthma is often managed alongside daily life with medication, but, for people with severe asthma, the condition can be deeply disempowering, and more likely to be experienced as biographical disruption (Eassey et al., 2019).

Developmental considerations

Scholars taking a developmental psychology perspective argue that biographical disruption occurs in a different way for children and adolescents than for adults. For example, Spray's (2022) study in Aotearoa New Zealand with children with asthma, and their parents, showed that while the children expressed acute fear in relation to their severe breathing problems, these were framed as "rare events that punctuated otherwise near-normal life" (Spray, 2022, p. 326). In contrast, the parents were profoundly affected by these acute moments, and their notions of normality fundamentally disrupted.

Accounting for such differences in children's experiences of biographical disruption, Spray (2022) drew on neuroscience to argue that childhood development involves the brain assessing and calibrating what is normal for the "body-within-a-world it occupies" (Spray, 2022, p. 337). Thus, when children experience a disruption, they adapt to a new normal and/or fluctuate between different states, with the effect that disruption is experienced more momentarily than for adults. For children, Spray suggested, the concepts of ruptures, discontinuities, and interference, function as alternatives to biographical disruption. These concepts reflect children's experiences of illness as disruptive, but not creating the radical challenge to self that it might do in adults.

Temporal rhythms of illnesses

Researchers have highlighted how creating a "new normal" after biographical disruption is difficult for people managing health conditions that are ongoing, changing, and unpredictable. Cluley et al. (2023), for example, discussed how, in their UK study, patients with kidney disease had to continuously negotiate multiple physical, psychological, and social disruptions. And that their strategies to address these disruptions did not lead to permanent or satisfactory solutions because new problems occurred, or solutions to solve the problems created further problems. For example, to manage financial insecurity a participant moved back to his parents' home, but found the experience "suffocating" as parental concern overrode his parents' ability to recognise, or give legitimacy, to his attempts to live a close-to-normal life. Drawing on the philosophy of Hegel, which proposes that ideas unfold through a continuous process of contradiction and negation, the researchers offered the alternative concept of "biographical dialectics" to describe this "recurrent pattern of *issue, problem, answer*" (Cluley et al., 2023, p. 7; italics in the original).

When illness is the norm

Biographical disruption is not relevant for people who experience illness as the norm, such as people who have been ill from an early age or who are part of communities where the onset of illness is to be anticipated. For people in these circumstances, researchers have proposed the concept of “biographical flow”, in which illness is integrated into expected life trajectories without too much disruption (Faircloth et al., 2004).

Definitions of biographical disruption and its alternatives

Biographical disruption is when a person’s expected life narrative is profoundly challenged by illness (Bury, 1982).

Biographical ruptures, discontinuities and interference, describe how illness can challenge normative life narratives in more nuanced and temporary ways, especially for children (Spray, 2022).

Biographical dialectics describes when illness creates a continuing experience of disruption, as new issues continuously develop, even as other ones are resolved (Cluley et al., 2023).

Biographical flow (Faircloth et al., 2004) is one of several concepts put forward to describe how illness might not significantly disrupt a person’s life. These include “biographical reinforcement” (Carricaburu & Pierret, 1995), biographical continuity (Williams, 2000), “biographical erosion” (Lippiett et al., 2022), and “narratives of unconcern” (Harris, 2009). With different emphasis, these concepts describe how onset of an illness may not create a radical or immediate disruption to a person’s sense of self after diagnosis.

Centring issues of equity in illness

Biographical flow, and its variants, are more likely to occur in marginalised and disadvantaged communities where illness is the norm. In such communities, illness norms may apply to children as well as adults. Monaghan and Gabe (2015, p. 1250), for example, showed how children from the Irish traveller community³ experienced managing a chronic health condition, even when it created serious experiences requiring hospitalisation, as “‘not that bad’, when all things were considered”.

Such research highlights the importance of centring issues of equity in understandings of illness. It also throws into sharp relief how psychologised the concept of biographical disruption is, with its focus on how individuals negotiate the emotional challenges that an illness diagnosis can bring. Instead, as Williams (2000) asked in his critical assessment of biographical disruption: given that people often account for their illness in terms of stressful events that weakened them or triggered an illness, should we not focus on social structures causing illness, rather than psychological responses to it? Echoing the idea that illness experience is produced through, and within, its social context, Locock, et al. (forthcoming) state:

3. A traditionally nomadic ethnic minority group indigenous to Ireland.

Living with a long-term illness is not just an individual experience arising as a consequence of unfortunate personal circumstances. People with a long-term condition or disabilities face discrimination in the public and private spheres which restricts equal participation and opportunity in education, health service provision, employment, housing, transport, the built environment, and leisure and social activities. Thus, the “disruption” is neither caused nor experienced on the level of an individual’s life story. (Individual biographies and social structures section, para. 1).

Relatedly, critical disabilities scholars problematise the “personal tragedy” framing of illness in biographical disruption. Instead, they foreground a social model of disability, and the need to ask:

How are people becoming disabled, debilitated, run down, worn out by violence both fast and slow: capitalist exploitation, environmental racism, war, state violence, policing, infrastructural neglect, gender violence, denial of health care? And under such conditions, conditions that do not fall equally, what can it possibly mean to desire disability? (Kafer, 2013, p. 419).

Is biographical disruption a reflection of our modernist times?

In Chapter 1.2, we described two taken-for-granted Western ideas about people:

- people are unique, bounded, and generally integrated wholes, which is challenged by research showing that it is not the norm across world cultures (Geertz, 1974).
- a stable state of full health and autonomy is the ideal norm, which is challenged by arguments that, often, health fluctuates and people are reliant on each other, thus Western ideals of health represent a [“mythical norm”](#).

We can see these ideas in the concept of biographical disruption. The concept of the person that underpins biographical disruption is individualised and coherent, evident in the associated existential questions of “Who am I?” that imply a core self. Further, expectations for continued, stable health reproduce the mythical norm.

Relatedly, some poststructuralists critique the idea within biographical disruption of a body that impinges on the self, because this idea constructs the self as separate to the body in Cartesian, modernist ways. For further discussion, see Williams’s (2000) critique and a rebuff from Leder (2020).

From this, the question becomes: Is biographical disruption a robust concept to explain illness experience because it reflects a natural, universal truth of human experience? Or does this robustness reflect the dominance of modernist ideas of self and health?

Conclusion

In this chapter, we have explored the question: How do people experience illness? We started by considering the multiple factors that shape that experience. These factors include:

- personal and cultural ways of making sense of illness
- access to resources, including social support, medical treatment, and financial
- broader institutional and discursive frameworks that shape how illness is understood and experienced.

In considering these factors, we have shown how illness is complex and enmeshed within the social context, demonstrating how the experience of being ill is significantly more than personal interpretations of specific disease symptomology. Seeking a theoretical framework to manage this complexity, we turned to narratives and the power of stories. Considering key concepts and illness narratives, we discussed how illness can create “biographical disruption” requiring new stories to be told. Drawing on the foundational work of Arthur Frank, in particular, we discussed restitution, quest, and chaos illness narratives, and how each creates conflicting forces that need to be resolved.

We have also considered scholarship demonstrating illness stories beyond biographical disruption. In this, we critically reflected on taken-for-granted ideas about norms of illness, highlighting how culture, developmental stage, and social and economic marginalisation shape the illness narratives people can tell. We also discussed critical disability scholarship’s emphasis on examining the social context in the production, and experience, of disability—arguments that we can also apply to illness.

Across the chapter, we have built on the foundational ideas set up in the previous chapters, connecting with our critical health psychology **pou**, in the following ways:

- **Theoretical/conceptual thinking:** Building on our discussion of discourse and power in Riley et al. [chapter 1.4](#), we introduced the concept of narrative, and how stories shape people’s illness.
- **Challenging taken-for-granted understandings:** While acknowledging the value of Frank’s illness stories and the concept of biographical disruption, we highlighted their individualistic focus, critically examining how they assume autonomous, healthy bodies as the norm, overlooking the inherent interdependence of people and how these norms reflect positions of privilege.
- **Paying attention to issues of power and equity:** Our analysis highlighted how illness experiences are complex, socially influenced, and embedded in power dynamics.
- **Moving beyond individualism:** We emphasised the role of broader discourses and narratives in helping people make sense of their experiences, for instance, discussing Sparkes’ (2014) critique of media portrayals of cancer as a “battle”. We also highlighted the importance of institutions in supporting people to live well with illness, such as accommodating “crip time”.
- **Considering knowledge as produced in context:** Throughout this chapter, we demonstrated that meaning-making is socially situated. We invited readers to question whether dominant narratives about the self are truly universal human experiences or products of prevailing discourses, such as Western ideals of autonomous individualism.

In the next chapter we apply this thinking to how people experience treatment (Riley et al. [Chapter 1.6](#)). We also note how the foundational concepts we have covered here will be developed in [Part Two \(Understanding Health and Illness\)](#), which considers how symptom interpretation and diagnosis are socially negotiated.

Knowledge Check



An interactive H5P element has been excluded from this version of the text. You can

 view it online here:

<https://oercollective.caul.edu.au/critical-health-psychology/?p=611#h5p-5>

Want to know more?

Watch:

- [Why chronic illness is not a 'battle'](#), Saimun Singla. TEDxGreenhouse Road.

Listen:

- The [audiobook preview](#) of Arthur Frank's *The Wounded Storyteller*.
- Biographical disruption is evident in a range of public stories. See for example, Radio New Zealand [interview with Jai White](#) the wheel black rugby player.
- Maya Shankar's "[A slight change of plans](#)" podcast.
- "[Place](#)": In this episode of The Operative Word, an ISCHP podcast, Dr Britta Wigginton challenges us to think about place, and suggests that psychological research needs to consider the role of place in health.

Read:

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1.6 Experiencing treatment

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Overview

In this chapter, we ask: **How do people experience treatment?** To address this question, we discuss the different elements that can shape a person's experience of treatment, showing how it is produced through multiple and interconnected personal, social, cultural and physical elements. Returning to [more-than-human theory](#) introduced in Riley et al. Chapter 1.3, we consider “**assemblage**” as a conceptual framework for understanding the interplay between these psycho-socio-material elements, and as a tool for evaluating treatment in terms of increasing capacities for action. Through this discussion, we aim to achieve the following learning objectives:

Learning objectives

1. Analyse the experience of treatment as a complex, socially influenced phenomenon embedded in power relations.
2. Examine how the concept of assemblage provides a useful lens for understanding the experience of treatment.

What shapes our experience of treatment?

In healthcare, “treatment” generally refers to the interventions and actions taken by healthcare providers in professional and other settings, to address a patient's health condition or related issue (e.g., pregnancy). Treatment usually aims to cure, alleviate, reduce or prevent symptoms, or enhance the outcomes of natural processes, such as childbirth or menopause.

Even for a relatively mild issue, treatment occurs within multiple, interconnected elements that make it a complex and dynamic experience. In this section, we consider some of the personal, social, material, discursive, and organisational elements shaping the experience of treatment. We separate them out for clarity, while recognising that they are connected and affect each other. As noted in the introduction to this book, critical health psychologists often look for a theoretically strong conceptual framework to make sense of their topic. This is because theories provide us with a framework for organising, interpreting, and explaining the information we have about an issue, which can be especially helpful when there are multiple elements involved – such as in the experience of treatment. In Riley et al. [Chapter 1.5](#), we discussed the way that stories function to contain a range of complex information in an accessible and meaningful format. In this chapter, we draw on the concept of assemblage.

An “**assemblage**” is a dynamic, open-ended system, within which multiple components **intra-act** with each other. These components are not limited to a particular kind and include both discursive and material. To help make sense of assemblage theory, imagine a map of a transport system, such as the [London](#)

[Underground](#) [PDF]. It is made of multiple stations, connected by train lines, over which trains run, and carry passengers, who themselves are connected to other assemblages, such as the streets that connect to the train system, meaning that the train system is not closed and connects to other systems. The train system is also constantly in flux, allowing flows of machines, people, air, and so forth. And although they look like fixed objects at first glance, we could also argue that the train system's components, such as machines and people, are not fully formed before they intra-act with each other, but are "co-constituted" through their intra-action. For example, at different moments in the day, the same carriage will have different people, levels of cleanliness, or might have its doors open or closed. The carriage therefore does not have a 'pure' existence outside of these other elements shaping its existence, moment to moment. The number of stations and the number of lines between these stations also impact on the train assemblage, because the more connections there are, the greater variety of journeys can be made – increasing the capacities of travellers. For example, they might be able to change at a station with disabled access. In assemblage theory, the lift/elevator has agency (when defined as being able to affect another) in shaping that journey. From this, we might say that a "healthy" London Underground is one where all the lines are open and running on time, and where multiple existing and new connections can be made. Sometimes though, there may be an abrupt (potentially temporary) change, such as when there is a fire at a station that closes a whole section of the network. Sometimes this might be more permanent, as Sarah found once, when a new line had been built while she had been away, which changed a once familiar, but difficult journey, into a new, easy travel experience.

Key takeaways for understanding assemblage theory

The concept of assemblage was advanced by Deleuze and Guattari (1987) and has since been substantially developed. Here we highlight the key elements of the concept as outlined in our transport system analogy above:

- a number of different kinds of components interact, shaping each other in the process, so that moment to moment these elements are reconfigured through such "**intra-actions**"
- both the human and nonhuman have agency in this process
- they are part of an open-ended configuration that is constantly in flux
- this unfolding can take abrupt and unexpected directions
- because these components are in constant flux, and shape each other, analytic attention is directed towards the forces or 'affective relations', between them
- components should not be thought of as fixed, but are themselves parts of other assemblages
- in general, the more connections that can be made, the healthier the assemblage, because it increases capacities for action.

Below we discuss a range of interconnected elements in the "treatment assemblage", and why they matter when trying to understand how people experience treatment.

- **The personal ("psycho") elements.** These include personal interpretations, life histories, individual differences, and emotional responses.
- **The socio-cultural elements.** These include social positions, cultural perspectives, social and

organisational discourses.

- **The material elements.** These include elements of the physical body, disease physiology, technologies used in treatment, and the space and place where treatments happen.

Although we separate these elements out for clarity, keep in mind that they are part of an assemblage, thus shaping and co-constituting each other.

Activity

Keep a notepad by your side and draw out the relationships between the elements of the “experience of treatment” assemblage we outline below. You could do this by creating “nodes” for each of the elements and then drawing lines between them where you see connections. Write across those lines a brief description of how they might shape and co-constitute each other. You could share your assemblage maps with others, such as in a classroom setting or learning group. If you like, you can also post your map on our [Health Psychology LinkedIn page](#) to spark discussion with a wider community of learners and practitioners. *(Note: You'll need to request to join the group first.)*

Personal elements

There are significant individual differences in how people experience treatment. These differences are shaped by multiple elements, including personal interpretations, individual differences in how treatments are physically and psychologically experienced, and life histories – including past experiences and personal or family stories that inform how a person approaches and experiences a treatment. Such elements shape some of the unique thoughts and feelings that people experience when undergoing treatment. For example, people vary in their coping strategies for chemotherapy (Mendonça et al., 2021), and in their pain tolerance during procedures, such as needle insertions for dialysis (Xie et al., 2022). There is also wide variance in how people make sense of treatment experiences. For example, some people see hospitals as places of care and healing, while others associate them with distress (Radley & Taylor, 2003).

Treatments are also experienced in relation to time. For example, having an illness with a short treatment duration and a good prognosis may lead to a more positive treatment experience, as individuals can anticipate its end and envision a future in which they are healthy again. In such cases, time proceeds linearly, with the past leading to the present and a hopeful future. However, as discussed in Riley et al. [Chapter 1.5](#), people can have more complex experiences of time. Screening, for instance, is often framed as obtaining objective knowledge that can improve future health by detecting diseases early; actions in the present are thus keeping an unwanted future at bay. Yet, participating in screening brings the possibility of illness into the present imaginary, often provoking anxiety rather than comfort. Additionally, waiting for results can create a **liminal** state in which individuals exist in uncertainty—neither fully healthy nor diagnosed with a disease—leading to an ambiguous sense of the future (Mol, 2002; Stronge, 2013; also see our discussion of Willig, 2009 in Riley et al. [Chapter 1.3](#)). In these examples we can see how an individual's experience of treatment “**intra-acts**” with **temporality**, as well as the kind of illness a person has, and if the treatment is preventative or curative.

Socio-cultural influences on treatment experiences

Along with personal components of a person's treatment assemblage, are socio-cultural elements, which shape how people understand themselves and how they are perceived by others. In the context of treatment experiences, these elements include:

- social positions
- cultural perspectives
- wider social discourses

Social positions

Social positions (sometimes called “**positionality**”) refer to the ways intersecting social categories—such as gender, sexuality, ethnicity, race, class, dis/ability, and body size—shape how individuals perceive themselves and how they are understood by others. Social positions are not fixed individual traits, but socially constructed in an on-going way within specific contexts. For example, a doctors' surgery that is easily accessible might mean a person's disabled status is less salient, or that they experience themselves as ‘fitting’ in with the world or are viewed as such by others. In contrast, if they require help to use the facilities—if a ramp needs to be brought out for a wheelchair user for example—their social position as a disabled person is produced quite differently.¹

Beyond traditional sociological categories like class, social positionalities also encompass widely held social constructs that shape identity. Motherhood, for example, carries social expectations that mothers are responsible for their children's health, which can lead to heightened scrutiny of their parenting (Riley et al., 2019). As a result, seeking treatment for a child can be an emotionally charged experience, not only due to concern for the child's well-being but also because of the desire to be perceived as a “good mother”. Yeabsley (2024), for example, found that mothers reported positive experiences of treatment when the doctor attended to the guilt they experienced in their struggles to feed their children a healthy diet.

Social positions shape people's access to healthcare in subtle but profound ways, with the potential to affect the type of treatment they receive, how it is delivered, and how they engage with or resist medical recommendations. As Fox and Powell (2023, p. 231) describe, interacting social positionalities create “a thousand tiny advantages and disadvantages [that] enable or constrain a body's capacity for well-being”. For instance, in Sarah and Siobhán's [reproductive health study](#) (discussed in Chapter 1.5), one participant shared that she had avoided seeing a doctor for seven years because she expected her concerns to be dismissed due to her body size and ethnicity, saying:

I don't really like going to the doctor's. So umm because I'm brown, so everything's about being fat or [laugh] any of the you know, like all of that stuff. So I just don't really go to the doctor.

Her experience reflects how healthcare professionals are part of wider society and, as such, can hold implicit biases that affect the treatment experience of their patients. Studies have documented, for example, how

1. See Garland Thompson (2011) for further discussion of how fitting and misfitting in social and physical spaces can “materialise identity” (p. 601).

weight stigma affects medical care, including doctors failing to refer fat² patients for diagnostic testing or limiting treatment recommendations to weight loss alone (see Chrisler & Barney, 2017; Phelan et al., 2015; Tomiyama et al., 2018 for how sizeism can negatively impact on fat people's experience of treatment, including intersectional differences related to racial and gendered positionalities).

The stigma surrounding body size can also contribute to healthcare avoidance. Many fat people delay seeking medical care due to fear of judgment, making them more vulnerable to chronic stress and poorer health outcomes (Lupton, 2018; Phelan et al., 2015; Tomiyama et al., 2018). As Lewis (2015, p. 1) wrote in a patient experience response in the *British Medical Journal*:

When I worry that I might be unwell, I often try to avoid visiting a general practitioner. Almost every consultation I've ever had—about glandular fever, contraception, a sprained ankle—has included a conversation about my weight; and that's inevitably the conversation that destroys any rapport or trust that might have existed between me and my doctor.

These examples highlight how social positions—especially in the context of stigmatised identities—can profoundly shape healthcare experiences, influencing whether people seek treatment, how they are treated, and how they engage with medical advice.

Example: LGBTQIA+ experiences of cancer treatment

How LGBTQIA+ community members experience healthcare systems offers an example of how social positionalities are produced within specific contexts. For example, many members of this community report carefully managing their relationships with their doctors, including controlling disclosure of their sexuality or gender identity (Adams et al., 2008; Withey-Rila et al., 2024).

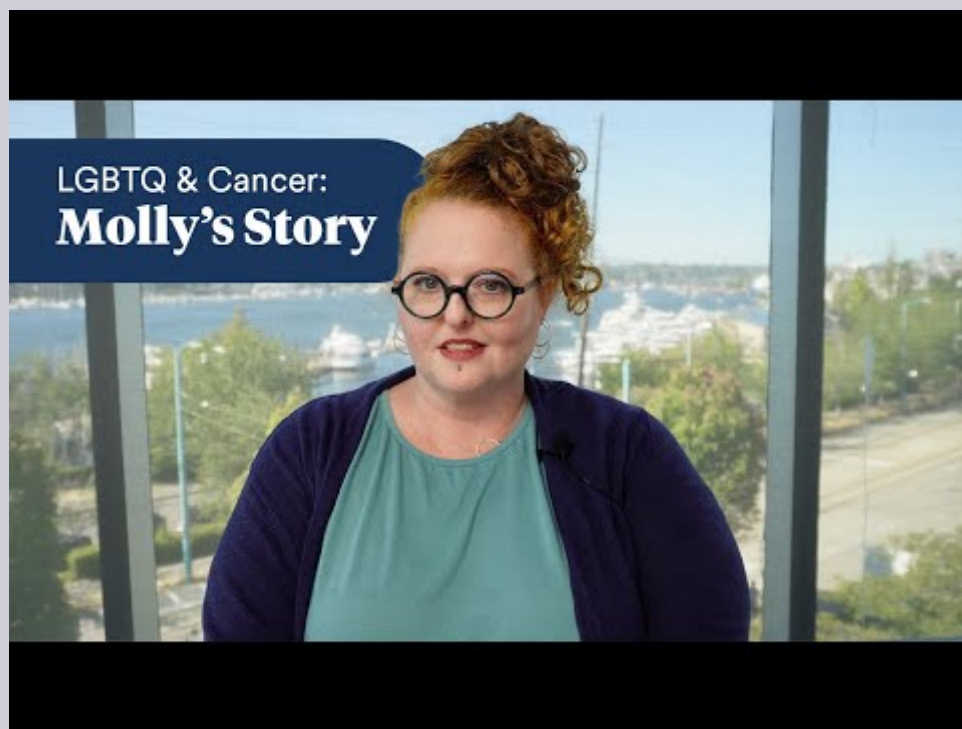
In relation to experiences of cancer care, healthcare systems are often structured around **cis-heteronormative** assumptions that shape the experiences of LGBTQIA + people in accessing and navigating care. For LGBTQIA + people diagnosed with cancer, these structural biases are experienced in various ways, such as inadequate representation in health promotion materials, repeatedly having to disclose their identities to healthcare providers who are working on a cis-heterosexual norm, or having their diagnostic or treatment needs ignored.

Such erasure creates significant barriers to optimal cancer care, producing disparities in early detection, diagnoses, treatment, reoccurrence, and survivorship outcomes (Eckhert et al., 2022). For example, lesbian and bisexual women may delay seeking medical care more frequently than heterosexual women due to previous negative experiences with providers and cis-heteronormative assumptions. This provides an explanation for why, in Aotearoa New Zealand, there are lower

2. We use the term fat to avoid the medicalised stigmatising connotations of the term “obesity” and as an attempt to use it as a neutral description of bodily variation. As Calogero et al. (2019, p. 23) explain “We use *fat* to describe a person, much as we would use *tall*, *short*, and *thin*... if we shun the use of the word fat, we validate and perpetuate the stigma this term evokes”.

cervical screening rates among sexual minorities, leaving them at greater risk of undiagnosed cervical cancer (Ellis, 2023, 2025).

The video below, from the Fred Hutchinson Cancer Center in the USA, offers an example of how cis-heteronormativity shapes diagnosis. In it, Molly, who identifies as bisexual and nonbinary, recounts how their doctor did not believe it was worth testing for HPV throat cancer because it mostly affects men, without considering that this is because a risk factor for this cancer is sex with women. Molly attributes their delay in diagnosis—stage 4a throat cancer—to bias.



A title screenshot from the YouTube video called [LGBTQ & cancer: Molly Wilvich](#).

Watch: [LGBTQ & cancer: Molly Wilvich](#)

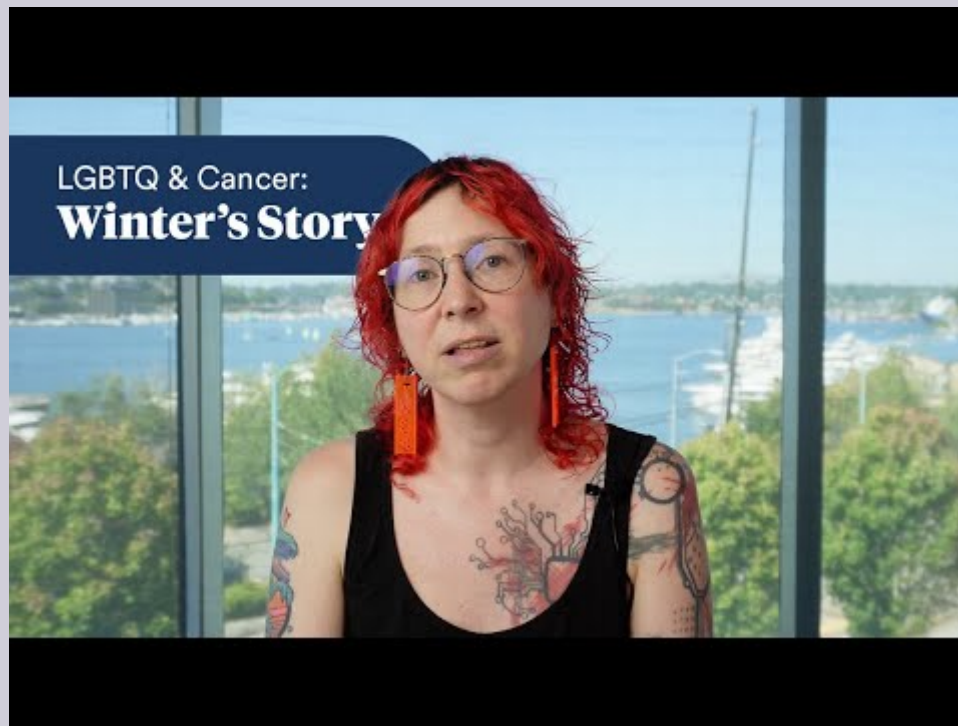
Cis-heteronormativity also stops LGBTQIA+ people from getting the kind of care they need after diagnosis. As one of Ussher et al.'s (2023, p. 8) Australian participants explained:

I feel alienated when discussions around fertility and sexual health post cancer are so cis-heteronormative. I don't feel comfortable "outing" myself to my doctors in these contexts when it's assumed that fertility is related to heterosexual penetrative sex. I'm too scared to ask whether I'm able to preserve my fertility (eg freezing eggs? I don't even know what the options are because it's never been spoken about) so that a same-sex partner could carry a pregnancy, or any other alternative for queer pregnancies (cis woman, bisexual, lymphoma, age 26).

Relatedly, in the video below, Winter Downs, who identifies as nonbinary, expresses frustration with the gendered assumptions that shaped their cancer care, including how the clinic had "women" in the name, creating "a foundational expectation that everyone coming through the door was a woman and wanted to be read that way".

Winter also describes how the treatments on offer reproduced normative assumptions of

heterosexual middle-class femininity, such as assuming everyone would desire a full breast reconstruction and have a private car and office that would allow normal daily life to continue during chemotherapy. In contrast, Winter did not want new breasts and took a bus to work in an open plan office.



A title screenshot from the YouTube video called [LGBTQ & cancer: Winter Downs](#).

Watch: [LGBTQ & cancer: Winter Downs](#)

Many LGBTQIA+ cancer patients are hesitant to disclose their sexual and gender identities to healthcare providers due to fears of discrimination and hostility. Young people may also lack confidence in disclosing their identity, or correcting healthcare practitioners when misidentified. As a result, they may receive inadequate care and experience feelings of inauthenticity (Ussher et al., 2023).

Transgender people face additional barriers, including the misgendering of their bodies in medical discussions, challenges in accessing gender-affirming care during cancer treatment, and systemic gaps in knowledge regarding the effects of hormone therapy on cancer risk and management (Ussher et al., 2023).

Cis-heteronormative assumptions in healthcare also mean that LGBTQIA+ patients' partners are often overlooked. Partners may have to repeatedly explain their sexual orientation or gender identity to different healthcare providers to be acknowledged, even in high-stakes situations such as ICU visits, oncology consultations, or surgical planning (Power et al., 2022).

The concept of **minority stress**—which refers to the chronic stress experienced by marginalised groups due to stigma and discrimination—is useful for understanding these challenges within LGBTQIA+ cancer care (Power et al., 2022). The compounded stress of navigating both cancer and systemic biases results in distress levels that are three to six times higher than those reported by non- LGBTQIA+ individuals in comparable studies (Ussher et al., 2022).

Although progress has been made in addressing healthcare disparities, significant systemic barriers remain. Critical researchers warn of taking an individualist approach to addressing these barriers. Riggs and Treharne (2017), for example, argue that minority stress is the effect of ideology, which renders different people more, or less, intelligible to others. Further, that this occurs across multiple axes of marginalisation and privilege that can intensify, or provide protection from, ensuing stress and associated harm to health and wellbeing. The importance of emphasising the social, they argue, is that interventions then become directed towards social and organisational norms and are less likely to implicitly blame the victim (e.g., for a lack of resilience in the face of these challenges), or mask broader social patterns producing the stress (e.g., when locating the problem of bias in individual attitudes).

By actively working to understand and meet the needs of sexual and gender-diverse people, healthcare providers and institutions can contribute to more equitable and affirming cancer care (Jones et al., 2024). This work involves addressing the social norms that produce systemic barriers to healthcare equity.

Cultural perspectives

People's cultural perspectives also shape their experience of treatment. Western healthcare systems typically operate within White (often middle class) cultural norms. This adds an extra layer of difficulty for people who are members of socioculturally diverse groups, because it can produce a mismatch between their expectations, beliefs, values, and practices and those shaping the health services offered. Kidd et al.'s (2013) study on Māori men managing chronic illness, for example, found they often experienced health services as impersonal and misaligned with Māori values such as **whakawhanaungatanga** —the process of building strong relationships with others. These experiences led to **whakamā**, feelings of shame, embarrassment, or diminishment, which in turn resulted in delays in seeking help.

What do we mean by culture?

The word culture can have multiple meanings. Here we take a social science perspective to describe how groups of people can share a “culture”, that is, a way of seeing and doing things, often involving objects, practices, and shared forms of meaning making. Culture can shape people's conscious and unconscious belief systems, which in turn shape their thoughts and behaviour.

In another example, Upsdell et al. (2024) explored why Pacific peoples are underrepresented in chronic pain services despite experiencing high levels of pain-related disability and psychological stress. The researchers found significant disconnects between how their Sāmoan participants understood pain—and what they considered appropriate treatment—and the approaches used in Western health services in Aotearoa New Zealand. For example, participants interpreted pain as having causes beyond physiology, including spiritual factors. Pain was also viewed affirmatively, with endurance of pain seen as demonstrating **stoicism** – a

culturally valued trait – yet the health services were oriented around reducing pain and its associations with lower quality of life. The disjuncture between these two cultural approaches to interpreting pain (i.e., the traditional Pacific and the Western healthcare clinic), meant pain was devalued by the healthcare professionals while (potentially) valued by their patients. These different approaches to pain thus **intra-acted** in ways that shaped patients' experience in their treatment.³

Migrants are another group who are particularly vulnerable to a mismatch between their cultural perspectives regarding healthcare and those shaping the health systems they need to use in their host country. In regions with high levels of migration, therefore, many people navigate healthcare systems that may not align with their cultural expectations, understandings, or preferences. For example, Asian people make up approximately 17% of the population in Aotearoa New Zealand (Stats NZ, 2024), and research on their healthcare experiences underscores the importance of healthcare professionals understanding key aspects of their culture, including values, customs, and dietary practices (e.g., Chiang et al., 2021). For instance, patients are more likely to follow dietary recommendations when they recognise and regularly consume the foods suggested by dietitians (Xie et al., 2022).

Differentiated social positions within communities, as well as between them, can also shape treatment experience. Pacific peoples in Aotearoa, for example, have normative expectations for couples to have children, and Pacific women have slightly more live births compared to the total population. They are also an ethnic minority. These intersecting factors complicate the experience of infertility and seeking treatment. On one hand, infertility is stigmatised within many Pacific communities, making it difficult for individuals to discuss or seek support. At the same time, racist stereotypes about Pacific peoples' fertility can lead to their reproductive health being problematised in public discourse. As a result, couples seeking fertility treatment must navigate a double stigma that affects the experiences of treatment by creating barriers to both accessing care and receiving social support (Fehoko & Shaw, 2023).

Wider social and organisational discourses

So far, we have discussed social positions and cultural perspectives. Here, we consider the wider social and organisational discourses as a third socio-cultural element shaping the treatment-experience assemblage. We use the term “**discourse**” to describe broad forms of shared sense-making that make objects, issues, and/or people intelligible in a particular way. We saw this in our examples of LGBTQIA+ experiences of cancer treatment above, where cis-heteronormativity shaped the way their bodies and identities could be understood. Discourses, therefore do not neutrally describe reality; “they bring realities (including who we are) into being” (Miller & Rose, 2008, p. 252).

Wider social discourses are those that circulate in public spheres. Typically, they are disseminated by organisations with power to shape public discourse, such as those related to media, government, law, education, medicine, health, and psychology. Some discourses remain mostly circulating within an organisational arena (we might call these “organisational discourses”), while others circulate across a range of sites and actors, related to and beyond organisations, and may be reproduced in everyday talk. These “wider social discourses” have significant power in shaping collective meaning making across large parts of society. As we outline below, some examples in relation to treatment experiences include healthism, positivity, the curative imperative, and compliance.

3. Upsdell et al.'s. (2024) study is also important for exploring symptom interpretation, which we cover in Morison and Gibson [Chapter 2.2](#). It also illustrates how health policies that claim to serve “all” can reinforce systemic health inequities for Indigenous peoples; resulting in the attribution of persistent ethnic health disparities to individual factors or characteristics of ethnic groups (also the Penney et al. (2011) textbox). In Aotearoa New Zealand, such research, along with governmental reviews of health services, highlights the need for systemic change, including integrating equity and anti-racism within the health sector (Came et al., 2020, 2021).

Healthism

Healthism is a discourse that links health to morality, and which circulates across society through a range of actors (see Riley et al. [Chapter 1.4](#)). For example, public health campaigns often seek to change behaviour by raising awareness around risks for disease, such as those that associate lung cancer with smoking. But, in so doing, they can circulate healthism, which constructs individuals as morally responsible for their health through lifestyle choices, and by association, for their illness. Consequently, people with lung cancer may be judged for their perceived “poor” lifestyle choices,⁴ which can shape how they are treated by healthcare practitioners and those who might otherwise offer social support, reducing their possibilities for affirmative treatment experiences (Brown & Cataldo, 2013; Chapple et al., 2004).

Positivity

Positivity discourses are those that position upbeat emotional management as a valued—even moral—psychological orientation to life. Although positivity discourses are not new, they are highly common in contemporary sense making and form an important part of the socio-cultural fabric of contemporary treatment assemblages. Maintaining a positive outlook can have beneficial psychological and physical effects. For example, Winkler’s (2022) participants described the importance of having a positive attitude when adjusting their life goals and priorities so they could focus on what they could do and not what they could not, when dealing with their ‘new normal’ of being dependent on home parenteral nutrition (intravenous feeding). However, positivity does not always lead to positive outcomes, and relationships between positivity, treatment experiences, and health outcomes are complex and nuanced (Aspinwall & Tedeschi, 2010).⁵

Despite this complexity, the need for positivity when facing illness and treatment is a dominant social discourse. In this context, individuals may adopt a positive attitude toward treatment for various reasons—because they believe it will help, because it brings them comfort, or because they feel societal or interpersonal pressure to do so, including from their healthcare practitioners, friends, and family (Crossley, 2003; Egan et al., 2016; Wilkinson & Kitinger, 2000).

Cheer as an example of positivity in treatment

In their ethnographic study of a neuromuscular clinic in Canada, Setchell et al. (2019) examined the

4. Despite the fact that, (1) smoking is related to social economic status and thus social inequities (see, for example, Pizzato et al., 2022); (2) many people diagnosed with lung cancer are not smokers (CDC, 2024); (3) health risk information is not a sufficient tool for behaviour change in general, including stopping some people from smoking (Heikkinen et al., 2010; also see our critique of socio-cognitive models of health behaviour in Riley et al. [Chapter 1.2](#)); and (4) we all make mistakes. Thus, adding social stigma to the experience of a diagnosis of lung cancer, regardless of smoker status, is highly problematic.

5. Reviewing a range of literature associated with positive psychology, Aspinwall and Tedeschi (2010) describe multiple pathways for how a positive mindset might enhance treatment outcomes. However, they also highlight that the strength of this relationship varies and that the protective benefits of positive thinking and feeling vary by disease, and in relation to mortality, can have weaker or non-significant protective benefits. They raise concerns about assuming positivity is always good, such as when patient attempts to recognise their adversity is read by their healthcare providers as them failing to be positive.

deliberate use of positivity to create a strengths-based focus and a cheerful atmosphere aimed at reducing distress and anxiety, particularly for children in clinical settings. Their research revealed the complexities of how “cheer” was employed and the various effects it produced.

For example, the authors describe a 10 year-old boy with Duchenne muscular dystrophy who was encouraged and cheered on while performing a lung capacity test. Initially, this encouragement was validating when he could complete the task. However, as his degenerative disease progressed, his inability to meet the task’s previous score highlighted his decline, reinforcing a sense of failure in relation to normative health standards.

This example shows that while positivity can play a valuable role in treatment, it can also be harmful when it dominates at the expense of other important aspects of care. Patients may need space to express grief and loss, have their non-normative bodies and lives accepted, and have their alternative experiences and embodied knowledge acknowledged.

The curative imperative

The “curative imperative” is a discourse that defines ideal treatment as treatment that “fixes” the broken body (Stramondo, 2022) and is an example of an organisational discourse connected to health and medicine. Seeking a cure often leads to the best outcomes, but the unquestioned application of this imperative can undermine people’s capacities for experiencing positive treatment. This occurs if the curative imperative reduces healthcare practitioners’ capacities to consider patient preferences and needs, and/or if it reinforces societal notions of normalcy. One example is the way cochlear implants are marketed. You may have seen social media advertisements of a child born deaf receiving a cochlear implant, then hearing their parent’s voice for the first time—framed as a “perfect” cure. However, as Robinson and Henner (2017, p. 1416) explain, “culturally identified deaf people inhabit a different centre of knowledge than the non-deaf ... [the] core of this knowledge is the role of sign language in developing language, cognition, and social structures”. For those in the Deaf community, Deafness is a cultural identity not an impairment to be fixed, and this perspective—and associated possibilities for action—is masked by the dominance of the “curative imperative” (Burch & Kafer, 2010; Chapman, 2021; Garland-Thomson, 2011). *Deaf Gain*, is a term coined to “counter the frame of hearing loss as it refers to the unique cognitive, creative and cultural gains manifested through deaf ways of being in the world” (Bauman & Murray, p. 1). It therefore counters the curative imperative that ignores affordances of disabled bodies, and how the Deaf community can work through affirmative affects. For further discussion, see Graham & McGuigan’s section on the [medical model of disability](#) in Chapter 3.4.

The curative imperative can also divert resources from supporting people to live well with their health condition. For example, in her ethnographic study of a UK hospital treating patients with liver disease, Lynch (2024) showed how, in this setting, liver transplantation was considered the ultimate and most desirable treatment for patients with irreversible liver damage, shaping the hospital’s focus around transplantation and its imagined promise of a cure. And, since available donor livers are scarce, significant effort was devoted to creating a fair allocation system for this high-status treatment—benefiting only a select few. Meanwhile, far fewer resources were allocated to the work of a single nurse who provided ongoing patient care through regular paracentesis, a procedure that removes fluid buildup and helps patients maintain function with their existing liver.

Compliance discourses

Rates of people not doing what their healthcare practitioner told them range from around 25% to 80%, depending on the study, illness, and treatment being considered (Van Dulmen et al., 2007), with the World Health Organisation estimating that only 50% of people managing chronic health conditions take their medication as prescribed (World Health Organization, 2003). Thus many people regularly do more, less, or differently than prescribed, even though this is linked to worse patient health outcomes (see for example, Pal et al., 2021) to the extent that a UK clinician-led review argued that developing interventions to increase patients' adherence to prescribed treatments "may have a far greater impact on the health of the population than any improvement in specific medical treatments" (Horne et al., 2005, p. 10). Not following prescribed treatments as directed is thus a common but problematic practice, and several discourses have been used to frame this issue, with implications for how people experience treatment. These discourses include compliance, adherence, concordance, and engagement.

Compliance

Compliance is "the extent to which the patient's behaviour matches the prescriber's recommendations" (Horne et al., 2005, p. 12). The compliance discourse constructs patients in a subordinate role to the practitioner, and produces several **subject positions**, including health professionals as experts, and patients as enactors of that expertise. But, since many people do not enact that expertise, this produces other subject positions, including frustrated/concerned/anxious doctor and demoralised/failed/bad patient. A compliance approach can therefore leave both parties in a lose-lose situation.

An example of a lose-lose situation when patients and practitioners operate within a compliance discourse

Penney et al. (2011) interviewed clinicians and Māori service users about their engagement with healthcare services. The researchers identified how the health professionals (14 non-Māori, 5 Māori) constructed their Māori patients as generally non-compliant, attributing this to factors such as ignorance, poverty, wilfulness, fatalism, and self-destructiveness. In contrast, the Māori participants gave detailed descriptions of actively trying to engage in recommended health practices, such as dietary change, but also finding this difficult, frustrating, sometimes distressing (e.g., medicine side-effects), and limited by structural barriers, despite being presented as simple and straightforward by their clinicians.

Adherence

Adherence is "the extent to which the patient's behaviour matches *agreed* recommendations from the prescriber" (Horne et al., 2005, p. 12). Seeking a win-win situation for both patients and clinicians, the adherence discourse emphasises mutual agreement on treatment practice. The adherence discourse constructs patients and practitioners as active partners with equal, but different roles, producing several subject positions, including doctors as collaborative experts, and patients as health citizens making informed choices about their treatment.

However, health citizenship evokes responsibilities for people to act in ways that are associated with health.

This “**responsibilising**” of individuals has the potential to produce anxiety, shame, and blame if a person does not achieve a stable state of health, since that is the measure of good health citizenship. Further, although adherence envisages the patient and doctor mutually organising a treatment regime together, if the patient does not enact it, then they risk being positioned as non-adherent. The discourse of “adherence” could therefore intensify the patient experience of failure, since non-adherence is both failing to comply with treatment and failing to comply with health citizenship.

Contraceptive decision-making scripts

Morison et al. (2022) interviewed people in Aotearoa New Zealand and South Africa about their experiences with contraceptive services where they were offered a long-acting reversible contraception option. The researchers identified three decision-making **scripts** that shaped contraceptive choices. In relation to the adherence discourse described above, the *collaborative decision-making script* positioned both providers and patients as active participants. While this script accounted for interactive knowledge sharing between patient and doctor that helped level hierarchical power dynamics, the providers remained positioned as the “experts”. Nonetheless, participants described collaborative decision making as their preferred approach, as distinct from the *expert-led script*, where healthcare providers dominated decision-making, and the *patient-led script*, which shifted full responsibility onto the patient.

Concordance

In response to the above critiques, the concordance discourse recognises that non-adherence/compliance may be a rational response for patients in relation to their personal perceptions of illness, treatment, and social context. Both doctor and patient are constructed as collaborative experts, tasked with working together to find a treatment that is likely to be a good fit for that person’s situation. The patient is positioned as self-determining, but within the parameters enabled by their social context; while the doctor is positioned as a collaborative partner who facilitates their decision making.

Although this approach helps level power differentials between practitioners and patients, the time needed to carefully understand a patient’s context is often greater than standard appointment times (Atal et al., 2019), and not all patients are able, or willing to act as collaborative experts. Examples include when health literacy is low, when expert knowledge is held as having more value—especially for the final decision, or when expert knowledge contradicts other valued ways of knowing or being (Chung et al., 2012; Horrocks & Johnson, 2014; Robson et al., 2024).

Further, despite the consideration of social context, concordance remains individualist, positioning the patient as an autonomous individual, and constructing decision making as an event between individuals in the consulting room. Concordance thus misses an understanding of “decision making being dynamic and embedded within a networked collective, the medical doctor being but one (although very often a crucially important) node in the network” (Dew et al., 2014, p. 40). One of us authors of this chapter, for example, has not taken medicine at the time prescribed for fear that the noisy packet would wake our partner. In this example, an **assemblage** of packaging, medications, loving partner subject positions, and bedtime schedules intra-act to produce nuanced moments of non-compliance/adherence.

An example of how patient attempts to define themselves become framed as non-adherence

Gibson et al. (2021) offer a case study of “Michael”, a young man with Duchenne muscular dystrophy (DMD), navigating being positioned as ‘non-adherent’ by his medical team. In the context of clinical meetings, Michael and his body are positioned within an assemblage of medical knowledge, clinician expectations and expertise, medical technologies, and parental anxieties, in which certain ideas and ways of being are valued, one of which is independence. Outside his home, Michael has a powered chair that facilitates his independence, but he resists having one in his home, which, within this framework is constructed as a problem. The researchers note how the power chair offers independence but also draws attention to Michael’s disability. In a world where disabled bodies are devalued, Michael wants to be like everyone else, and the non-powered chair facilitates that. At home, Michael’s assemblage, produced through non-medical human and non-human elements, offers affirmation in the subject position of “a teenager who sits in regular chairs” (p. 298). Within one assemblage Michael’s behaviour is understood as a problem that needs solving. Within the other, his desires and interests are prioritised, with clinical expectations constructed as the problem.

Engagement

The engagement discourse emphasises the need for patients to be actively involved, or “engaged”, in the treatment. This discourse is often prevalent in rehabilitation literature and incorporates considerations of patients’:

- behaviour (such as if they do the recommended physiotherapy exercises)
- physical and mental capacities to perform these behaviours
- psychological motivation (Jull et al., 2019; Kortte et al., 2007).

Like the other compliance-related concepts discussed above, engagement can be an individualising concept, creating subject positions of the preferred engaged patient and the dispreferred disengaged patient. Seeking to address this, Bright et al. (2015, 2017) developed a relational construct of engagement, arguing that patients and practitioners are in mutually reinforcing, dynamic, and reciprocal relationships that enhance or reduce patients’ engagement with treatment. One example is when practitioners’ enthusiasm and belief in the practice enhanced patients’ motivation to engage with it. Read through assemblage theory, this is also an example of **intra-action**: neither the practitioner nor the patient was a stable entity, but rather changing in relation to each other as patients responded positively to enthusiastic practitioners, and vice versa.

As we have shown above, compliance, adherence, concordance, and engagement produce multiple dispreferred **subject positions** for patients. Further, these constructs primarily reflect an individualist perspective, rooted in broader **neoliberal** and **healthism** discourses that emphasise self-management through informed choice that, in reality, is often hard to do. The challenge of navigating self-management, collaborative decision making, and healthcare engagement is further intensified for members of marginalised groups, as these processes require resources—such as financial means and health literacy—that are often less accessible to them (Erickson & Polfuss, 2021).

Materiality

So far we have considered the “psycho-socio-cultural” elements of the treatment-assemblage, highlighting the importance of wider social and organisational discourses, along with social positions and cultural perspectives. There is also the “material”, a term used to refer to elements of the physical world that include bodies and their components, as well as the spaces, places, inanimate objects, organic living and non-living matter, and technologies. **Green** and **social prescriptions**, for example, leverage these relationships, recognising that interconnections between people, place, and nature may enhance treatment experience and outcomes (Husk et al., 2020; McGrath & Reavey, 2018; Palmer et al., 2017; Pretty et al., 2005; Tsunetsugu et al., 2010).

The body

Disease symptomatology shapes the experience of treatments because different conditions require treatments that vary in how pleasurable, invasive, or distressing they may feel. The specific characteristics of a disease also determine where treatment takes place; these healthcare places and spaces are not a “backcloth” for human practice” but intrinsic to it (Fox & Powell, 2023, p. 229). For instance, hospitals have greeter services to allow people to negotiate complex buildings and to experience a sense of care when they enter. In this example, the human (e.g., patients, visitors, greeters, cleaners, porters) and nonhuman (e.g., hospital entrance, wayfinding marking, information kiosk, dedicated sections for specific treatments) are enmeshed in an unfolding process that is both relational and situated in time and place. For example, the more familiar people become with a hospital, the less likely they are to need the greeter service or wayfinding.

Examples of how the materiality of place/space interconnects with the psycho-social elements of treatment experience

Age: Young people may have less experience to draw on when negotiating the healthcare systems involved in their treatment, and their bodies or identities may not “fit” within systems often designed for either adults or children. Sligo et al. (2019) showed this in her research with young people with asthma or cancer, aged 15-27, whose experience of treatment was shaped by an institutional context where they often felt at a disadvantage because of their age. This included, not knowing the role of different clinicians or being put in hospital wards with much younger children. In this context, they were often reliant on clinicians to recognise their specific needs, as in the example below:

The hardest thing was arriving at the hospital and they took us through the oncology ward and everyone else was really sick. Really, really sick. That was really frightening to be honest. And then my doctor came in and there was a lot of other doctors with her, which was really intimidating. She was lovely. She really took the focus away from having that many people there (Sligo et al., 2019, p. 664).

Ethnicity: Seeking to address health inequities in accessing cervical screening and associated higher incidents and mortality from cervical cancer in Māori women, Ormandy et al. (2024) piloted a community colposcopy clinic at an urban **marae**. Users of the service described how having the

service in a place organised around their own cultural values gave them a sense of welcome, safety, and confidence that they would be understood. They also had less logistics to manage, including travel distances, concerns around parking, and childcare, since children had a safe place to play.

In her autobiography of receiving a short course of adjuvant chemotherapy for breast cancer, Greenhalgh (2017, p. 340) highlighted the importance of including a material analysis for understanding the experience of treatment. She described how her treatment produced three kinds of “strangeness” in experience: the “existential strangeness” of biographical disruption that we covered in Riley et al. [Chapter 1.5](#), but also “material strangeness” and the “lived body strangeness”. Material strangeness related to how and where the treatment was delivered, including unfamiliar buildings, uniformed escorts, a large room that hosted several pods treating individual patients, intravenous delivery of multiple bags of chemicals – some of them poisonous to the touch, specialist nurses performing high levels of emotional care and technical expertise, and a cold cap that dropped the temperature around her head to -4° to reduce hair loss. The effect of this treatment produced a “lived body strangeness”, of experiencing the world through an unfamiliar and unpredictable chemotherapy-induced sick body of unfolding dryness, nosebleeds, constipation, diarrhoea, ulcers, acne, cold sores, and soggy toenails. These existential, material, and lived embodied strangenesses characterised the assemblage of her chemotherapy therapy, which, delivered over 12 weeks—and with the promise of a good prognosis—added temporality into this unfolding strange process of being made sick in order to be made well.

Technologies

From a more-than-human theory perspective, materiality, including technologies, have agency because they affect other elements in the assemblage.⁶ Technologies are therefore not neutral tools, but rather shape what is known, possible, and expected. Linked to **productive power**, technologies render the body knowable and “actively intervene in the situations in which they are put into use” (Mol, 2000, p. 9). For example, menstruation tracking apps teach users to understand their cycle as hormonal, and can increase users’ capacities for communication with their healthcare provider by providing a record of their periods (Riley et al., 2025). These examples align with the design intentions of digital health technologies, which are to empower users by providing information that will enhance their ability to live more autonomous, healthier—and thus—happier lives.⁷

However, these and other technologies are products of human decisions and thus often underpinned by existing norms and discourses, such as those related to health citizenship (Lupton, 2014). Digital health apps, for example, reproduce a vision of a controllable and productive body that, aligning with **healthism**, positions people as individually responsible for keeping their bodies in stable states of health through making “good” lifestyle choices—such as using a health app. This logic produces a form of health citizenship, which, as we have discussed above in relation to compliance discourses, and in Riley et al. [chapters 1.4](#) and [1.5](#), can create dis-preferred subject positions associated with stigma, anxiety, and shame for people experiencing illness.

In relation to treatment experiences, digital health technologies extend the reach of health citizenship to

6. For example, the way having a lift/elevator in an underground train station affects the possibilities for travel for disabled travellers.

7. Another key design intention is monetary, since many of these are developed commercially.

include using digital health technologies knowledgeably to manage their health—that is, being a “digitally engaged patient” (Lupton, 2013; Petrakaki et al., 2021). As we show in our text box below, being a digitally engaged patient can be a complex endeavour, with the risk of becoming a failed digital health citizen, thereby undermining the treatment experience.



Figure 1.6.1 Photo of a continuous glucose monitor attached to a person's arm. (Photo by [Sweet Life](#), via Unsplash. [Unsplash licence](#). Photo has been cropped)

The psycho-socio-material dynamics of using continuous glucose monitors

Along with careful management of eating and exercise, people living with type 1 diabetes typically require regular administration of insulin, a hormone that manages blood glucose. Successful management of their diabetes reduces people's risk of a range of serious health problems. To help, biosensors, such as continuous glucose monitors, can be inserted under people's skin to offer real time, or close to real time, measures of blood glucose. These technologies enable patients with diabetes to monitor their physiological markers in ways that were once the domain of healthcare professionals. Research shows that using these technologies can enhance glycaemic control and increase psychological wellbeing and treatment satisfaction (Marks et al., 2022; Natale et al., 2023).

Yet, the uptake, and sustained use, of these technologies has not been at the level expected. Accounting for this discrepancy, researchers have sometimes positioned patients as failed digital health citizens. In contrast, researchers considering the social context within which these

technologies are used highlight how the technology can reduce people's ability to live a life that feels normal or valuable. As we outline below, this is because such technologies can increase labour, elicit negative feelings, and produce an unwanted sense of self (Lupton, 2017b; Natale et al., 2023).

Labour: Rather than freedom-creating, health technologies may be experienced as labour-creating, since they require adjustment and regular self-monitoring, work that people can come to resent.

Surveillance: Although patients are self-monitoring, they need to discuss the outputs with their healthcare professionals, creating a sense that every action related to their glycaemia—including what they ate, drank, or how they moved—would be under future scrutiny. As a participant in Danesi et al.'s, (2018, p. 130) study on glucose monitoring, said *"Sometimes I say to my diabetologist 'Are you done Big Brother?'"*

Negative affect: People report that their biometric data can make them depressed, anxious, guilty, demoralised, or worried, especially when they felt that they had implemented the recommended health practices but still received negative results.

Unwanted selves: People sometimes report struggling between being a "good" self-managing patient and a "bad" obsessive one. Some feel they lose agency in how they manage their condition since they have to respond to the monitor and not their own sense of what to do. Others find that the technology produces a constant, and unwanted, reminder that they are ill.

Social media is also an important technology shaping the experience of treatment, such as when people share experiences online and use that to create collective forms of activism. We mentioned this process in relation to how Long COVID became a recognised illness within the medical establishment in Riley et al. [Chapter 1.5](#). Relatedly, people can use social media to influence treatment practices, and thus their experience of treatment. For example, in a study where individuals shared their difficult experiences with **intrauterine device** (IUD) insertion, they recognised how common their experiences were—including pain, inadequate practitioner communication about pain expectations, insufficient pain relief, and the dismissal of their concerns (Taghinejadi et al., 2024). From sharing these experiences, they engaged in collective action, ultimately leading to the U.S. Centre for Disease Control and Prevention updating its guidelines, recommending various forms of pain relief (Curtis, 2016).

Organisations

Above, we have separated out, and discussed some of the key psycho-socio-material elements that shape people's experiences of healthcare treatment. In the context of treatment, many of these elements are situated within medical, governmental, non-governmental (NGO), and/or commercial organisations, which often operate in interconnected ways. For example, NGOs may provide services funded by governments, or they may step in to address gaps where government services are lacking. Balint et al.'s (2024) study of U.S. blog posts from meningitis survivors, for example, highlighted the crucial role of charities in meeting patient needs not addressed by health services. As we show below, treatment possibilities can be produced through relations between governments and commercial organisations, and are also shaped by the sectors in which they occur.

Direct-to-consumer advertising (DTCA) describes when companies communicate to consumers about their products, including through television and billboard advertising. New Zealand and the United States are the only two industrialised countries that legally allow DTCA for prescription medicines, which usually have an explicit recommendation that consumers speak to their physicians about the product.

There is strong consensus that DTCA shapes people's desires and behaviours (Mintzes, 2009), and multiple concerns have been raised (e.g., Bélisle-Pipon, 2022; Every-Palmer et al., 2014; Gilbody et al., 2005; Schulz et al., 2023), which include:

- emphasising benefits and minimising risks
- overemphasising pharmaceutical solutions and **disease-mongering**
- promoting expensive medicines
- being misinterpreted as health information
- negatively affecting doctor-patient relationships
- producing over prescribing
- having no demonstrable, additional beneficial health outcomes.

Social media is also an important site for DTCA. Many people seek information and/or support to enhance their experience of treatment on social media (Gupta et al., 2022). In this space, which is less regulated than traditional broadcasting, marketers employ a range of practices including developing information websites, apps and online support communities; creating "grass roots" lobbying groups; and covertly interacting online with people discussing treatments (Bélisle-Pipon, 2022; Rosário & Dias, 2023). Such covert behaviour has marketing terms such as, "priming the market", "stealth branding", "unbranded social media engagement", and "seeding disease education" (Lupton, 2017a, p. 71).

The concern is that commercial interests undermine the best interests of the people being targeted. Health marketing therefore needs to employ ethical benchmarks and governments develop regulations to uphold these. (See Bélisle-Pipon's (2022) case studies read through the lens of different ethical frameworks.)

Sectors of care

One way to consider how organisations shape the experience of treatment, is to look at the different sectors where care is delivered. As we outline below, these can be categorised into three sectors of care: popular, professional, and folk (Kleinman, 1980; Lyons & Chamberlain, 2006; Stephenson et al., 2003).

The popular sector refers to everyday, lay people's care, including self-care. Juicing fruit to boost one's immunity when ill, watching cat videos on social media, or following wellness influencers are examples. Taking over the counter medications is also a lay person's practice, but requires the professional sector.

The professional sector refers to treatment delivered by healthcare professionals, such as pharmacists, nurses, doctors, and other allied healthcare professionals and technicians. Typically, the kind of treatment they offer occurs in organisational settings, including hospitals, diagnostic and screening centres, and hospices; and is performed by people with qualifications recognised by an awarding body.

This sector is part of a globalised Western medicine that shares knowledge and best-practice. Patients might, therefore, expect relatively standardised treatment, but research shows significant variation. For example, pregnancy is expected to last 40 weeks in the UK and Aotearoa New Zealand, but 41 in France, which means conversations about treatments, such as inducing labour, start later for French patients. As Payer wrote in her germinal text on medicine and culture, “while medicine benefits from a certain amount of scientific input, culture intervenes at every step of the way” (Payer, 1988 p. 26; cited in Lyons & Chamberlain, 2006, p. 246).

The folk sector relates to complementary or alternative treatment practices (“CAM”). These can be wide ranging, offered by practitioners such as traditional healers, acupuncturists, reflexologists, and so forth. Despite their heterogeneity, they often share a more holistic approach to healing, considering a person’s wider context, which may include their cultural worldviews and spirituality. CAM appointments also tend to be longer than professional sector treatments. Combined, such appointments can give a sense of being treated as a unified whole (Marques et al., 2021).

Many householders engage in “healthcare pluralism” (Helman & Helman, 2007, p. 81) by using CAM alongside professional medicine, for example, supplementing prescribed treatments, like antibiotics, with folk sector treatments, like probiotics and high doses of vitamins (Ramadurai et al., 2016). Despite this normative pluralistic approach, people might not tell their healthcare providers that they are doing so, either because it does not arise in consultation, or because they fear judgement or critique of their choices (Eisenberg, 2002). See text box below for an example facilitating these connections (also see Brittain & Kora [Chapter 1.1](#)).

Combining Rongoā Māori (traditional Māori healing) with Western treatments

Koea et al., (2024) trialled a Rongoā Māori-Western medicine collaboration in a general surgical outpatient setting. Both practitioners were Māori but trained in different traditions; one as a surgeon and clinical researcher, the other as a traditional Rongoā Māori practitioner and registered Medical Herbalist. They trained each other in their approaches, and then offered shared patient sessions where patient whānau (family) were welcome. Both patients and practitioners reported benefitting from the shared sessions. Benefits included how the patients’ families became more active participants in supporting the patient; how the practitioners could collaborate (e.g., treating a skin condition with both cream and antibiotics that worked “hand-in-hand”); and that the approach provided a holistic, and humanising, sense of care.

People may also turn to CAM because of concerns around the pharmaceutical industry, represented in “big Pharma” discourses that position it as exploitative and profit driven in ways that harm people’s health. However, this turn to CAM can be leveraged by pharmaceutical companies when they manufacture what were once folk remedies on an industrial scale, and by the wellbeing industry, which positions itself as distinct, despite its huge commercial interests⁸ and lower regulation since supplements are not classified

8. To give you a sense of this, the Global Wellness Institute estimates the global wellness at US\$6.3 trillion with forecasts to reach US\$9 trillion by 2028 (Global Wellness Institute, 2024).

as medicine. The outcome is that patients might be negotiating multiple concerns around “Big Cam”, “Big Herba” and “Big Wellbeing” (Davies, 2015; Lyons & Chamberlain, 2006; Roche, 2023).

Connections, capacities, and lines of flight

So far, we have discussed how the experience of treatment is shaped by multiple elements that operate in different spheres. These are summarised in the textbox below.

The multiple elements of a treatment-experience assemblage

- **the personal** (e.g., personal interpretations, life histories, individual differences)
- **socio-cultural** (e.g., social positions, cultural perspectives, wider discourses)
- **material** (e.g., physical bodies and components, disease physiology, technologies, space and place)
- **organisational**, operating at the intersections of the discursive and the material (e.g., government bodies, traditional and social media, and professional and complementary/alternative health sector)
- **temporal**, operating both in relation to linear processes (e.g., when a disease progresses or goes into remission, or the unfolding of the assemblage), and non-linearly (e.g., when the mind draws on past memories or future imaginaries to make sense of the present).

The experience of treatment is thus complex, socially shaped, relational, and embedded in power relations. When designing treatments, or trying to better understand a patient or loved one's experience of treatment, we therefore need to consider these multiple elements and their complex interplay. To help conceptualise how those diverse elements connect together we have drawn on the concepts of **assemblage** (Deleuze & Guattari, 1987) and **intra-action** (Barad, 2007). We offered a practical example of these concepts, drawing on Bright et al.'s, (2015, 2017) work on patient engagement, where patients and practitioners were changing in relation to each other, as patients responded positively to enthusiastic practitioners, and vice versa.

Connections

In **mainstream psychology**, health models might theorise that when certain factors come together, it leads to a particular outcome, and that interventions might target one or more of those factors to change the outcome. The factors in these health models, such as self-efficacy, are theorised as relatively fixed and measurable (for further discussion see Riley et al. [Chapter 1.2](#)). In contrast, elements in an assemblage are conceptualised as part of in a dynamic unfolding process, only momentarily taking a particular form as they **intra-act** with each other.

Elements can only intra-act, though, if they are connected in some way, so the more connections there

are within an assemblage, the greater the available capacities for action are available. For example, in our discussion of sectors of care above, we highlighted how people might engage with multiple sectors of care, but not disclose these to their different practitioners for fear of judgement. From an assemblage perspective, the lack-of-acceptance discourses that produce people's fear of judgement, and the lack of information that the practitioners subsequently receive, means potential connections are not made. Without these connections, both parties' capacities for action are reduced.

Capacities for action

In focusing on the connections between elements, and valuing the capacities for action enabled by them, assemblage theory suggests that we can assess how healthy an assemblage is by exploring whether people's capacities for action are increased or diminished within a current assemblage (Fox & Powell, 2023). As Lupton (2019, p. 2002) explained, the question we can ask from this perspective is "What relational connections, affective forces, and agential capacities are generated?". For example, as we showed above, although imperatives for positivity are often deployed with positive intent (e.g., to enhance health), in practice, they can sometimes reduce patients' capacities for action, such as their ability to express feelings of fear and loss. A focus on connections that maximise capacities for action also helps us recognise that an environment that is good for one person may not be good for another, rejecting the idea of finding a universal correct solution (Fox & Powell, 2023).

How assemblage theory throws light on non-adherence, by Melinda Lewthwaite

My PhD work employed interviews and food diaries with women with irritable bowel syndrome (IBS). Assemblage theory offered insights into how and why these women did not follow treatment advice for symptom alleviation. For example, Bella (a 28 year-old Pākehā teacher) explained how her doctor prescribed her laxatives to use immediately after she realised a food had triggered her symptoms, which included constipation, pain, and bloating. However, this treatment only sometimes worked. At other times Bella experienced no effect, or too much effect very quickly.

In the absence of a predictable and knowable future outcome, Bella often delayed taking laxatives until she was in a place she felt able to respond to their potential impact, such as when she was at home, rather than work, and with no other responsibilities (e.g., childcare). Her experience of unpredictable bodily experiences, situated within her social context, differed from her doctor's framing of her as being able to attend to symptoms as soon as they arose, and this caused her further distress:

*If I do end up at the doctor they're like why did you leave it so long, and it's always my fault...
I'm gonna have to explain this to the doctor who's gonna judge me for not fixing it sooner
when I physically couldn't*

In Bella's—and other participants' similar stories—I understood their experiences to be part of a treatment assemblage that included dynamic and unpredictable connections between food and bodies, as well as wider discourses, such as **healthism**. This treatment assemblage produced these women as failed health citizens because they were not seen to be "good" self-managers, appropriately active in their own care (Ellis et al., 2017). I also saw parallels with Mol's (2008) analysis of diabetes treatment assemblages in how the "choices" available to those with chronic health

conditions often fail to take into consideration the varied contexts and messiness of lives within which self-care occurs.

Lines of flight

Within an assemblage, are “territorialising” forces that attempt to constrain and impose stability and order, and “de-territorialising” forces that produce new connections and reformulations, enabling the assemblage to dynamically change into new configurations. In this process of change, sometimes a threshold is crossed that produces a “line of flight” into a completely new assemblage (Deleuze & Guattari, 1987). For example, the pilot community colposcopy clinic at an urban **marae** we described earlier (Ormandy et al., 2024) could be theorised as a line of flight—transforming the treatment assemblage from hospital-difficulties-unfamiliar-no childcare, to community-accessible-childcare-safe feeling. Should the clinic continue, this new assemblage may, in turn, become de-territorialised, with the potential for further lines of flight. Viewed as an assemblage, this theoretical framework conceptualises the experience of treatment as a continuous emergent process—quite different to what we might otherwise imagine as ideal treatment practices, such as finding the “right” way to do it and sticking with it.

An assemblage thought experiment

The New Zealand Cancer Action Plan 2019–2029 (Ministry of Health, 2020) includes several recommendations to improve cancer diagnosis and treatment outcomes. Alongside initiatives such as managing the distribution of specialist cancer surgical services and ensuring early access to new medicines, are expectations of supporting the use of traditional and complementary therapies within well-coordinated care plans.

These guidelines are put into practice through “treatment mapping”, a process in which clinicians outline a patient’s entire treatment journey (e.g., for breast cancer). This involves identifying the services involved, gaps, efficiencies, and points of communication needed between different practitioners or sectors of care, thereby developing connections between the elements in the assemblage. By mapping out the treatment process, clinicians and patients can explore a wider range of treatment options, fostering a more comprehensive and connected approach to care.

Activity: Extending the idea of treatment mapping practices through the concept of assemblage – identify a treatment that you, or someone close to you, has experienced recently. On separate post-it notes, small pieces of paper, or digital versions on [miro](#) write down the different elements of that treatment experience considering the:

- psychological (e.g., personal interpretations, emotions)
- socio-cultural (e.g., positionalities, cultural perspectives, organisations, discourses of health)
- material (e.g., physiology of disease specificities, hospital buildings, technology).

Organise your examples into piles of similar elements on a piece of paper and draw lines between these themes to show how they connect. Reflect on how these connections shaped that experience

of treatment. Notice too, if there are some elements with less or no connections. Using a different coloured pen draw connections between those elements that are not connected and reflect on how the experience of treatment might have differed if these elements were able to affect each other through that connection. What affordances are made possible with these connections?

If you want to take this thought experiment one step further, see if you can identify any territorial forces holding your assemblage together (e.g., take-for-granted ways to understand or do things). Can you imagine a line of flight to a different assemblage?

Conclusion

In this chapter, we aimed to address the question: How do people experience treatment? Using assemblages as an organising concept, we have illustrated how people's experiences of treatment are not just individual, but shaped by multiple, intersecting, psycho-socio-material elements. We discussed how these elements represent a range of components in the "treatment assemblage" and showed why they matter if we want to understand how people experience treatment. These elements included:

- **The personal ("psycho")**, such as:
 - personal interpretations
 - life histories
 - individual differences.
- **The socio-cultural**, such as:
 - social positions—including intersecting social categories related to a person's gender, sexuality, ethnicity, race, class, dis/ability, and body size, as well as social identities forged through wider social discourses, such as motherhood
 - cultural perspectives that shape expectations and interpretations of treatment, with the potential to create disconnect for people from cultural views that differ from those providing health services
 - social and organisational discourses that can create imperatives for both patients and practitioners, such as positivity. We also considered how healthism and associated health citizenship shape treatment experience, and how many of the subject positions produced in contemporary health discourses make the experience of treatment fraught with the risk of dispreferred identities and associated shame and anxiety.
- **The material**, which, within more-than-human theory, has agency since it affects other elements in the assemblage, including how people think and feel about their treatment. These elements include:
 - elements of the physical body
 - disease symptomology
 - technologies used in treatment
 - the space and place where treatments happen.
- **Organisations:** At the intersections of discourse and materiality, we also considered medical, government, non- governmental, and commercial organisations, such as the pharmaceutical and wellbeing industries, as well as social and traditional media, and the popular, professional, and folk sectors where treatment occurs.

In examining these elements, we addressed our critical health psychology **pou** by paying attention to issues of power and equity (e.g., in our discussion of discourse), and moving beyond individualism to a more

socially situated approach with our emphasis on locating the person—and their sense making—in their socio-material context. We have also foregrounded theoretical thinking, drawing on more-than-human theory, especially Deleuze and Guattari's (1987) concept of **assemblage** and Barad's (2007) **intra-action**. This allowed us to theorise the elements shaping treatment experience as part of dynamic system of multiple discursive and material elements, co-constituting each other through their intra-actions and territorialising and de-territorialising forces. This theoretical framework also gave us a way to conceptualise a healthy treatment assemblage as one that is highly networked, with multiple connections that offer a wide range of capacities for action. It also allowed us to consider how lines of flight represent moments of radical change, catapulting people into a new assemblage.

Discussing critical disability studies, Goodley et al., (2019, p. 976) argued that “the key purpose of theory is to understand and intervene in the social world ... contemporary social theory, if it is to offer anything, has to be attuned to the complexities of the contemporary moment”. In this chapter, we hope to have shown the usefulness of assemblage theory for students, researchers, and practitioners seeking to better understanding the complexities of how people experience treatment, and offered a conceptual position from which to intervene and develop more healthy treatment assemblages.

This chapter also completes Part One of the book. Drawing together this chapter, and the range of issues we have covered in Part One, we finish with a call for psychologists to include the socio-material in their thinking. We consider this move a de-territorialising act that can be contrasted with individualism, which acts as a territorialising force in psychology that often fixes our thinking, reducing the possibility for different connections to be made and new opportunities to arise. A psycho-socio-material approach thus offers a potential line of flight from the territorialised assemblage of individualistic health psychology, and lines of flight to new ways of thinking and doing health psychology.

Knowledge Check



An interactive H5P element has been excluded from this version of the text. You can view it online here:

<https://oercollective.caul.edu.au/critical-health-psychology/?p=756#h5p-6>

Want to know more?

Watch: Professor Jane Ussher from the “Out with Cancer” Study on experiences of cancer and cancer survivorship

- Presentation: [Do LGBTQI+ people with cancer have unique needs and experiences?](#)
- Presentation: [Translating findings from the out with council study into training materials.](#)

Listen:

- Dave Nicoll's Paradoxa [Podcast with Professor Barbara Gibson](#), who holds the Holland Bloorview Kids Rehabilitation Foundation Chair in Childhood Disability Studies.

Read:

- Gibson, B. E., Fadyl, J. K., Terry, G., Waterworth, K., Mosleh, D., & Kayes, N. M. (2021). A posthuman

decentring of person-centred care. *Health Sociology Review*, 30(3), 292-307. <https://doi.org/10.1080/14461242.2021.1975555>

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PART 2 - APPROACHES TO UNDERSTANDING HEALTH AND ILLNESS

Part Two: Approaches to understanding health and illness

TRACY MORISON

Part Two explores the complex journey from the recognition of bodily signs to the nuanced dynamics of interacting with healthcare providers. In this section, we trace the process by which individuals interpret changes in their bodies, communicate these experiences as symptoms, and ultimately engage with healthcare systems through diagnosis and in patient-practitioner relationships.

We take a holistic approach to health, considering *both* physical and mental health, which are deeply interconnected in people's lives. This departs from traditional distinctions within health psychology, which historically separated physical and mental health to mark health psychology as distinct from clinical psychology. From a critical perspective, such divisions can obscure the complex ways social, political, and cultural forces shape all aspects of health and illness.

Part Two offers a critical and holistic view of **how health and illness are understood, experienced, and managed**. Ultimately, it points to **the importance of more equitable, culturally responsive, and contextually grounded approaches to care**. Questioning the taken-for-granted assumptions of dominant medical paradigms, the chapters in this section explore how these broader forces shape bodily experiences, symptom interpretation, help-seeking, social reception, and the care people receive. **Readers will gain insight into how:**

- health is constructed across different cultural and historical contexts;
- bodily experiences are interpreted and validated (or not);
- the socio-political nature of diagnosis as a practice;
- diagnostic categories carry both benefits and risks; and
- power is negotiated in healthcare relationships.

We wish to encourage curiosity about how health and illness are understood across cultural contexts. In doing so, we include a range of cultural perspectives on health and wellbeing, drawing on examples from both Aotearoa New Zealand and other parts of the world. Our location in Aotearoa New Zealand shapes the examples and scholarship we draw on, particularly our engagement with Māori models and understandings of health. We use the term *Indigenous* to refer broadly to the first peoples of any land, and *Māori* when referring specifically to the Indigenous people of Aotearoa. While Part One focuses more closely on the Aotearoa context—including a dedicated chapter on Māori health (Chapter 1.1)—Part Two aims to complement this with a broader range of cultural and global perspectives.

Some of the concepts explored in this section—like social constructionism, cultural understandings of health, and critiques of the biomedical model—will be familiar from Part One. However, we build on those foundations by looking more closely at how these ideas play out in practice. While Part One focused on introducing key frameworks and perspectives, Part Two applies them to everyday experiences of health and illness: how people make sense of bodily changes, how diagnoses are made, and how care is provided. The aim is to take you deeper into the ideas you have already encountered, showing how they help us critically understand real-world health contexts.

We include Indigenous and non-Western scholarship where possible, and refer to Māori examples where directly relevant, while being mindful not to speak on behalf of Māori scholars or communities. Our aim is to support the decolonisation of psychology by making space for multiple ways of understanding health that are often marginalised in mainstream texts, without collapsing distinct worldviews into a single category.

Chapter 2.1, “Perspectives on health and illness”, encourages readers to think critically about how different societies construct ideas of health and illness, and what that means for both individuals and health systems. It challenges the conventional biomedical model, which treats health as a neutral, objective state, and instead shows how definitions of wellness and sickness are shaped by cultural values, historical contexts, and social norms. By comparing biomedical approaches with alternative frameworks—including Indigenous and community-based models—Tracy Morison and Alexandra Gibson show how dominant definitions of health can marginalise other ways of knowing, and why it matters who gets to define what counts as healthy or ill.

Building on these foundational ideas, **Chapter 2.2, “Making sense of bodily experiences”**, explores how people make sense of changes in their bodies, showing that bodily sensations are not interpreted in a vacuum but within social and cultural contexts. It highlights that bodily experiences are not just biological signals—they also carry meaning shaped by norms, expectations, and interactions with others. Tracy Morison and Alexandra Gibson examine how individuals decide whether symptoms are serious and whether to seek care, emphasising that symptom interpretation is both a personal and social process. By drawing attention to these dynamics, the chapter reveals how embodiment and culture intersect in shaping health experiences.

Delving deeper into others’ responses to reported symptoms, the next chapter, **Chapter 2.3, “Diagnosis as a social and political practice”**, considers how symptoms are interpreted in the process of diagnosis. Tracy Morison and Clifford van Ommen invite readers to understand diagnosis not as a neutral act of naming illness, but as a powerful social and political practice. They examine how diagnoses are shaped by values, norms, and institutional power, showing they can open up access to care while also potentially stigmatising or reducing complex experiences to narrow categories. They also explore the implications of diagnostic labels and the role of medicalisation in framing everyday experiences as medical problems. Through this critical lens, the chapter encourages reflection on whose voices are heard, whose bodies are recognised, and whose suffering is legitimised.

Finally, **Chapter 2.4, “Healthcare interactions: patient–practitioner relationships”**, homes in on the dynamics of care once a diagnosis is made. Alexandra Gibson examines what happens when people seek care and interact with healthcare professionals, highlighting how power, identity, and system-level factors shape these encounters. She traces the shift from traditional, top-down models of care—where patients are passive recipients of treatment—to more collaborative, patient-centred approaches that emphasise shared decision making. She explores the different roles that healthcare professionals play and how these roles can support or constrain patient agency, using case studies to illustrate how clinical interactions are deeply affected by social identities, institutional contexts, and histories of marginalisation.

These chapters invite readers to reconsider established assumptions and to reflect on the social, cultural, and political forces that shape people’s experiences of the body, care, and health systems. The aim is not only to deepen understanding of what it means to be healthy or ill, but also to highlight how practices like symptom interpretation, diagnosis, and healthcare interactions are embedded in broader structures of power and what that means for different people and groups.

2.1 Perspectives on health and illness

TRACY MORISON AND ALLY GIBSON

Overview

Taking a critical perspective, as we do in this book, involves going beyond the surface appearance of an idea or phenomenon to determine why it is the way it is (Baum, 2015). For (critically oriented) health psychology, this means scrutinising health-related issues through a lens that questions underlying assumptions, power dynamics, and social structures. It also means questioning our very understanding of the notion of health, which we frequently take for granted, and which is the focus of this chapter. The questions that may spring to mind are: **What is the point of recognising and unpacking different, changing understandings of health and illness? And, Why is taking this critical perspective necessary or valuable?** This chapter tackles these questions.

Learning objectives

In this chapter, we cover the following learning objectives.

1. Explain how social and cultural factors shape different understandings of health and illness.
2. Recognise and describe the main concepts influencing Western views and approaches to health and illness.
3. Compare and contrast the biomedical model with alternative approaches, emphasising the limitations and benefits of each.
4. Reflect on the significance of recognising and unpacking various interpretations of health and illness for improving healthcare practices and policies.

Introduction

How we conceptualise health and illness has significant implications for how health is addressed—both in terms of individuals' lived experiences and the practices of those who provide care. Different understandings of health and illness shape how people experience and respond to disease and how society organises the treatment and management of illness—if it chooses to do so at all. At an individual level, one's interpretation of illness directly influences the experience of symptoms. For example, if I interpret a headache as a sign of serious illness, I may feel anxious or distressed. In contrast, if I attribute it to tiredness, I am likely to be less concerned. These interpretations, in turn, influence how I respond to the symptom. This reflects a reciprocal (two-way) relationship between meaning making and action.

The same dynamic operates at the societal level: collective definitions of health shape how health issues are understood and addressed. Health policy offers a clear example of this (Baum, 2015). When “obesity” is framed primarily as a result of individual failings—such as a lack of self-control or motivation—policies tend to emphasise behavioural change, such as encouraging improved diet and exercise. In contrast, when

broader structural perspectives are adopted, policy responses may target systemic contributors like “**food deserts**”, “**obesogenic**” **environments**, and socioeconomic inequities.

Both the examples mentioned above show that different ways of understanding health and illness—at the individual and societal levels—have very real material consequences. This is the central theme of this chapter and of the broader discussion in Part Two.

Health and illness as socially constructed

Health, as a concept, carries considerable cultural and social meaning; it is central to cultures worldwide and encompasses important ideas, deeply held values, and ideals (Baum, 2015). Different ways of understanding originate “from particular histories that are linked to distinctive cultures and places” (Pickren, 2019, p. 2). Therefore, as Radley (1994, p. 20) argued:

We cannot assume that words like ‘ache’, ‘pain’ or ‘doctor’ – or even ‘health’ and ‘illness’ for that matter – refer to things that remain the same wherever and whenever they are applied. This is true of the experiences of the sick as well as of the practices of the physicians and nurses who attend to them.

A valuable lens for understanding the different meanings attached to health and considering the socio-historical nature of understandings of health and illness is that of **social constructionism**. Social constructionism was initially very influential in medical sociology (Barker, 2010; Conrad & Barker, 2010; Nettleton, 2020) and only later taken up in psychology and drawn on by critical health psychologists (Burr, 2015; Chamberlain, 2015; Lyons, 2011). The following video provides a helpful overview. (You may also want to take a look at [Chapter 1.2](#) for a more general discussion of social constructionist epistemology and [Chapter 1.3](#) on using this theory as a research lens.)



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/critical-health-psychology/?p=148#oembed-1>

What do we mean when we say illness is socially constructed?

Social constructionism is a theoretical perspective that encompasses an array of theories that, as Burr (2015, p. 2) puts it, bear a “family resemblance” toward one another. This “family of approaches”, according to Burr (2015), commonly:

- takes a critical stance toward taken-for-granted knowledge (i.e., question what is assumed to be common knowledge/the way things are),
- treats all ways of understanding the world as historically and culturally specific (i.e., how people understand the world depends on the time and culture they live in),
- sees social interaction as sustaining different forms of knowledge/ways of understanding the world,
- shows how specific ways of understanding maintain some social actions, behaviour, or practices while limiting or preventing others, affecting how people are allowed to behave in society and how people from different social groups may be treated (e.g., given advantage or disadvantaged).

Claiming that something is socially constructed, therefore, is to draw attention to its taken-for-granted

nature and the social practices it sustains (Barker, 2010). Accordingly, a social constructionist perspective of health holds that “what counts as health or sickness and which problems need health care are culturally and socially constituted” (Pickren, 2019, p. 2). Scholars taking this approach call attention to the inter-relationship between constructions of illness and how illness is expressed, perceived, understood, and responded to at the individual and societal levels (Barker, 2010).

Importantly, claiming that an illness is socially constructed is not to deny its biological basis. We are not suggesting that illness is imagined or denying people’s suffering or pain. Instead, taking a social constructionist perspective means seeing illness as having *both* a biological basis *and* a symbolic dimension. The social meanings ascribed to certain conditions—and health and illness more broadly—are shaped by biological and social factors (Barker, 2010; Olafsdottir, 2021). Indeed, social and cultural factors impact so many aspects of health and illness, including how we as individuals and societies comprehend biological anomalies, respond to disease, and interact with medical personnel, as well as how treating and caring for the sick are conducted (Olafsdottir, 2021).

Accordingly, those studying health and illness from a social constructionist perspective focus on how cultural and social systems shape the meanings and experiences of sickness or bodily impairment (Conrad & Barker, 2010). Researchers generally consider the following three focal areas, identified by Conrad and Barker (2010):

1. **The cultural meaning of illness:** Illness carries cultural meanings (e.g., ab/normality, im/morality, danger) that affect how society treats people with those illnesses and how those illnesses are experienced.
2. **The subjective experience of illness:** Illnesses are socially constructed in the sense that the experience of illness is shaped by how people understand and deal with it, drawing on various personal and social meanings.
3. **The social production of medical knowledge:** Instead of being value-neutral, medical knowledge can reflect and perpetuate social inequality.

The idea that illness is socially constructed can initially be quite challenging. Most people take the physical experiences of illnesses for granted as real, with little awareness of how these are shaped by the ways their culture makes sense of illness. The understandings and responses that flow from them seem completely obvious and normal from within a particular time and place. “The last thing fish would notice is water” (Linton, 1936, in Conrad & Barker, 2010, p. S69), as the saying goes. Therefore, considering these experiences, understandings, and responses as embedded in specific worldviews and social and historical settings can feel somewhat jarring (Olafsdottir, 2021).

Sometimes, stepping out of one’s own frame of reference allows one to recognise what is often taken for granted as “just the way things are”. Doing so can involve examining how social meanings about health and illness are re/created in social interaction across place and time: turning either to other cultures or looking back in time at one’s own culture, as we do below.

What we mean by “culture”

We use the term *culture* to refer to the inherited set of implicit and explicit guidelines a society provides for understanding the world, responding to it emotionally, and behaving toward others.

Cultures are systems of shared meanings—transmitted through language, symbols, rituals, art, and institutions—that shape what we value, how we act, and how we interpret health and illness.

As Helman (2007) explains, culture influences not only beliefs about the causes of illness and acceptable forms of care, but also who is seen as responsible for health, and what it means to live a “healthy” life. Durie (1985, 2001) emphasises that cultural identity influences how people define health goals, interpret illness, and engage with healthcare. In this view, culture is not a static background factor but a dynamic, living context through which health is made meaningful.

This broad, systemic understanding of culture helps us move beyond narrow definitions that equate culture only with ethnicity or nationality, referencing culture as a demographic label or variable. Instead, we approach culture as central to how people experience their bodies, define illness, seek care, and imagine healing.

Cultural variation: different understandings across place



Figure 2.1.1 This image of a sak yant shaman at work in Ayutthaya, Thailand, disrupts dominant Western imaginaries of healing as clinical, sanitised, and disembodied. Seated among ritual tools, cigarette butts, and sacred objects, the shaman embodies a different configuration of healing authority—one that is informal, embodied, and spiritually grounded. The presence of smoking paraphernalia unsettles biomedical norms of “healthy” behaviour, inviting reflection on culturally specific logics of care and power. (Photo by [Pasha Chusovitin](#), via Unsplash. [Unsplash license](#).)

People make sense of health through a variety of cultural meaning systems. These may include distinct

models of disease, frameworks for understanding wellness and illness (such as magic or spiritualism), culturally specific conditions, traditional and Indigenous healing practices, and, more recently, Westernised forms of healthcare and their associated norms (Vaughn et al., 2009). These meaning systems serve as explanatory frameworks and draw on diverse sources, including social networks, media, biomedical knowledge, early childhood learning, folklore, and more (Vaughn et al., 2009; Ward, 2019). As Ward (2019, p. 19) observes, “there is no single, canonical body of facts about illness. There are knowledges.” These various forms of knowledge may complement or contradict one another, and differ across cultural contexts, reflecting the diverse ways that people around the world understand health, illness, and healing (Vaughn et al., 2009).

Research—including cross-cultural studies¹—on health perceptions highlights how these understandings are subjective and shaped by a person’s socio-cultural location and the specific meaning systems available to them. Individuals draw on the dominant knowledge systems in their context—such as religion, science, or folklore—to interpret bodily sensations like pain or discomfort. These frameworks suggest likely causes (e.g., spirits, sin, germs, stress, laziness), and inform appropriate responses (e.g., exorcism, prayer, herbal remedies, antibiotics, rest). (See [Chapter 2.2](#) for more on this.) In doing so, particular physical sensations may be granted significance—or not—affecting how illness is experienced (Barker, 2010), and in some cases, making certain conditions recognisable only within specific cultural settings (Shorter, 2008).

Findings from cross-cultural studies also reveal that some illnesses appear in certain societies but not others. These are known as culture-bound or culture-specific conditions (Barker, 2010; Baum, 2015). They are sometimes also referred to as psychosomatic conditions, given their combination of psychological and physical (somatic) symptoms. As King (2020, p. 295) explains, these conditions “are subject to a particular set of cultural beliefs and practices, rather than being a tangible medical ‘truth’ that is universally recognized, across all cultures.” The examples in Textbox 1 illustrate how culturally specific beliefs shape the experience and reporting of symptoms, producing conditions that are recognisable only within particular cultural frameworks.

Textbox 1. Examples of culture-specific conditions

Suudu: A culture-specific syndrome of painful urination and pelvic “heat” that is prevalent in women and men in South India, particularly in the Tamil culture. It is commonly ascribed to an increase in the body’s “inner heat”, often due to dehydration. Tamil cultural norms about health, body regulation, and environmental adaptation shape the concept of Suudu. The idea of managing body heat reflects the cultural importance placed on harmony within the body (Chhabara et al., 2008). Though the symptoms of painful urination and discomfort may overlap with conditions like urinary tract infections or dehydration, the local attribution to “inner heat” is unique to the cultural context of South India. In biomedicine, the idea of internal heat as a cause of illness is not typically recognised, marking this condition as culturally bound due to the localised understanding of its aetiology (cause) and treatment.

Pre-Menstrual Syndrome (PMS): “A highly ‘culture-bound’ phenomenon” (King, 2020, p. 295), pre-menstrual syndrome (PMS) is characterised by physical and emotional symptoms in Western

1. Cross-cultural psychology typically uses a comparative approach. Other approaches, such as cultural and Indigenous psychologies, take more emic, contextually grounded perspectives.

women before menstruation, such as mood swings, irritability, and fatigue. Unlike women from other cultures, who report primarily physical changes (e.g., water retention), Western women experience significant psychological changes. PMS is linked to socio-cultural factors and Western gender norms, reinforcing the stereotype of women as “irrational” (King, 2020). The “myth of the irrational female”, which portrays women as pathologically emotional (King, 2020, p. 288), supports Western cultural constructions of the pre-menstrual phase as a time of psychological disturbance and debilitation. Research shows that societal perception of women and their bodies impacts symptom perception of pre-menstrual bodily changes (Chrisler, 2008; Johnson, 1987).

The example of culture-specific illnesses illustrates “the social constructionist claim that illness and disease are something beyond fixed physical realities; they are also phenomena shaped by social experiences, shared cultural traditions, and shifting frameworks of knowledge” (Barker, 2010, p. 148).

Historical variation: changing Western understandings of health and illness



Don de P. Bouteux

*Costume d'un Chirurgien quarantenaire des
Lazaret, de Marseille en 1849.*

Figure 2.1.2 A 19th-century plague doctor in Marseille, complete with beaked mask and hooded robe. While often viewed as a curiosity of medical history, such images challenge the assumption that “strange” health beliefs only belong to non-Western cultures, reminding us that Western medicine has its own peculiar past and all medical systems are culturally shaped. ([Plague doctor's costume](#), via Wikimedia Commons. [CC BY 4.0](#))

It can be tempting to consider other cultures’ “strange” or “exotic” understandings of health as socially located while taking one’s own cultural framing for granted. From a social constructionist perspective, however, all conceptualisations of health and illness, *including our own*, are culturally based belief systems; this position necessitates seeing all cultural knowledge as relative (Pickren, 2019). As Barker (2010, p. 148) states:

From a social constructionist perspective, the task is not necessarily to determine which of the two societies has the correct ideas about illness or which illnesses found only in certain places or certain times are “real”. Instead, the task is to determine how and why particular ideas about illness appear, change, or persist for reasons that are at least partly independent of their empirical adequacy vis-à-vis biomedicine.

Thus, social constructionists reject questions about whether some conceptualisations of illness more accurately reflect reality than others (Barker, 2010). Therefore, the modern, medically dominated Western context in which health psychology is situated should not be taken for granted; it must also be considered a product of time and place, with strengths and limitations (Radley, 1994). This historical specificity is evident when considering shifts in Western understandings of what it means to be ill or well, as in the example of body ideals and health in Textbox 2.

Textbox 2. Body ideals, eating, and health

How people feel about their body shape and weight is a powerful example of how culture and historical differences affect how people think about health. This example highlights how cultural norms and values shape perceptions of physical health and influence diet, exercise, and body image behaviours.

How people think about body weight has continually changed throughout history in Western countries, influenced by religious, philosophical, and medical views (Sampson, 1996). Being thin has become increasingly seen as a sign of health, beauty, and success. In the 20th Century, this cultural ideal became more popular thanks to the growth of mass media, fashion trends, and medical discourse that stressed the dangers of obesity. Thinness may have been seen as a sign of being poor, sick, or not getting enough food, not as a sign of being successful or beautiful. Vintage advertisements for weight gain medications and exercise plans illustrate that at points in time in the West, weight gain was aspired to as earnestly as many aspire to weight loss today. The vintage advertisement below (Figure 2.1.3.) from the UK’s Daily Mail newspaper shows how skinniness was associated with poorer health and unattractiveness.

GAIN WEIGHT!

STOP BEING SKINNY AND TIRED!

Amazing Scientific Plan Adds New Attractive Pounds and Inches

AS FAST AS YOU WANT . . . OR YOU PAY NOTHING!

START GAINING WEIGHT TODAY . . . AND KEEP ON GAINING HEALTHY POUNDS AND INCHES!

Don't be skinny . . . Put on pounds and inches of new, attractive flesh . . . and feel like a new person. **Vitamin Tonic and Appetite Stimulant** is an amazing Scientific Formulation for counter weight gains. It helps you gain pound after pound, which makes your figure better looking . . . while you eat the foods you choose. It puts up Vitamin deficient Appetites . . . automatically you gain weight without conscious effort. And at the same time, you lose that "tired feeling," have more resistance, sleep better at night. If you are skinny and tired because of poor appetite or poor eating habits . . . this medically safe, easy way helps you gain energy faster, and gain on pounds and inches of new weight, for a shapelier figure.

NOW YOU CAN LOOK BETTER . . . HAVE A HEALTHIER, MORE ROBUST FIGURE!

Vitamin is entirely safe, contains no drugs, no stimulants, but is a medically scientific Concentrated Food Formula that's EXTRA RICH in order to stimulate caloric, fortified with other proven weight building elements. Many underweight people have smaller than normal stomachs. Halfway through a meal, they're full . . . can't eat no more. **Vitamin** is more than a meal. Yes, each daily supply of **Vitamin** is as rich as calories in many a skinny person's regular full meal.

Several ingredients will build body tissue, strong bones, and supply your body with the needed materials of **Hormone Nutrition**.

2. Switched B-12 . . . Called the structural growth vitamin, this is the world famous "oil vitamin" doctors prescribe to build healthy robust appetites . . . has a remarkable ability . . . proves in clinical tests on children to cause weight and growth gains.

3. Special Food (From Farnam Science) . . . Helps correct your deficiency anemia, which makes you feel tired, listless, and run down. Helps rich, red blood for added pep, and energy too.

4. Stimulating S-1 . . . Two average doses of **Cos-**

THE SECRET OF THIS SAFE, DOCTORS APPROVED WEIGHT GAINING FORMULA!

The ingredients in **Vitamin** have been most thoroughly tested over a longer period of time, by more doctors in more clinics and hospitals than any other product could anywhere without a doubt! **Prescriptions:** Doctors have given some and some again that the wonderful ingredients in **Vitamin** are completely safe and produce no unpleasant side effects.

You may take **Vitamin** with complete confidence, based on the knowledge that the ingredients have been selected for safe without prescription. It is one wonder that **Vitamin** not only helps you gain an attractive, more shapely figure, by fortifying weight maintaining meals with its concentrated ingredients . . . but also helps you get good looking flesh on face, neck, arms, legs, thighs, hips and ankles. Why be skinnier . . . why let your life slip by without trying . . . No matter what you've tried, **Vitamin** is the one product that can help you! It's a shortcut to firm, soft, and pleasant weight gains. Unconditionally Money Back Guaranteed if it doesn't work for you! Yes, this is one unconditional guarantee . . . **Vitamin** must gain weight for you . . . or it won't cost you a penny!

PROOF POSITIVE



Figure 2.1.3 An early 20th-century advertisement for a weight gain product in the Daily Mail newspaper. (Source date unknown)

On the other hand, larger bodies were often seen as signs of wealth, fertility, and social status in many societies in the past. For example, in some cultures, particularly in parts of Africa and Polynesia, larger body sizes were traditionally associated with prosperity, fertility, and social status. This view persists in many societies beyond the West. For example, in Pasifika² cultures, larger bodies may signify strength, status, and familial wellbeing—meanings that are often stigmatised in Western public health discourse, yet are deeply embedded in community values (Warbrick, 2019; In this [snippet from her TEDTalk](#), medical anthropologist Nancy Chen reflects on how the cultural histories of body ideals have changed. As she discusses, a fuller figure may still be viewed as a symbol of beauty and health. Individuals in these spaces may face less pressure to conform to Western standards of thinness. On the other hand, Warbrick et al. (2019, p. 128) argue that “Indigenous peoples in Western countries commonly experience racism and fat shaming. Rather than improving health for indigenous peoples, weight and weight loss-centred approaches may actually cause harm. Initiatives based on indigenous knowledge are more relevant than those focussed on weight loss”.

The example above shows the changeability of understandings of health within place, as they are shaped by

2. Indigenous Pacific Islands peoples based in Aotearoa New Zealand.

shifting frameworks of knowledge, shared cultural preoccupations, norms, and experiences. Likewise, some illnesses—like **fugue**, **hysteria**, and **neurasthenia**—that existed in late nineteenth- and early twentieth-century Western societies—have disappeared (Barker, 2010).

Changing understandings of health and illness are related to contextual changes, which have, in turn, shaped how sickness is treated (Radley, 1994). For example, in the West, before the emergence and dominance of the biomedical model, supernatural or religious explanations of ill health linked physiological functioning to a person's emotional and spiritual life, which had several implications (Ferngren, 2012). Emphasis on spiritual causes meant that treatment often consisted of (Christian) religious practices, such as repentance, exorcism, or prayer, rather than physicians performing physical examinations. Pre-Christian beliefs conflated illness or suffering with people invoking the anger of gods, who thus brought on plagues, famine, or other misfortune. Such beliefs prompted and justified people being abandoned by others. While early Christian beliefs perpetuated the link between illness and sin, people who were unwell (physically or mentally) were viewed compassionately and as having an opportunity to restore health through spiritual practice (Ferngren, 2012). At the same time, due to the poor efficacy of medical treatment, medical care involved helping patients bear their ailments and was an (expensive) last resort. As the effectiveness of medical treatment improved, doctors focused increasingly on the body and not the psyche, to save the person rather than their soul.

As Western society gave way to secularisation in the nineteenth and twentieth Centuries—and a move away from the power of the church—medicine became a profession separate from religion, with spiritual practices erased from medical treatment. At the same time, health and illness became increasingly associated with employment and productivity, providing motivation to cure the sick so they could work. This linkage of health and productivity was strengthened by the rise in capitalism through these centuries as the prevailing socioeconomic system of Western society (Radley, 1994; Olafsdottir, 2013)—as discussed further below.

Given the successes and resultant status of Western medicine, founded upon the biomedical model, Olafsdottir (2013, p. 49) acknowledges:

It is possible to consider medical knowledge as neutral and simply reflecting reality. Along those lines, changes in how we think about health and illness, as well as treatment, reflect scientific processes, and if they change over time, it is because we know more now than we did in the past.

Without diminishing Western medicine's gains, Olafsdottir (2013) problematises this assumption and its underlying progress narrative. She argues that, like all human knowledge, medical knowledge is produced in a specific socio-political setting, as explained below and throughout Part Two of this book. Research highlighting the social construction of medical knowledge illustrates how biomedical definitions of health and illness, like all knowledge systems, have components that may have less to do with scientific norms than with various cultural and political agendas (Conrad & Barker, 2006; Olafsdottir, 2013).

For example, a large body of research highlights how medical knowledge is shaped by the current gender norms of the era during which it is produced (Martin, 1991). Western patriarchal beliefs about femininity and women's sexuality and "proper" place (i.e., submissive or subordinate) in society are shown to be embedded in medical knowledge regarding pregnancy, pre-menstrual syndrome (PMS), childbirth, and menopause. This knowledge can be used to limit women's freedom in ways that seem factual and ideologically neutral; for instance, by claiming that women are too "hormonal" to hold leadership roles or are naturally more suited to domestic roles than economic ones (Ussher, 2008, 2022; Ussher & Perz, 2013). We unpack such arguments in more depth in [Chapter 2.3](#), where we discuss diagnosis and medicalisation.

Taking a step back: looking critically at the biomedical model

The biomedical model is central to how people think about health and illness, particularly in Western/ised societies. As Crawford (2006, p. 403) points out, “the meaningful practice of health is inextricably linked to the science, practice and layered meanings of biomedicine.” Understandings of health, disease, and bodies are thus heavily influenced by the principles and practices of biomedicine, which has become the dominant framework through which we interpret the body, diagnose illnesses, and approach treatment. To fully grasp how health is viewed today, it is essential to understand the biomedical model and its close alignment with dominant Western values. To reiterate, the aim is not to assess the truth or accuracy of this model but to understand it as a knowledge system that, like all systems of knowledge, has strengths and limitations.

The biomedical model has undoubtedly contributed to significant advances in disease prevention and treatment, leading to the development of medications, vaccines, and surgical procedures (Lyons & Chamberlain, 2006; Rohleder, 2012). However, critics argue that these successes have sometimes been overstated, with less attention given to adverse outcomes or side effects (Olafsdottir, 2013). These critiques also highlight that the most substantial improvements in population health can be attributed to earlier public health measures, such as better living conditions, poverty reduction, and improved hygiene and nutrition, rather than medical advances—though these certainly played a role later (Wilkinson & Marmot, 2003). We discuss these in more detail later in this chapter.

The contribution of these social and environmental factors to disease began to be recognised early in the 1800s. At that time, researchers began recognising the clear links between disease and poverty. For example, Friedrich Engels (a German philosopher) demonstrated how England’s poor living and working conditions contributed to ill health. Engels showed that diseases like “the black lung” in miners were linked to suboptimal working conditions and were, therefore, preventable. He also demonstrated that the overcrowded, squalid living conditions faced by the working class could explain the higher mortality rates among English labourers than professionals. Similarly, John Snow’s famous discovery of the Broad Street pump’s role in spreading cholera highlighted the social and environmental factors contributing to disease. These early efforts demonstrating the social dimensions of health laid the foundation for public health measures and “social medicine”, but were largely ignored by the biomedical model (Germov, 2009).

Instead, mainstream medicine followed a different path: that of biomedical science, neglecting social determinants in favour of biological explanations. The biomedical model is grounded in the same logic as physical sciences, prioritising empirical observation and measurable data. Hence, it emphasises biological processes and treats the body as an object of study. The focus on the observable body means that the biomedical model often neglects how the broader social context plays a role in health outcomes, largely disregarding social and environmental factors. This narrow focus, as we explain next, is the result of the time and place biomedicine originated: during what has become known as the Western Enlightenment era.

The biomedical model as a product of the Western Enlightenment

The Enlightenment, a period of intellectual and cultural transformation in the 17th and 18th centuries, profoundly reshaped Western thought by championing scientific reasoning, empirical observation, and individualism. During this time, thinkers emphasised the power of human reason to understand the world, favouring knowledge based on evidence that could be observed, measured, and tested. This shift towards scientific inquiry and rationality laid the foundation for modern medicine. Emerging from these Enlightenment ideals, the biomedical model privileges objective, measurable knowledge about health and illness, treating the body as a biological system whose diseases can be diagnosed, managed, and treated through scientific methods (Pickren, 2019). While instrumental in advancing medical science, this focus on observable physical phenomena often overlooks subjective experiences and social factors contributing to health, shaping how we understand and respond to illness today (Nettleton, 2020).

Scientific reasoning and the dominance of empiricism

The biomedical model adopted physical science's empiricist epistemology, which is evident in its view that knowledge about health and illness should only come from observable, measurable, and testable evidence (e.g., physical signs, laboratory results, and clinical data) rather than subjective experiences or social factors (Pickren, 2019). Nettleton (2020) identifies five limitations of the biomedical model that stem from biomedicine's grounding in the scientific model, namely,

1. the body can be treated separately from the mind (*mind-body dualism*),
2. disease is something to be treated in *mechanistic* ways,
3. a preference for *interventionist* approaches to treating disease,
4. explanations of disease are exclusively related to biology (*biological determinism*), and
5. biomedicine, and its pharmaceutical or surgical treatments, is privileged as the most valid approach to health and illness, often dismissing or devaluing other cultural or traditional approaches and treatments (known as biomedical ethnocentrism).

These points echo the critiques of critical health psychologists (as discussed in [Chapter 1.2](#)). These assumptions, as discussed below, are linked to the particular social, historical, political, and cultural context of medicine developing within capitalist, neoliberal Western society.

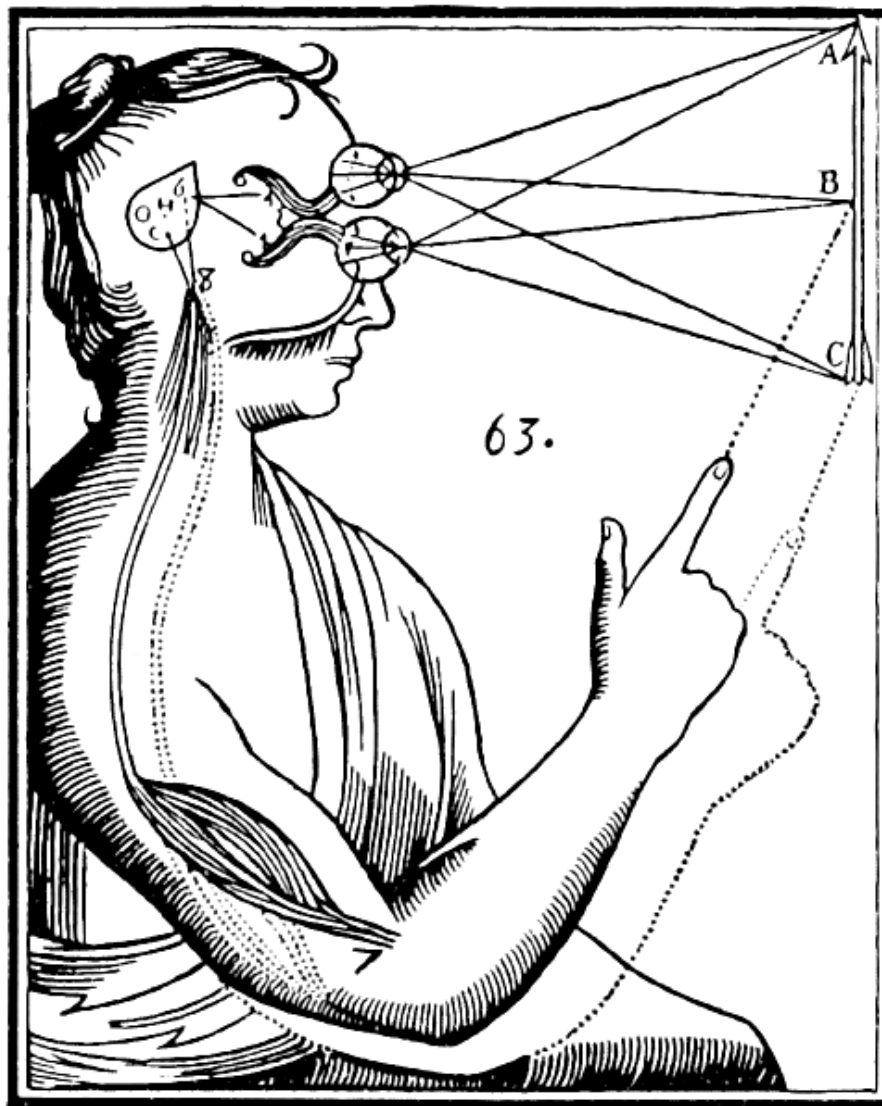


Fig 2.1.4 Descartes' illustration "Treatise of Man" proposes the pineal gland as an organ for a mind-body interface. This proposal was crucial to his dualistic philosophy that divided the material body from the non-material mind. ([Mind and body](#), Rene Descartes, via Wikimedia Commons. Public domain)

Mind-body dualism is a philosophical concept initially proposed in the 1600s by French philosopher René Descartes, asserting the existence of two distinct entities: the mind and the body (Borcherding, 2021). This concept suggests that the mind and body function separately. The mind is considered the centre of consciousness, thought, and personal experience, while the body includes physical characteristics and functions. Although this idea has been thoroughly debated and challenged, it has historically influenced Western medical thinking, leading to the distinction between mental and physical health as separate areas, each needing a different approach to diagnosis, treatment, and care. In contrast with *dualism*, *monism* is the view that the mind and body are integrated as a single, unified substance or reality, not separate entities. In this way of thinking, mental and physical states are aspects of the same underlying reality, with consciousness and physical existence often framed as interconnected expressions of one unified system.

Psychological research in **epigenetics** and **psychoneuroimmunology** underscores the deep integration and inseparability of physical and mental states. For instance, chronic stress has been shown to alter immune function, increasing susceptibility to illness and illustrating the direct impact of mental states on physical health. These findings emphasise that mind and body operate as an interconnected system, where psychological experiences can manifest in physical changes, and biological states can, in turn, shape

mental wellbeing. For example, historical trauma is shown to impact the health and wellbeing of Indigenous peoples in complex, harmful ways. Studies show that traumatic experiences can affect how genes are expressed. As these genetic modifications are passed to subsequent generations, they can experience increased vulnerability to bodily and mental conditions associated with trauma, stress, and adversity (e.g., Pihama et al., 2014; Reid et al., 2019; Schafte & Bruna, 2023).

The biomedical model is grounded in and reinforces mind-body dualism, separating psychological processes from the social realm. This separation supports a **mechanistic view** of the body, likening it to a machine with distinct yet interacting parts. In this model, health is understood as the efficient functioning of the body, and illness is seen as a breakdown that requires repair, removal, or replacement (Baum, 2015; Thompson, 2014). Treatments and techniques, like vaccinations, behaviour change programmes, medications, and surgeries, are continually developed to cure or alleviate symptoms in a highly **interventionist** “clockwork model of medicine” (Baum, 2015, p. 3).

As medicine and science became more intertwined in the 19th Century, the biomedical model of health emerged from natural sciences such as physiology, anatomy, and biochemistry (Nettleton, 2020). While some environmental and social factors are acknowledged, the focus is primarily on the individual body when explaining diseases (Nettleton, 2020; Radley, 1994; Rohleder, 2012). In this view, illness is caused by biological factors (e.g., organ or system dysfunction) or pathogens (i.e., germs, viruses) (Pickren, 2019). This approach is known as **biological determinism**, where biology is considered the primary determinant of health and illness. However, it has been criticised for its **reductionism**, as it narrowly focuses on biology and often neglects psychological and social influences on health (Nettleton, 2020).

Likewise, building on this biological reductionist view, biomedicine and pharmaceutical treatments or surgical interventions are seen as more valid and prioritised over other cultural perspectives, leading to “biomedical ethnocentrism” (Ferngren, 2012, p. 8). This belief (of the superiority of biomedicine) is based on the view of every disease as attributable to a particular physical entity (be it a virus, bacterium, toxin, parasite, and so on), and treatable by targeting and eliminating or controlling that entity through surgical and pharmaceutical interventions such as antibiotics, antivirals, or vaccines. As a result, other knowledge systems (e.g., Complementary and Alternative Medicine, Chinese Medicine) are often devalued (Ferngren, 2012).

Individualism and personal responsibility

The Enlightenment marked a significant shift in Western thought, emphasising the importance of individual rights, self-reliance, and personal responsibility. Western philosophers like John Locke championed the view that individuals are rational beings capable of making informed choices. This focus on individualism encouraged people to view themselves as agents in control of their own lives, shaping not only their destinies but also their health (Yadavendu, 2013). As a result, health began to be seen as a personal endeavour where individuals are responsible for their wellbeing, leading to the notion that a healthy life depends largely on one’s choices and actions.

This thinking gave rise to individualism, the philosophical and socio-cultural perspective that emphasises the individual’s autonomy, agency, and distinctive characteristics as the most critical factors shaping experiences and choices related to health. Individualism supports an overarching ethos in which health outcomes are primarily linked to human behaviours, choices, and biological predispositions, emphasising personal autonomy and responsibility for wellbeing. This viewpoint frequently emphasises the significance of self-care, self-regulation, and informed decision making as fundamental principles of health management (Baum, 2015).

The biomedical model reinforces the concept of health as an individual issue by framing illness primarily as a result of personal behaviours and lifestyle choices. This perspective positions health management

as largely dependent on individual responsibility, implying that people must take proactive steps—such as maintaining a healthy diet, exercising, and avoiding harmful habits—to prevent illness. Consequently, public health messaging often emphasises personal accountability over collective responsibility, which can lead to the marginalisation of social determinants of health, such as socioeconomic status and access to healthcare, ultimately overlooking the broader context in which health is experienced (Vera, 2020). Along with critical health psychologists, Indigenous scholars have extensively critiqued the emphasis on the individual human body, highlighting the pitfalls of overlooking the significance of socio-historical processes, such as colonisation, and cultural factors in understanding health (e.g., Dudgeon, 2020; Wilson et al., 2019). These factors account for a significant portion of health issues, as shown in Figure 2.1.5.

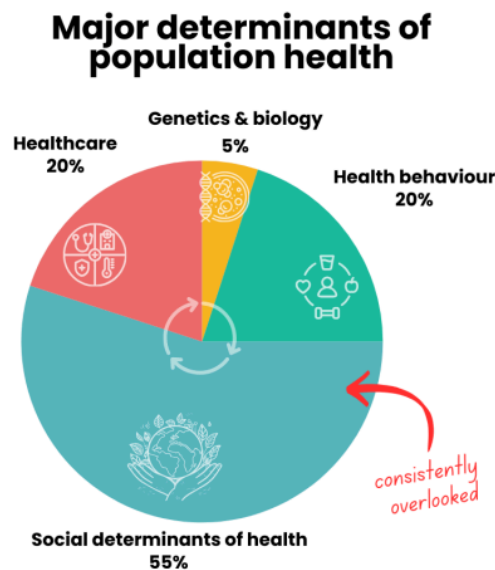


Figure 2.1.5 Despite being the largest influence on health, social determinants are consistently overlooked in health policy and practice. (Adapted from Germov, 2019. Original source [U.S. Centers for Disease Control and Prevention](#) webpage, link no longer available)

The rise of neoliberalism and its influence on health

Neoliberalism is an economic and political philosophy that grew out of and dovetails with the dominant Western ethos of individualism. This perspective prioritises market-driven solutions, advocating for minimal government intervention (e.g., social welfare, health promotion) and instead favouring individual responsibility and personal accountability. Importantly, under this framework, health transforms into a commodity that individuals are expected to manage as part of their personal goals. This shift positions health as something to be achieved through consumer choices, like fitness programmes, dietary supplements, and medications (Crawford, 2006). In this neoliberal perspective, the biomedical model's interventionist approach aligns seamlessly with the belief that individuals should take charge of their health through various medical treatments and lifestyle decisions. This convergence reinforces the notion of self-management and also underscores individuals' responsibility for their health outcomes, often neglecting the broader social and environmental factors that also play a crucial role (Petersen & Lupton, 1996).

With its strong emphasis on personal choice and responsibility, neoliberalism “is a significant driver of rising inequality” (Morison et al., 2019, p. 5). It has also been implicated in supporting and furthering European **imperialism** during the late nineteenth and early twentieth centuries (Ratangee, 2023). The field of critical health psychology has been instrumental in explaining the intricate relationships between

social disadvantage and health outcomes, drawing on decades of research in related health fields, like epidemiology and public health, that points to the fundamental role of the social environment in staying healthy or becoming unwell (Marmot et al., 1978; Marmot et al., 1991; Wilkinson & Marmot, 2003). This work shows that disease and mortality rates differ according to one's social location, such as gender, sexual identity, ethnicity, race, and religion (See Part Three for more on this.)

A recent example of this is the COVID-19 pandemic, during which both prevalence rates and adherence to public health guidelines showed cultural variance. Individualistic countries exhibited higher rates of incidence and mortality and lower compliance rates with prevention measures compared to collectivist societies (Maaravi et al., 2021). Similarly, income inequality has been associated with rates of depression, identifying societies of higher income inequality as exhibiting higher population rates of depression (Patel et al., 2018).

Healthism: an offshoot of neoliberal ideology

The emphasis on individual responsibility has been reinforced and intensified by the rise of **healthism**, an offshoot of neoliberal ideology that gained dominance in the West during the later twentieth century. [Chapter 1.4](#) provides a helpful background discussion of the ideology of healthism. Here, we focus on this relatively new Western way of understanding health and illness as part of the longer thread of Western thinking that privileges rationality and individual autonomy (free will). As such, healthism (and neoliberalism more broadly) go hand-in-glove with the biomedical model because, as we explain further below, it focuses on market-based solutions to health issues, promoting medical interventions and health products as solutions while minimising the role of broader social, economic, and environmental factors. Ultimately, this contributes to the dominant Western framing of health as a personal responsibility rather than a social issue, shifting the focus from social determinants of health to individual lifestyle choices (Bell, 2010; Brown & Baker, 2012).

“Healthism” refers to an ideology or worldview in which health is considered one of *the* most important pursuits in life. The term healthism was coined by Robert Crawford in 1980 to describe what he saw as a growing health consciousness in Western societies, which he described as “the preoccupation with personal health as a primary—often *the* primary—focus for the definition and achievement of well-being; a goal which is to be obtained primarily through the modification of lifestyles” (Crawford, 1980, p. 368). The central assumption of healthism is that health is completely within an individual's control. Accordingly, health is considered a personal achievement, and individuals are expected to actively invest time, money and effort in their wellbeing through conscious lifestyle choices, regular medical checkups or interventions, and health products and services (Crawford, 1980; 2006).

The ideology of healthism, as a branch of neoliberal thinking, also supports the positioning of people as consumers of healthcare services and products (Bell, 2010). In this regard, Crawford (2006) highlighted the connection between healthism and consumer capitalism. A growing self-improvement or wellness mindset (which he called a “therapeutic ethos”) in Western societies encourages people to see health and self-care as critical aspects of their identity, making people more susceptible to consumerism as they pursue health-related products and services aligned with self-improvement. This mindset or “ethos” aligns with corporate interests as corporations profit from and reinforce the growing demand for wellness and health as a project of self-improvement. (Healthism's origins in neoliberal economic thinking and its links to capitalism are explained in [Chapter 1.4](#).)

Healthism, therefore, “situates the problem of health and disease at the level of the individual” (Crawford, 1980, p. 365) and fits well with the biomedical model of health. Even when wider environmental or social factors are acknowledged as contributing to health issues, it is still considered the individual's responsibility to prevent or treat these problems (Crawford, 1980). To illustrate, Evans et al. (2018) give an example of the food traffic light system in the United Kingdom, which indicates the amount of salt, sugar, and fat in

particular products. This system makes individual consumers responsible for monitoring their nutritional intake, but does little to regulate food producers' practices, like advertising, portion sizing, and producing hyper-palatable foodstuffs.

Healthism creates a moral imperative of self-control and risk management (Crawford, 1980). A good illustration of this ideology in operation is the framing of cancer as an imminent "risk" to be avoided through constant self-surveillance and wise lifestyle choices in neoliberal Western societies (Bell, 2010; Gibson et al., 2015). While individual practices may well be beneficial, focusing solely on individual action can inadvertently position people as responsible for preventing cancer *and* to blame if they do become ill or fail to "beat" cancer. An individual-level focus can also make it difficult for people with cancer to express negative emotions, like a sense of helplessness or despair, as shown in work by critical health psychologists Gibson, Lee and Crabb (2015). Their research showed how healthism comes to bear on the illness narratives of Australian women with breast cancer. These women's accounts of their illness experiences were shaped by the social expectation that they present themselves as taking responsibility for getting well through proactive self-monitoring (Gibson et al., 2015).

Healthist ideology, therefore, presents maintaining a healthy lifestyle as a moral duty both to oneself and society and, in this way, working to achieve health and wellness becomes an implicit marker of someone's worth. Those considered to prioritise their health correctly are seen as disciplined, self-controlled, good citizens and, importantly, morally superior to those who are seen as neglecting their health (Brown & Baker, 2012). Those who fail to maintain healthy lifestyles are thus open to critique and sometimes even social stigma.

A classic example of this moral dimension of healthism is "fat shaming," which is rooted in the assumption that people have complete control over their body size and health. Some of the views related to diet and exercise on which such stigma is based, and which readers may recognise, appear in Textbox 3. People are, therefore, held fully responsible for their weight gain and any associated medical issues. Those who fail to make healthy lifestyle choices are considered bad citizens and a burden on society (Spratt, 2023; Warbrick et al., 2019). Thus, healthism reduces (or over-simplifies) a complex issue into a matter of personal failure or success: "losing weight through diet and exercise [becomes] a simple matter of changing one's behaviour when, for many, that behaviour is formed through a lack of choice, which is ultimately caused by conditions that are beyond their control" (Spratt, 2023, p. 89), such as biological, structural, and social factors. This narrow focus on personal responsibility not only reinforces stigma but can also obscure broader systemic factors that affect health inequities across different populations. In this regard, Indigenous people and people of colour are most often disadvantaged, and fat shaming is therefore said to have "a racist edge" (Warbrick et al., 2019, p 128).

Textbox 3: Healthism in action

- Framing exercise, fitness, and weight loss around ideas of self-discipline
- Describing oneself as "bad" for enjoying dessert or not exercising
- Making remarks about others' body shapes, sizes, or weights
- Commenting on what others are eating or their habits
- Needing to "earn" a meal by exercising first
- Rewarding oneself by restricting food or burning a set number of calories
- Selecting foods solely according to calorie count, fat content, or carbohydrate levels and considering some meals a "cheat meal"

- Labelling foods “good” and “bad” based on how “un/healthy” they are

The possibility of social judgment or stigmatisation, as in the example of fat shaming, reinforces the perception of one’s value as intrinsically linked to one’s health status. Consequently, people often feel societal pressure to conform to health norms, leading them to pursue wellness regimens that can be dangerous and often feel like a requirement rather than a choice (Crawford, 1980).

The limits of the biomedical model

During the twentieth century, the limitations of this biological focus became increasingly apparent. Initially, this awareness arose from the “epidemiological transition” in Western societies, where increased food security and public health improvements shifted population patterns, including life expectancy and mortality. This transition replaced acute, infectious diseases (e.g., influenza, tuberculosis, measles, pneumonia) with chronic, degenerative diseases (e.g., heart disease, diabetes, cancer) as the leading causes of death (Wilkinson, 1994). Unlike acute illnesses, “chronic illnesses such as heart disease, cancer, stroke and diabetes are multiply determined disorders and psychological, behavioural and social factors play roles in their development” (Lyons & Chamberlain, 2006, p. 11). They are also strongly associated with routine daily behaviours (like diet, exercise, and smoking), and so are often called “lifestyle diseases” (Nettleton, 2020). The critical role of social factors in disease—as signalled by the broad shift from acute to chronic disease—is not accounted for by the biomedical model, leading scholars to question whether it alone is enough to address contemporary diseases (Wilkinson, 1994).

A significant overall limitation of biomedicine is that it has largely failed to consider the impact of illness on the lives of those affected (Baum, 2015), both in terms of their personal circumstances and cultural contexts. Since the biomedical model assumes that the human body is fundamentally a natural, objective, and neutral entity, the implication is that the body functions “normally” unless diseased, and that its functioning is experienced in essentially the same way by all people across cultures (Radley, 1994). These assumptions have been challenged by social science disciplines, like sociology and psychology, for neglecting the ways that psychological and social factors shape health at the individual level and beyond (Rohleder, 2012).

Another major critique of biomedicine is related to the power it is granted. This aspect was initially highlighted by Mishler’s (1988) investigation of the dynamics of doctor-patient consultations. His findings showed how “the voice of medicine” frequently dominated the conversations, allowing physicians to retain control. In contrast, “the voice of the lifeworld”, which reflects patients’ perspectives of their illnesses and lives, was routinely silenced, interrupted, and disregarded, leading people to feel misunderstood by healthcare providers. These findings are supported by much subsequent social scientific research, showing that the more powerful role of healthcare practitioners in healthcare interactions may lead to disregarding patients’ experiences and embodied knowledge, which do not fit neatly into medicalised frameworks and treatment plans. Healthcare providers’ objectives and desires also consequently dominate the concerns of patients (Berndt & Bell, 2021; more on this in [Chapter 2.3](#) and [Chapter 2.4](#)).

Similarly, other researchers have looked beyond the interactional level to consider how medical power functions more widely. From a slightly more critical, Foucauldian perspective, this work emphasises how medical knowledge and disease entities do not simply reflect “given” biological realities that can be discovered, but involve judgements that draw on current values and ideals of society about what counts as illness and how it should be treated (Cooper & Thorogood, 2013). ([Chapter 1.4](#) offers a thorough discussion

of Foucauldian theory.) Medical definitions of health reflect the culture in which they are generated. For instance, in eighteenth- and nineteenth-century Europe, “hysteria” was commonly considered a physical ailment affecting women (Ussher, 2022). It became a common medical diagnosis for women who thwarted cultural ideals of women as submissive, even-tempered, and sexually inhibited, which functioned as a means of social control over “unruly” women (McVean, 2017; Ussher, 2022). Therefore, medical diagnoses can reinforce aspects of the status quo, serving those in power (Jutel, 2021; this is discussed further in [Chapter 2.3](#)).



Figure 2.1.6 Jean-Martin Charcot demonstrating hysteria in a hypnotised patient at the Salpêtrière. Etching by A. Lurat, 1888, after P.A.A. Brouillet, 1887. ([Jean-Martin Charcot demonstrating hysteria](#), A. Lurat, via Wellcome Images. [CC BY 4.0](#))

To sum up, the biomedical model emerges not only from scientific advancements but is also deeply intertwined with the ideologies of individualism, neoliberalism, and healthism, which shape how health is understood and managed in Western societies. This model has proven effective in many instances, but its grounding in the physical sciences is better suited to understanding and treating *purely physical* phenomena. However, it is lacking when it comes to human issues, like health and illness, which are intricately interwoven with the social and cultural. Moreover, its strong emphasis on individual responsibility often overlooks crucial social factors contributing to health disparities. This narrow focus can limit the model's effectiveness in addressing broader public health challenges, highlighting the need for a more integrated approach that considers individual choices and the wider social context. These limitations lead critical health psychologists to argue for a more holistic view to treat modern health conditions, as well

as ensure that everyone can access what they need to be healthy, including those who are economically disadvantaged (Morison et al., 2019).

Beyond the biomedical model

We have argued thus far that the dominant Western biomedical model is a culturally based belief system, just like any other cultures' conceptualisations of health and illness, but it has increasingly become globally dominant. It follows then that we must see health psychology in the same way: as deriving from a particular time and place and offering particular ways of understanding health and illness. These different understandings have since developed into different “strands” of health psychology as the discipline has matured (see Marks, 2002). In the interests of casting a critical gaze on our own discipline—as all good critical scholars ought to—in the final section of this chapter, we trace the rise of health psychology as part of growing efforts in the social sciences and beyond to develop more encompassing models for understanding health that consider its essential social and cultural dimensions.

The biopsychosocial model of health and the rise of health psychology

Health psychology was born from the growing realisation of the critical role of behavioural, psychological, and social factors in (especially chronic) diseases. The biomedical model of health has prevailed in the medical field for over two centuries, remaining largely unchallenged until more recently (Thompson, 2014). The questions levelled at the biomedical model prompted a widespread rethinking of the biomedical understanding of health as simply the absence of disease. There was a conscious shift in Western societies away from a purely reductionist, mechanistic understanding of health, and attempts to formulate a holistic understanding that includes the role of the psychological and social in people's health (Schramme, 2013). This endeavour is most evident in the well-known definition of health in the World Health Organization's (1948) constitution: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. This definition was intended to reflect the view that health is affected by various factors, including individual characteristics and behaviours, physical and social environments, income, and education levels (World Health Organization, 2017).

This questioning and critique does not underplay the value of modern medicine, nor does it suggest that we should do without it! Without a doubt, the biomedical model has significantly impacted disease prevention and treatment, producing a large amount of valuable knowledge that has supported the development of physical treatments for disease, like medications, vaccines, and surgical procedures (Rohleder, 2012). However, as mentioned previously, some critics claim that the successes of biomedicine have been over-emphasised over some of its adverse outcomes, harms, or side effects. They also point out that the most substantive gains in population health were related to the above-mentioned improvements in people's living conditions—reducing poverty and supporting better hygiene and nutrition—and not medical advances (although these later played a role) (Olafsdottir, 2013.).

The growing dissatisfaction with the dominant Western biomedical model of health, especially through the 1970s, nevertheless led to the development of the biopsychosocial model, which provided an alternative approach to understanding health and illness and a basis for the new sub-discipline of health psychology. The model was developed within the medical specialisation of psychiatry by George Engel (1977) as an alternative to the biomedical model and the dominant approaches of behaviourism and psychodynamics within the field. Engel (1977) argued that the dualistic view of mind and body in medicine meant that for the psycho-social dimensions of mental illness to be given any meaning in psychiatry, they had to be first reduced to physiology or biochemistry. He, therefore, advocated for “a new model for medicine” (cited in Delfosse, 2015, p. 36): a more comprehensive approach rooted in general systems theory, which he believed

would recognise a patient as a whole person—including their thoughts, feelings, and history (Gatchel et al., 2020).

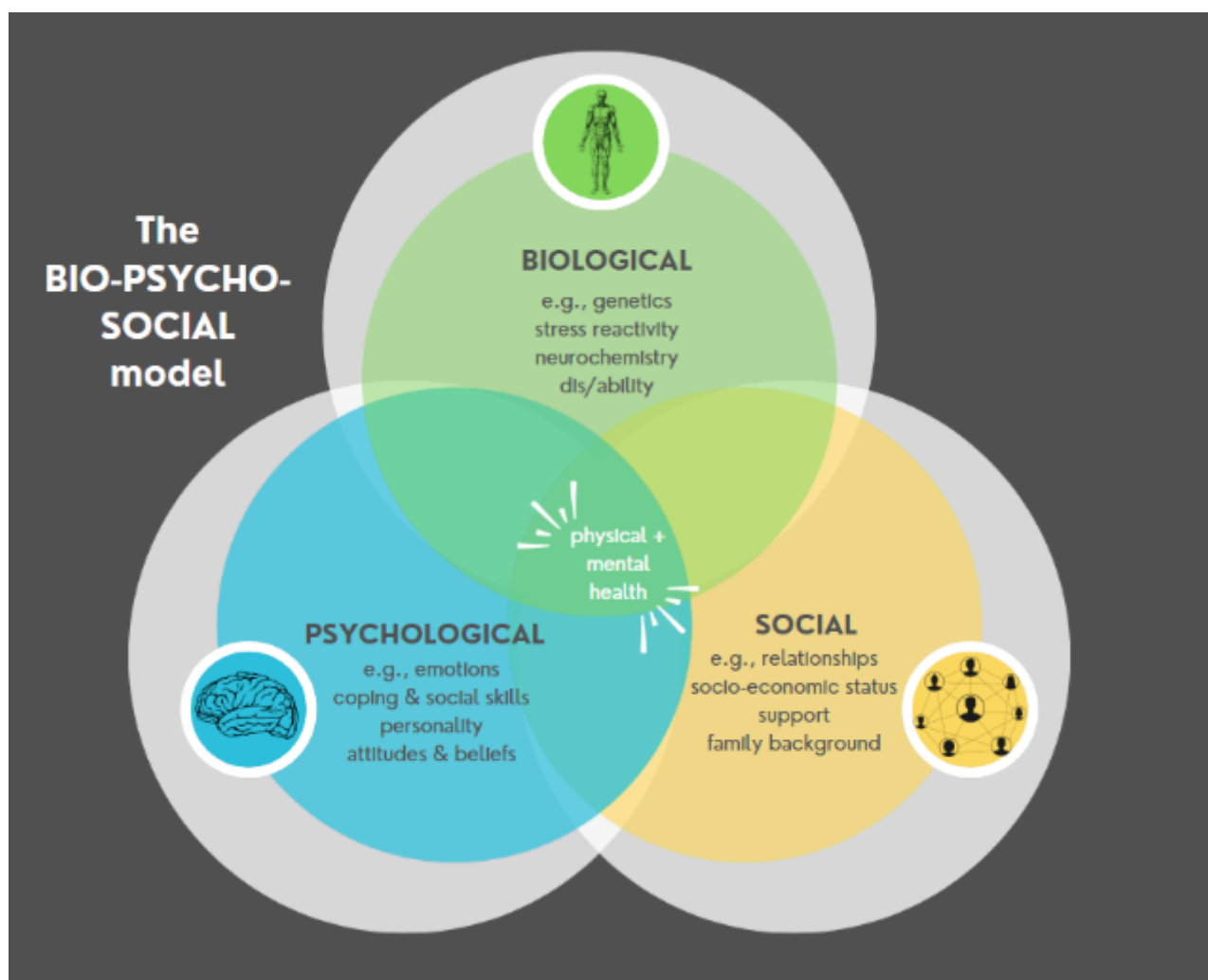


Figure 2.1.7 The bio-psycho-social model shows how biological, psychological, and social factors interact to shape physical and mental health. (Tracy Morison. [CC BY-NC 4.0](#))

The biopsychosocial model holds that the complex interaction of biological, psychological, and social factors influences health and illness. The model deviates from the biomedical model in understanding that all three factors can affect the cause and progression of illnesses, not only biological ones (Miles, 2020). For instance, the development of a specific disease, such as cancer, can be influenced by various biological factors (e.g., genetic predisposition), behavioural factors (e.g., smoking and stress), and social conditions (e.g., social support and peer interactions).

While the idea that multiple factors contribute to a person's particular form of ill health was not entirely new, what was novel about Engel's model was its view of the dynamic *interconnections* between the three domains of biological, psychological, and social functioning. For example, psychological factors can impact biological functioning (e.g., changes in the autonomic nervous system and hormone production) and, in turn, be affected by biological processes (e.g., prompt cognitive impairment or influence mood).

Drawing from general systems theory, rather than taking a linear causal understanding that is more suited

to the natural or biological world, health issues are understood in terms of dynamic, multilevel, multi-system interactions. Put simply, the biopsychosocial model organises all levels of biological complexity along a continuum, from somatic to intrapsychic to interpersonal (see Figure 2.1.8). When arranged vertically, each of these levels is embedded in the ones above and contains the ones below, ranging from the molecule, cell, and organ system to the individual, dyad, family, community, culture, nation, and biosphere. While the biomedical approach holds that all phenomena are best understood at the lowest level of natural systems (e.g., cellular or molecular), a biopsychosocial perspective recognises that different medical situations can be scientifically understood at multiple levels along the natural systems continuum (Watson, 2012). In this sense, the model offers a holistic view of health.

The model encourages clinicians and researchers to look beyond the physical and to integrate knowledge from different domains for better understanding and treatment of health issues. Its strengths, therefore, lie in its holism and inclusiveness. The model's fundamental premise has been validated by health psychology research highlighting the significance of psycho-social factors in illness (Miles, 2020).

At the same time as the biopsychosocial model emerged in the 1970s, growing recognition of the need for a broader understanding of health—beyond the biological—led to the involvement of several social science disciplines in issues of health and illness, including within psychology. Many psychologists who began focusing on issues related to medical care became aware of the larger environment's role in people's physical health and overall wellbeing. They began arguing that health and illness must be understood holistically and studied in terms of how the psychological and social worlds interact with the biological or physical (Morison et al., 2019; Rohleder, 2012).

At that time, health psychology emerged as a sub-discipline of psychology, explicitly using the biopsychosocial model of health and illness Engel had proposed. The biopsychosocial model became a widely accepted framework in mainstream health psychology. The model is strongly supported by those interested in individual physical and mental health (Rohleder, 2012).

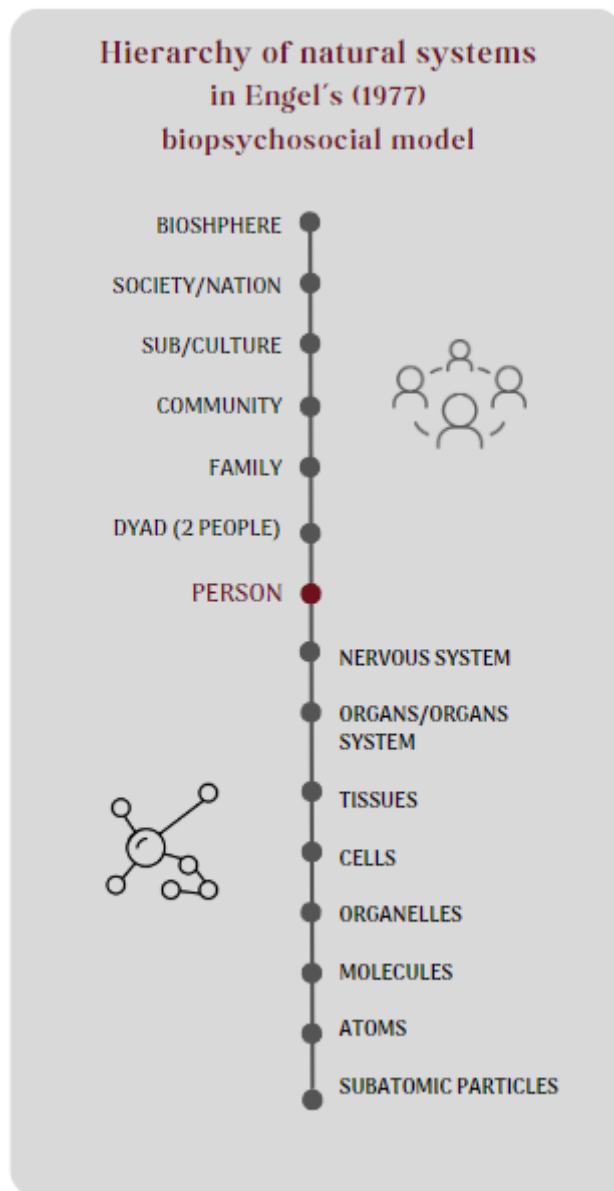


Figure 2.1.8 Engel's hierarchy highlights how individuals exist within interrelated systems, from the microscopic to the societal level.(Tracy Morison. [CC BY-NC 4.0](#))

Not social enough: the critical turn in health psychology

Over subsequent decades, into the 1990s, more and more critical scholars voiced the belief that the biopsychosocial model and other attempts to acknowledge the role of context in health and illness still fell short, giving rise to a “critical turn” in health psychology (Morison et al., 2019). While most health psychologists agree with the model's basic premise, many offered criticisms, including those detailed in Textbox 4, below.

Textbox 4. Problems with the Biopsychosocial Model

The biopsychosocial “model” is not a true model.

The biopsychosocial model does not hold the explanatory power of an actual integrated theoretical model (Crossley, 2000). According to Stam (2014), the model lacks theory and is vague. It therefore does not explain the relationship between the factors that are thought to influence one another and, therefore, cannot allow for investigation of a system’s different components and relationships (Rohleder, 2012). It has, therefore, been called simply a rhetorical device (Stam, 2014), a guiding framework (Suls & Rothman, 2004), or a way of thinking about health issues (Marks, 2002).

The biopsychosocial model privileges the biomedical; it remains essentially biomedical.

The model does not question the primacy given to the biological (Stam, 2014). Some scholars maintain that it “is still essentially biomedical and needs further theoretical work” (Lyons & Chamberlain, 2006, p. 12) to capture the social dimension in health psychology research.

The biopsychosocial model retains the biomedical model’s pitfalls.

Critics assert that because the model presents the mind, body, and society as largely separate, it retains biomedicine’s mechanistic view (Stam, 2014) and body-mind dualism (Crossley, 2000).

Critics argue that health psychologists often fail to apply the biopsychosocial model in a way that reflects its roots in systems theory. Instead of exploring how biological, psychological, and social factors interact dynamically, these elements are sometimes treated as a simple checklist of variables or referenced in overly simplistic, common-sense ways (Santiago-Defosse, 2014). (See also [Chapter 1.2](#) for a critique of how the biopsychosocial model shapes understandings of the person in health psychology.)

It is perhaps unsurprising that much research using the biopsychosocial model has been shaped by the traditional scientific methods dominant in biomedical research—emphasising prediction and control over deeper understanding (Stam, 2014). This tendency can be better understood by considering the historical and cultural context in which health psychology emerged. As noted earlier in this chapter, perspectives on health are not developed in a vacuum—they are shaped by the socio-historical conditions of particular times and places.

Health psychology originated primarily in the United States and has been heavily influenced by its socio-political and intellectual climate (Pickren, 2019; Stam, 2014). In the 1970s, US American psychology was dominated by a neo-behaviourist paradigm, arising from efforts to establish psychology as a credible scientific discipline aligned with post-World War II ideals of progress and rationality (Parker, 2002). Within this framework, much health psychology research focused on individual “social cognitions”—that is, how people perceive, interpret, and make sense of health-related issues. These cognitive processes were seen as central to shaping behaviour, and by extension, health outcomes.

Working under the assumption that what was going on “inside people’s heads” is key to understanding health behaviour, researchers and practitioners used social cognitive theories to examine how individuals’ beliefs and attitudes, alongside social influences (e.g., peer pressure), impact health-related behaviours (e.g., smoking cessation, diet and exercise adherence, medication compliance, seeking medical care) (Horrocks & Johnson, 2014; Lyons & Chamberlain, 2017). This assumption underpins widely used models such as the Health Belief Model (Rosenstock, 1974) and the Theory of Planned Behaviour (Ajzen, 1985), which remain influential in health psychology today. (See [Chapter 1.2](#) and [Chapter 3.1](#) for more on **social cognition models**.) These models aimed to modify individual behaviours that were assumed to cause poor health. For example,

Matarazzo (1982)—often credited with being one of the founders of health psychology—urged scholars to “aggressively investigate and deal effectively with the role of the individual’s behaviour and lifestyle in health and dysfunction” (p. 12). The development of the models was motivated by a wish to enable individuals to lead healthy lives and, importantly, to reduce healthcare costs for governments (Igarashi, 2015). This may help explain their enduring popularity in neoliberal contexts, where framing health as a matter of personal responsibility provides ideological support for reducing public investment in healthcare.

However, several health psychologists have argued that this individualised approach shares many of the same limitations as the biomedical model, reducing complex health issues to matters of behaviour modification and technical intervention (Igarashi, 2015). This critique was first raised by Stainton Rogers (1991), who argued that such models oversimplify human behaviour and obscure the broader socio-cultural context of health-related actions. These stripped-down explanations fail to meaningfully engage with the social, cultural, political, environmental, and historical conditions in which health behaviours are embedded (Horrocks & Johnson, 2014). As a result, they overlook the complexity, nuance, and at times, contradictions inherent in people’s everyday health practices (Mielewczyk & Willig, 2007; Murray & Poland, 2006).

Extending this argument, some critical scholars even questioned whether a health psychology that tries to be scientific can genuinely deal with the underlying causes of poor health, which are shaped by the larger social and cultural environments (Murray, 2012a; 2012b). Others argued that the emphasis on individual agency and responsibility in health psychology reinforces existing social hierarchies and sustains structural inequalities. These critiques highlight how individualistic models align closely with neoliberal ideals, which prioritise personal responsibility, self-management, and consumer choice as the foundation for health (Morison et al., 2019). Their concerns are backed by decades of evidence from epidemiology, public health, and medical sociology, including the Whitehall Studies (Marmot et al., 1978; 1991), The Black Report and Health Divide (Townsend et al., 1986), and the Acheson Report (Acheson, 1998).

In response to these critiques, there was a move towards extending the focus of health psychology beyond the individual, leading to the emergence of critical health psychology. One of the earliest and most comprehensive articulations of this field was offered by Stainton Rogers (1996), who envisioned critical health psychology not merely as a critique of biomedicine but as a broader reimagining of how psychology could engage with issues of power, inequality, and meaning in relation to health. Critical health psychologists introduced new ways of thinking and working—including the use of qualitative methodologies—to better capture the lived realities of health and illness (Chamberlain & Murray, 2017). By the early 2000s, critical health psychology had come to be recognised as a distinct approach.

While the early distinction between mainstream and critical health psychology was often described in terms of the quantitative/qualitative divide (e.g., Crossley, 2000), this is now seen as an oversimplification. Although qualitative methods remain central to critical work, what truly distinguishes critical health psychology is its openness to diverse ways of knowing and its commitment to advancing social justice (Morison et al., 2019). Reflecting this position, Wilkinson (2000) argued for theoretical and methodological eclecticism in critical health psychology research on the grounds that “all [methods] are useful, albeit for different kinds of research purposes, and in different applied contexts” (p. 360).

Despite methodological diversity, a unifying thread in critical health psychology is its commitment to understanding health in its full social complexity. This includes not only studying the impacts of structural inequalities and social determinants, but also challenging the systems and power relations that reproduce them. Critical health psychologists aim to contribute to real-world change through research, advocacy, and policy—efforts guided by a shared ethic of social justice (Morison et al., 2019). The [International Society for Critical Health Psychology](#) (ISCHP) summarises some of the core principles of critical health psychology, as shown in Textbox 5, which are further explored in [Part Three](#) of this book.

Critical Health Psychology's common aims and interests:

- awareness of the social, political, and cultural dimensions of health and illness (e.g., poverty, racism, and sexism)
- dissatisfaction with traditional psychology's positivist assumptions and lack of engagement with broader social and political issues
- application of critical theories (e.g., social constructionism, post-modernism, feminism, Marxism)
- use of qualitative and participatory research methods (e.g., discourse analysis, narrative inquiry, action research, and ethnography)
- active commitment to reducing human suffering and improving the conditions of life, especially for socially marginalised people.

Closing reflection

It is worth noting that in this chapter, we have examined how Western ideas about health and illness emerged and shaped modern health psychology, including the mainstream adoption of the biopsychosocial model as a more holistic alternative to biomedicine. We focused on Western perspectives because of their global influence, but it is vital to recognise that they are not the only ways of understanding health. Critical health psychologists have increasingly paid attention to Indigenous health models and methodologies that offer epistemological alternatives that foreground sovereignty, relationality, and lived experience (Durie, 2009; Haitana et al., 2020). For example:

- **Te Whare Tapa Whā (Māori, Aotearoa New Zealand):** A holistic health model that views wellbeing as a four-sided house, each wall representing a key dimension of health—taha tinana (physical), taha wairua (spiritual), taha whānau (family/community), and taha hinengaro (mental/emotional) (Durie, 1985).
- **Medicine Wheel (Various First Nations, North America):** A framework emphasising balance and interconnection among four aspects of life—physical, mental, emotional, and spiritual—often represented by the four directions (Kyoon-Achan et al., 2021).
- **Social and Emotional Wellbeing Framework (Aboriginal and Torres Strait Islander Peoples, Australia):** A model recognising the importance of cultural identity, community, family connections, land, spirituality, and ancestry in shaping health and wellbeing (Dudgeon, 2020; Dudgeon, Gibson & Bray, 2021).
- **First Nations Holistic Policy and Planning Model (Canada):** An approach that integrates traditional knowledge, community priorities, respect for Elders, spiritual values, and the interconnectedness of individuals, families, communities, and the environment (Reading, 2007; Reading, Kmetz, & Gideon, 2007).

Acknowledging these frameworks encourages a more inclusive and contextually grounded understanding of health and wellbeing. This has been shown to benefit Indigenous people (Haitana et al., 2020; Masters-Aawere et al., 2020), as, for example, in the First Nations Mental Wellness Framework (Kyoon-Achan et al., 2018) pictured below in Figure 2.1.9. Holistic understandings can also benefit the general population

more broadly (Durie, 2009). [Chapter 1.1](#) of this book discusses this issue in more depth, focusing on Māori understandings and health models.

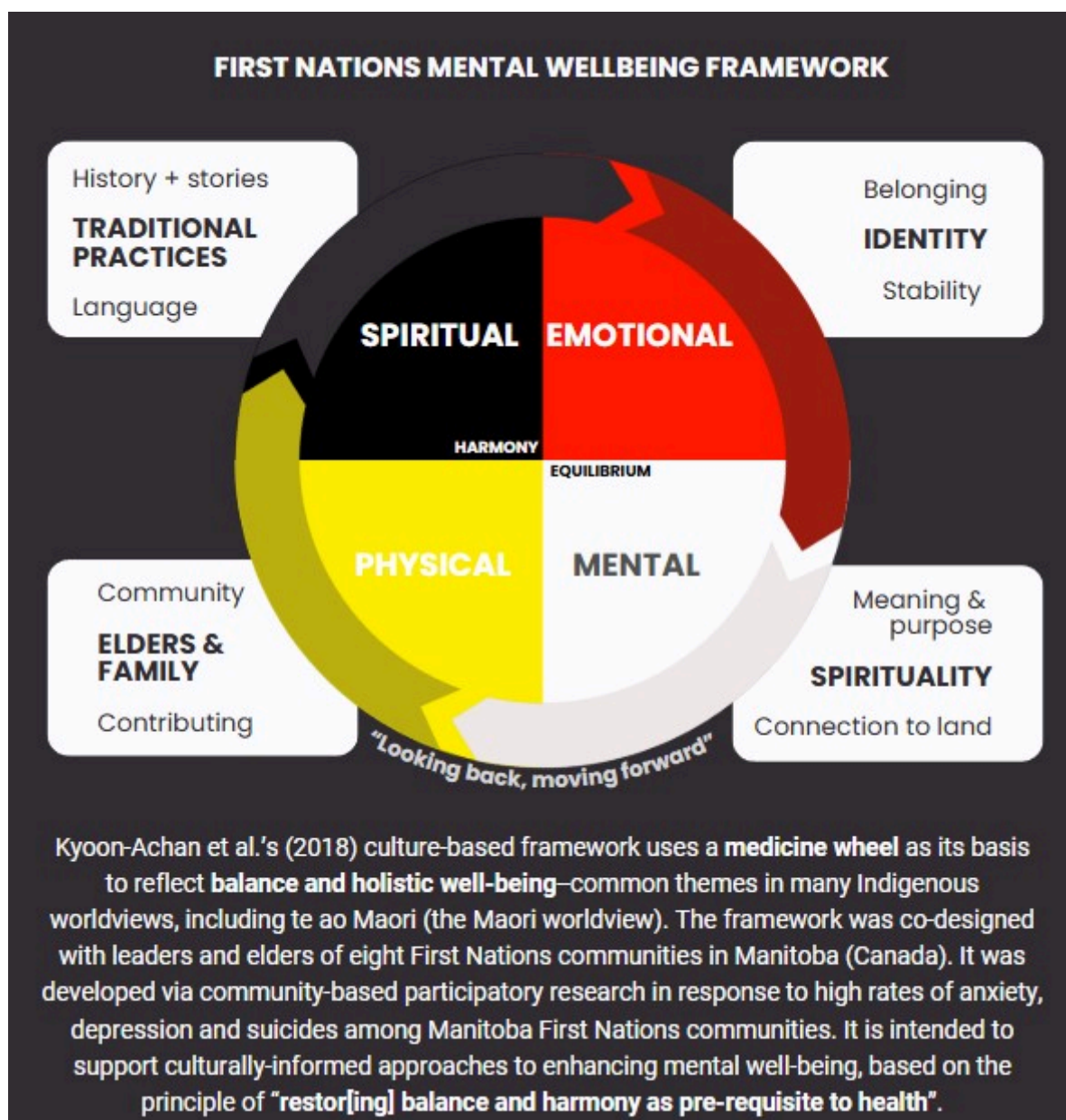


Figure 2.1.9 This First Nations mental wellbeing framework uses a medicine wheel to emphasise balance across emotional, spiritual, mental, and physical domains as essential for health. (Adapted by Tracy Morison from the original ideas. Permission granted by Kyoon-Achan and colleagues)

Conclusion

Critical health psychology is essentially about “new ways of seeing” with the fundamental aim of making a difference in people’s lives. In this chapter, we have explored how different understandings of health and illness are profoundly shaped by socio-cultural factors, and how these perspectives have evolved. We have critically examined the dominant biomedical model, highlighting its limitations while acknowledging its contributions. By contrasting this with alternative frameworks that incorporate social, cultural, and

psychological dimensions, we see that there is no single, universal way to understand health. Instead, health is a complex construct influenced by various factors, and taking a critical perspective helps to unpack these layers. Understanding and engaging with diverse views on health is essential for improving individual care and shaping more inclusive and effective healthcare policies. This holistic view opens new possibilities for addressing health and illness in a way that better serves individuals and broader society.

Summary of main points

Some key takeaway points from this chapter:

- Health and illness are not fixed or universal ideas; they depend on social, cultural, and historical contexts.
- Everyday understanding of health often reflect the dominant Western biomedical model, which treats health as mainly biological and overlooks social factors.
- The biomedical model comes from Western Enlightenment thinking, focusing on the body as a machine and encouraging individual responsibility for health.
- This view supports “healthism,” a Western ideology that treats good health as a moral duty and often blames individuals for their own poor health.
- Critics have argued that focusing only on biology and personal choices ignores how social conditions and inequalities shape health.
- In response to critiques, the biopsychosocial model was developed to integrate biological, psychological, and social factors, but it often still prioritises biomedical approaches.
- Critical health psychology goes further, examining power, inequality, and cultural differences that influence how people define and respond to illness.
- This social perspective shows that health beliefs and practices vary across cultures and change over time, challenging the idea that modern Western understandings are the only “truth.”
- Understanding health as profoundly social, and socially constructed, encourages looking beyond individual behaviours to address broader issues like poverty, discrimination, and social policies.
- Adopting a critical lens can lead to more equitable, culturally sensitive healthcare and public health strategies that consider the whole person and their material and social environment.

Further learning

Further reading

- Burr, V. (2025). *Social constructionism*. (4th ed.) Routledge. – *A highly accessible book and a must-read if you want to understand more about social constructionism*

- Chamberlain, K., & Lyons, A. C. (Eds.). (2022). *Routledge international handbook of critical issues in health and illness*. Routledge. – An excellent overview of contemporary health issues
- Pickren, W. (2019). *Psychology and health: Culture, place, history*. Routledge. – This book “traces the development of the relationship of health and psychology through a critical history that incorporates context, culture, and place”

More on body-mind interconnection and the social location of health

- Listen to this podcast by *fx Medicine* on [The emerging importance of psychoneuroimmunology \(PNI\)](#)
- Watch this [TEDTalk by David Williams](#) on “toxic stress”
- Read more on epigenetics and historical trauma in this blog post: Apter, T. (2020). The insidious legacies of trauma: Trauma is passed on from parent to child, but by what mechanism? *Psychology today*. <https://www.psychologytoday.com/us/blog/domestic-intelligence/202005/the-insidious-legacies-of-trauma>
- Read the classic article by Taylor, Repetti, & Seeman called [Health psychology: What is an unhealthy environment and how does it get under the skin?](#) [PDF]

Web resources

- [The International Society for Critical Health Psychology](#)’s website has links to some great resources, as well as their podcast and wonderful blog featuring posts on various health-related topics written by health psychology academics and students.

Reflection and discussion

- **The media play a significant role in shaping public understanding of health issues. What are some examples of an illness or health issue that has been the focus of media attention.**
 - How was the issue framed and what might the effects have been of framing it this way (i.e., treatment of sufferers, approaches to treatment, effect on general public)?
 - Can you identify some of the dominant Western perspectives that shape these representations (e.g., healthism, individualism, body-mind dualism)?
- **The diagnosis of hysteria is a good example of how understandings of what count as illness have changed over time. Reflecting on this “illness”, consider the following questions:**
 - Why do you think hysteria was predominantly associated with women?
 - What social and cultural factors contributed to the rise of hysteria as an illness?
 - What might this suggest about medical knowledge?
- **Healthism is a dominant ideology shaping understandings of health.**
 - How does this ideology show up in your own life or in society around you?
 - How does healthism and its “moral hierarchy of health” affect how people judge

- themselves and others?
- What are some ways to shift from this ideology toward a more holistic view of health?
- **Many Indigenous understandings of health offer an alternative view to the narrower views of health that dominate in the West.**
 - Choose an Indigenous health model mentioned in this chapter to research and contrast and compare it to the biomedical model.

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2.2 Making sense of bodily experiences: Interpreting signs and symptoms

TRACY MORISON AND ALLY GIBSON

Overview

This chapter is about how people make sense of the changes experienced in their bodies as an indication of illness. How do we know when a physical sensation is serious or just a fleeting discomfort? Deciding whether to seek medical care or ignore a symptom is a daily reality, but the process of interpreting bodily signals is far more complex than it might seem. By the end of this chapter, you will be able to understand **symptom interpretation** as more than a straightforward process. Instead, you will see it as a complex, socially negotiated act with significant implications for individual health, healthcare practices, and broader public health outcomes.

Learning objectives

By the end of this chapter, readers will be able to:

1. **Articulate the significance of studying symptom interpretation**, highlighting its relevance for understanding health and illness experiences.
2. **Discuss how social meanings shape views of the body** and explain the body's central role in interpreting symptoms.
3. **Differentiate between key approaches to studying symptom interpretation** in health psychology, identifying their strengths and limitations.
4. **Apply a critical perspective to symptom interpretation** by:
 - Explaining how symptom interpretation is influenced by social, cultural, and contextual factors.
 - Using core concepts to analyse and understand real-world health issues.

Introduction

Deciding whether a physical sensation is a **sign** of illness that requires medical attention or something that can be shrugged off is a routine part of daily life. It is an experience everyone is familiar with—those moments of wondering, “Is this something serious or just a passing ache?” But why, you might ask, is studying how people interpret these bodily sensations important? To answer that question, let us turn to the following memorable—and humorous—short film, “Just a little heart attack” from a U.S. health campaign. The film was intended “to educate women about the realities of heart disease” (American Heart Association, 2012), including recognising when they are having a heart attack.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/critical-health-psychology/?p=283#oembed-1>

This short film highlights that many women have missed the signs and risks of heart attacks, which can manifest differently for (cisgender) women and some (cisgender) men (Zbierajewski-Eischeid & Loeb, 2009). Consequently, women have suffered heart disease invisibly over much of the past century. Indeed, an analysis of the UK National Heart Attack Register in 2016 showed that women are twice as likely to receive a wrong diagnosis for a heart attack than men (Wu et al., 2018).

Our example of misrecognising a heart attack highlights the importance of understanding how individuals interpret their bodies' signals and the implications for timely medical care. Symptom interpretation can be a life-and-death matter. How people make sense of and then respond to bodily changes (or not) has a bearing on many aspects of maintaining good health, such as seeking medical care, treatment adherence, and self-management of **symptoms** (particularly for chronic conditions) (Scott & Walter, 2010). Early identification, reporting, and proper attribution of symptoms can facilitate effective treatment for many health conditions (Ginsburg et al., 2020; Lyons & Chamberlain, 2006).

This chapter highlights the important role of social meanings in people's interpretation and communication of bodily experiences, like those involved in coronary heart disease. Having established how socio-cultural factors shape understandings of health and illness in the preceding chapter ([Chapter 2.1](#)), we base this chapter on the premise that symptom interpretation is not just a personal experience but deeply shaped by social meanings and cultural norms. We begin by discussing the body as the central site of health and illness, as “speaking” through signs and sensations, such that symptom interpretation involves a complex interplay between the biological and the social. We then explore how people decipher these bodily signs as symptoms of illness within their specific cultural and social contexts, viewing symptom interpretation as both embodied and culturally situated. As part of this discussion, we critically evaluate traditional and emerging approaches to studying symptom interpretation, recognising their limitations and applying a socially embedded perspective to real-world health issues.

The body that “speaks”: bodies, social meanings, and symptom interpretation

Our bodies communicate through sensations, which we may interpret as signs of illness (Radley, 2004). Far from being neutral or purely biological entities, bodies are imbued with meanings shaped by social, cultural, and political contexts (Barker, 2010; Lupton, 2012). As Corbin (2003, p. 258) noted, “The body speaks to the person through sensations that are anchored in meaning. The meaning is derived through experience in the social world.” These meanings, in turn, influence how individuals understand their bodily sensations and how others—such as family, friends, or healthcare professionals—respond to their symptoms (Gibson et al., 2017).

Historically, medicine and psychology have treated the body as an object, often using the White male body as the standard for health and anatomy (Rosenfield & Faircloth, 2006; Watson, 2000). (This is the “mythical norm” discussed in [Chapter 1.2](#).) This objectification has focused on understanding the body in terms of biological components like genes, cells, and muscles, presenting them as objective and universal truths (Ussher, 2006). However, this biomedical perspective often ignores how social and cultural contexts shape how bodies are understood by individuals and society. In contrast, from a critical health psychology

perspective, the body can be seen as a “text” that conveys meanings and ideas. These meanings are not inherent to individual bodies but arise from broader societal norms and values that are constantly shifting and open to contestation (Burns, 2004). For instance, a thin body may be associated with health and attractiveness in some cultures, while in others, it might signal frailty or deprivation. These socially constructed meanings influence not only how people view their own bodies and interpret bodily signs and potential symptoms of illness, but also how others respond to the symptoms people communicate (Gibson et al., 2017).

Complementing and expanding on this perspective, **embodiment** theory proposes that bodies are central to how we experience and interact with the world. Bodies are not merely physical objects but dynamic entities shaped by ongoing interactions with sociocultural contexts (Lyons, 2009; Lyons & Chamberlain, 2017; Ussher, 2008). This interaction is illustrated by the example of coronary heart disease at the start of this chapter. This example highlights how societal norms about gender and pain shape symptom interpretation. The interplay between the social and the biological is further evident across generations. For instance, colonisation in Aotearoa New Zealand (historical and ongoing) has left enduring legacies for the Indigenous Māori, including land loss and associated trauma, which have been linked to poorer health outcomes (Thom & Grimes, 2022). (See [Chapter 1.1](#) for further discussion.)

These examples show how historical, social, and cultural forces shape the meanings attached to bodily signs and, consequently, how symptoms are understood, communicated, and acted upon. Symptom interpretation can, therefore, be thought of as reading or interpreting bodily signs. For example, pain or discomfort signals potential issues that require attention, such as a headache that might indicate dehydration, stress, or a more serious condition.

It is important from the outset to note an important distinction between bodily **signs** and illness **symptoms** (Radley, 1994; cf. Kugelman, 2003). These terms are often used interchangeably but have distinct meanings in health psychology and medicine more broadly (see Textbox 1).

Textbox 1. “Sign” versus “Symptom”

A **sign** is a change in the body that can be seen or measured, like a rise in temperature or the appearance of aberrant growths, and is considered objective evidence of disease.

A **symptom**, on the other hand, deals with the experiential aspect, the subjective experience of something out of the ordinary that an individual needs to make sense of (Saddock & Saddock, 2008).

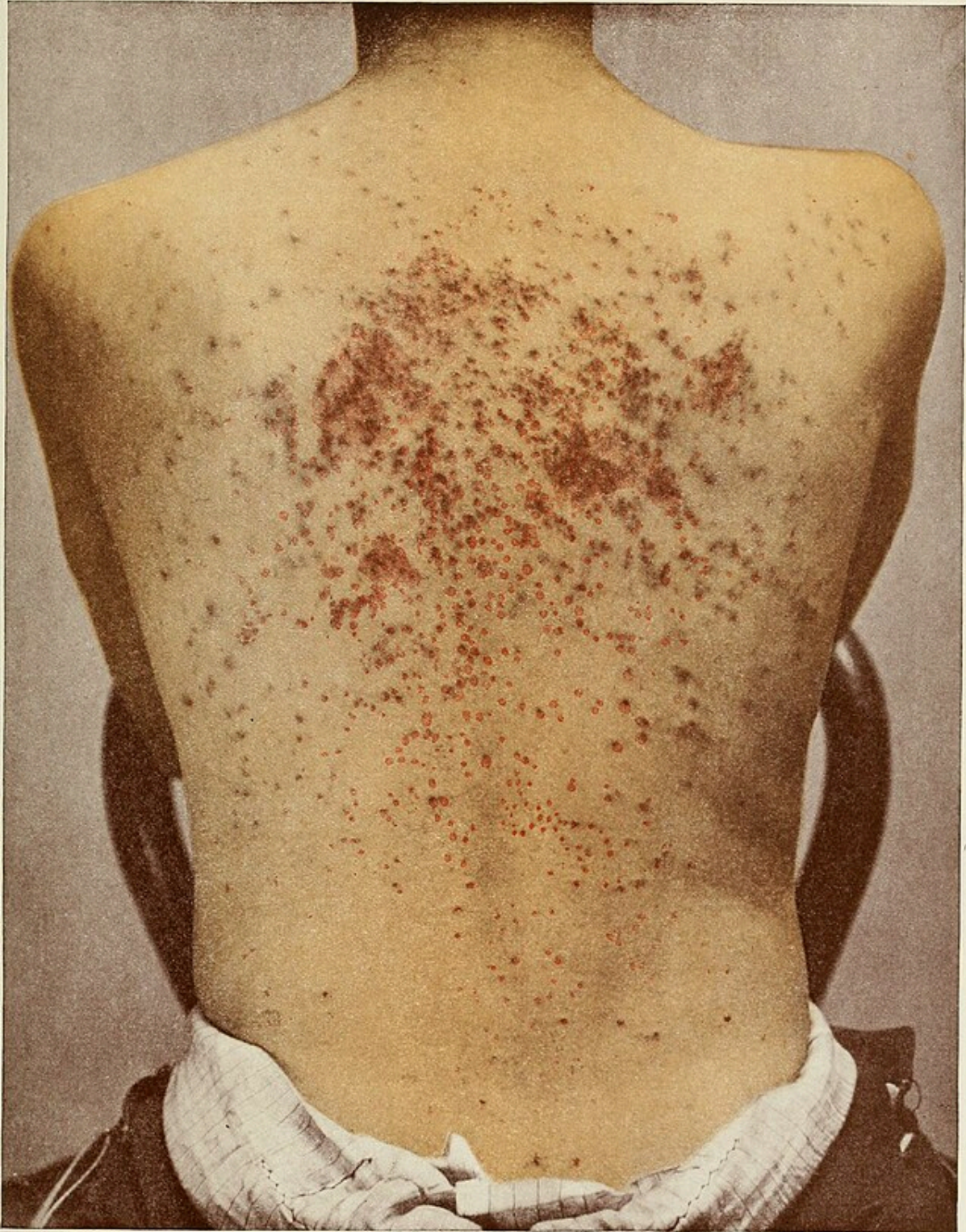


Figure 2.2.1 Bodily signs of a health condition: Eczema Papulosum. ([Eczema Papulosum](#), George Henry Fox, via Wikimedia Commons. Public domain)

For example, someone may have bodily signs that include red, scaly, inflamed skin, with oozing and crusting lesions. These bodily changes might be experienced as symptoms of itching, sensitivity,

irritability, and trouble sleeping. Reporting these to a health provider might result in a diagnosis of eczema.

Thus, put simply, signs are like the visible “evidence” of an issue, while symptoms are the experience of that issue. Both dimensions are involved in figuring out what may be happening with one’s body.

Deciphering “the language of body”: from signs to symptoms

Making sense of the bodily changes they experience is how people arrive at the perception of being well or ill (Corbin, 2003). The fundamentally embodied nature of the process of deciphering the body’s language is well captured by Corbin (2003, p. 265):

Construction of an illness begins with the advent of strange sensations or a change in appearance that can't be anchored [to] meaning. It's not the usual sensations caused by stresses and strains of living, like having a sore throat, knee, or elbow that one knows will hurt for a while, then the pain will go away on its own. These sensations are different. The familiar body becomes the unfamiliar body. There follows a period of watching, waiting to see what happens.

Corbin’s description conveys the personal meaning making involved in making sense of unusual or disruptive bodily experiences, depicting what health psychologists traditionally termed “symptom perception.” What it fails to capture, however, is how this process happens within a particular socio-cultural setting in which bodies and bodily experiences, like pain, are imbued with different meanings that inform people’s sense making. The process is about more than just perception; it also involves interpretation.

Critical health psychology has therefore expanded the focus to consider symptom interpretation—as we have approached it in this chapter. We discuss each of these approaches—symptom perception and symptom interpretation—in turn.

Symptom perception

Traditionally, health psychology focused on symptom perception using social cognitive theory, with explanatory frameworks such as cognitive labelling and attribution theory (Head et al., 2022; Phillips et al., 1999). This work is strongly based on social psychology’s perceptual or cognitive perspective and aligns with an individualistic view of the person. (See [Chapter 1.2](#) for a fuller discussion.) From this perspective, people are seen as privately or independently determining whether a certain sign means they are sick, and whether to go to the doctor or to treat themselves based on their own bodily experiences or what they observe others doing (Radley, 1994).

An example is Leventhal, Nerenz, and Steele’s (1984) cognitive model of self-regulation, pictured in Figure 2.2.2. In this model, bodily signs are processed as information by a person (“the perceiver”), who cognitively appraises possible causes and whether the sign indicates a potential risk or threat. Based on this cognitive process, the person may or may not see the bodily changes as a problem, and this perception will then influence whether the person tries to treat it or seek help or medical care.

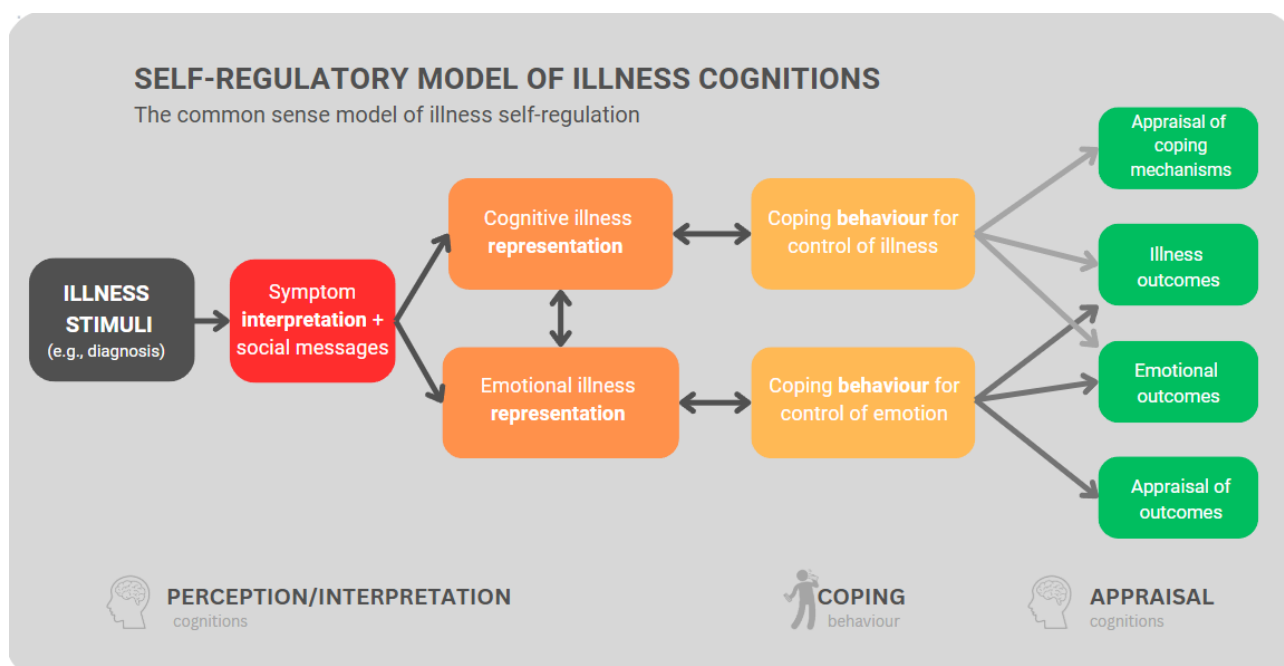


Figure 2.2.2 Example of a cognitive model of symptom perception. (Tracy Morison. [CC BY-NC 4.0](#))

As this example shows, cognitively based symptom perception models focus largely on solitary thought processes and individual factors. These include differences in “attributional styles” (i.e., how people typically respond to negative experiences affecting them), personality attributes (e.g., neuroticism, optimism), or individual biological differences (e.g., pain sensitivity). More recent models acknowledge factors external to the person, such as how social modelling or media influence the perception and interpretation of symptoms (Gastgeiger & Petrie, 2022). Overall, the primary focus remains cognitive; the goings on inside an individual’s mind is the main explanatory factor for how someone responds to bodily changes potentially signifying illness.

This individual-focused approach—which is dominant in psychology—has been described as “cognitive algebra”: a mental process whereby the person considers different pieces of information based on how important or valuable they appear. The information is then weighed or calculated to reach a final judgment or assessment (Stainton Rogers, 2012). Essentially, it is as though one’s brain is doing mathematics to determine what one thinks about something based on the information available. Particular kinds of thoughts then cause a particular behaviour, like going to a doctor for a diagnosis or ignoring the problem and hoping it will resolve itself. Such a cognitive process may indeed occur, but this is only part of the picture.

In the interests of generating more holistic explanations, critical health psychologists have argued that “explanations which rely upon individual decision-making are actually missing crucial aspects of what happens when people try to determine whether they are, or someone else is, ill” (Radley, 1994, p. 4). Approaches focused solely on what transpires “inside people’s heads” overlook the context in which health-related behaviours occur, including the interconnected nature of people and how they manage their health (Head, Bute, & Ridley-Merriweather, 2021). Therefore, cognitively focused explanations of symptom perception have been critiqued as insufficient to capture the nuance and complexity of how people make sense of their bodily experiences.

Symptom interpretation

Critical health psychologists—along with scholars from disciplines like medical sociology and anthropology—argue that making sense of bodily changes is much more complex than simply perceiving them. It is more akin to a process of interpretation in that people assign meaning to information or experiences based on individual perceptions, cultural beliefs, and contextual factors within social relationships (Head et al., 2022; Nettleton, 2020). Consider the following illustrative scenarios in Textbox 2, for example.

Textbox 2. Symptom interpretation involves individual perception and contextual factors



Making sense of bodily changes is complex and linked to cultural norms.

Figure 2.2.3 Making sense of bodily changes is complex and linked to cultural norms. (© Anut21ng via Canva.com (left); © Pixelshot via Canva.com (right))

Scenario 1: Mei and Aisha are dealing with the aftermath of going on a hike. Mei, raised in a traditional Chinese family, smiles tightly and dismisses her sprained ankle as a minor nuisance. “No need to fuss,” she tells Aisha stoically. Meanwhile, Aisha, hailing from a Western background, expresses concern, urging Mei to seek medical attention for her injury. Mei begins to feel a bit concerned when Aisha recounts her own experience of leaving an injury untreated, allowing Aisha to take her to the clinic.

Scenario 2: Michael, a middle-aged British construction worker, wakes up feeling unusually fatigued and short of breath. Despite experiencing persistent chest pains over the past week, he dismisses them as mere discomforts of his physically demanding job. “I’ll tough it out,” he mutters, unwilling to acknowledge any vulnerability or weakness. Concerned about Michael, his partner eventually persuades him to see a GP. He reluctantly agrees, “just to make her happy”.

These scenarios show different meanings assigned to bodily signs according to cultural and gender norms, and hence different responses to these.

In the first scenario, Mei and Aisha demonstrate cultural differences in pain perception, where suffering is more than bodily sensations and reflects deeply held cultural beliefs. Mei remains resolute, adhering to cultural norms that valorise endurance and self-sacrifice (Lewis et al., 2023). The second scenario highlights gendered cultural norms. Adhering to Western norms that equate certain kinds of masculine performance with stoicism and discourage expressions of vulnerability or reliance on others, Michael interprets the sensations in his body as “normal” fatigue or strain from manual labour rather than signs of illness. Michael’s failure to seek medical care draws attention to the enduring pressure on men to “harden up” and embody traits of endurance and self-reliance, and a tendency of some men to treat their bodies as machines. We may also note how men’s interactions with health services are shaped by gender norms, as their engagement is sometimes facilitated through their female partners (Anstiss & Lyons, 2014; Noone & Stephens, 2008; Seymour-Smith, Wetherell, & Phoenix, 2002).

Note about use of names¹

These examples highlight how personal *and* social meanings become attached to bodily sensations. The socio-cultural context thus plays a pivotal role in shaping people’s interpretations and responses to bodily sensations, influencing what is deemed bearable and acceptable regarding pain expression and subsequent help-seeking behaviours (Radley, 1994; Kugelman, 2017; Rosendal et al., 2013). Critical health psychologists, therefore, consider the process by which people recognise and interpret physical sensations in their bodies as signs of illness as (1) **embedded in the social context** and (2) **negotiated with others** (relational), as we discuss next.

Symptom interpretation as socially embedded

When people make sense of unusual sensations like fatigue, pain, or shortness of breath, they draw on their knowledge about sickness, including its bodily signs. This knowledge is connected to people’s socio-cultural settings and social identities, which comprise intersecting social categories (e.g., race, ethnicity, social class). There are also cultural expectations about which bodily disturbances require medical attention and which are considered “normal” (as discussed above). These cultural expectations thus guide as to when advice should be sought from others and extend to norms specifying how to present illness to others or ask for treatment (Brandner et al., 2014; Hay, 2008; Radley, 1994).

A good example of this is pain. Pain is a complex phenomenon that cannot be understood solely in biomedical terms, as its perception is impacted by socio-cultural, emotional, and cognitive factors (Kugelman, 2003, 2016; Perović et al., 2021; Prakash, 2020). The following case study offers a powerful illustration of how cultural and gender norms shape the interpretation and expression of pain. It involves a group of Somali-Canadian women who had undergone female genital cutting—a culturally specific and deeply gendered practice. While this context may be unfamiliar or confronting for some readers, the case

1. In the case examples throughout this book, we have used a range of culturally diverse names to reflect the global and multicultural context of health psychology. These names are not intended to signal specific cultural or ethnic backgrounds unless stated explicitly, and no cultural assumptions should be inferred from them.

offers important insight into how pain is socially mediated, and how cultural frameworks shape not only the experience but also the interpretation and communication of pain.

Textbox 3. “Are you in pain if you say you are not? Accounts of pain in Somali-Canadian women with female genital cutting” (Perović et al., 2021)



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.ca/ul.edu.au/critical-health-psychology/?p=283#oembed-2>

A mixed methods study was conducted with 14 Somali-Canadian women who had the most extensive form of female genital cutting. The researchers collaborated closely with members of the Toronto Somali community through a Community Advisory Group that guided all stages of the research, including recruitment, interview design, and cultural considerations. Although the researchers were not themselves Somali, this partnership ensured the research was community-informed and culturally sensitive.

The researchers hypothesised that female genital cutting² would cause neural changes that could lead to chronic neuropathic pain. Although quantitative sensory testing³ showed pain thresholds similar to those of women with chronic vulvar pain, participants reported no or low levels of pain when completing standardised questionnaires and when asked directly about pain in general terms. For example, they said things like, “My body feels fine” or “I don’t have a pain naturally anywhere in my body...I just feel good”, describing themselves as “good”, “healthy”, and “happy”. However, in other parts of the interview—especially when discussing specific activities like menstruation, intercourse, or daily movement—they described considerable and sometimes debilitating pain. This apparent contradiction reflects how cultural norms around stoicism, womanhood, and the meaning of “pain” can shape when and how pain is acknowledged.

The researchers interpreted this discrepancy between the physical sensations and the women’s experiences of it as related to the cultural normalisation of pain, especially women’s pain. In Somali culture, stoicism in the face of pain is highly valued, and children are taught from a young age to control pain expression. Labelling oneself as being in pain typically signals a need for urgent help, and endurance is associated with strength. The researchers state, “The women in our study may have conceptualised pain this way, explaining their insistence on not being in pain, despite reporting specific instances of pain in everyday life”. Consequently, women with female genital cutting see expressing pain, including during the original female genital cutting procedure as well as later (i.e., during childbirth), as shameful and express pride in their resilience.

2. The cultural practice involving the partial or complete removal of external female genitalia for non-medical reasons.

3. Quantitative sensory testing (QST) measures a person’s sensitivity to stimuli such as pressure, temperature, or vibration. It does not directly measure pain as a subjective experience, but rather helps identify heightened sensitivity, which may correspond with chronic pain conditions.

It may also be that when participants describe themselves as feeling “fine” and deny being in pain, they are accepting pain as a normal part of womanhood. In their culture, Somali women who have experienced female genital cutting recognise it as a rite of passage to womanhood and believe that womanhood itself involves pain. This is expressed in the poem by Dahabo Musa cited by Perović et al., (2021):

My grandmother called it the three feminine sorrows. The day of circumcision, the wedding night, and the birth of a baby [...] They say, it is only feminine pain, and feminine pain perishes.

These words strikingly capture the cultural normalisation, and subsequent minimisation, of Somali women's pain.

The experiences of these Somali-Canadian women undergoing female genital cutting vividly demonstrate that symptoms are not simply objective phenomena. Rather, as the example above illustrates, they are multidimensional constructions in which biological sensations may appear as symptoms, and weaken or intensify in response to various social and cultural contexts and psychological processes, as highlighted by cross-cultural and anthropological studies (Rosendal et al., 2013).

The case study demonstrates the complex nature of how bodily sensations are assigned meaning, showing how the process is socially patterned and shaped by what a symptom may signify. Responses such as worry, fear, or care—or the opposite—are therefore culturally based and fall under the category of “expected” emotions (Radley, 1994). In the case of the Somali-Canadian women, these include endurance and presenting oneself as “happy” and “healthy” despite pain sensations. Intersecting cultural and gender norms guide what women (and men) consider tolerable in terms of pain and when or whether it is acceptable to complain or to seek help or treatment. These findings are consistent with broader research highlighting disparities in pain experiences between genders (e.g., Jaworska & Ryan, 2018; Radley, 1994) and the impact of cultural norms and socialisation patterns (e.g., Lewis et al., 2023; Morunga et al., 2024; Upsdell et al., 2024).

These studies also emphasise the interconnectedness of social categories such as culture, gender, and social class in shaping health experiences and symptom interpretation. Such findings are not unique to particular cultural groups, like Somalis. Across different settings—including both Somali-Canadian and Western working-class contexts—pain may be normalised in ways that reflect broader expectations of gender, class, and cultural endurance. For example, like the women in Perović et al.'s (2021) study, working-class women in Western contexts may be more likely than middle-class women to view pain as something to be endured rather than treated—especially pain related to menstruation, childbirth, or caregiving. This reflects intersecting systems of gender, class, and, in some cases, race and migration status, which normalise women's suffering and shape access to care (Fang, 2023; Johansson et al., 1999; Rice, Connoy, & Webster, 2024). Such findings show that “pain cannot be reduced to a sensory state to be explained by the medical profession: it needs to be understood at the nexus of affective, psychological, social and communicative practices of people-in-pain” (Jaworska & Ryan, 2018, p. 107).

It is important to point out that the findings discussed above are not simply the result of suppressed responses (i.e., ignoring real pain), self-deception, or misinterpretation of bodily signs. Rather, how bodily changes are understood often shapes the bodily experience itself. This is evident, for instance, in cultural understandings about menopause, which “have a significant influence on women's experience of embodied change at midlife” (Ussher, 2008, p. 1786). Cross-cultural anthropological research shows geographical variation in both the symptoms that women report during menopause and the diseases

that may subsequently develop. Japanese women, for example, are much less likely than North American women to have most of the symptoms that medicine commonly associates with menopause (Lock, 1994; Lock & Kaufert, 2001). (Recall also the example of premenstrual syndrome in the previous chapter; this condition shows similar cross-cultural patterns, such that the condition can be considered a culture-bound syndrome.)

Making sense of these cross-cultural differences, anthropologist Lock (1998) showed how bodily feelings and reported symptoms are shaped by people's subjective experiences, which are based on culturally informed knowledge, expectations, and practices. In Euro-American and other Western contexts, a dominant "biomedical deficiency discourse" (Ussher, 2008, p. 1785) frames menopause as a disease requiring medical treatment, focusing attention on the biological aspects. It is commonly portrayed negatively: ranging from an unpleasant sign of old age decline to a hellish time of living decay (Lock, 1998; Perz & Ussher, 2008; Utz, 2010). In contrast, the Japanese have no word for this stage in the life cycle and tend to emphasise social, rather than biological, change in older age. Older women, for instance, remain engaged in childcare, which is considered an extension of their fertility (Hagège, 2020; Lock, 1994).

As in the example of menopause, critical scholars highlight that a culture's common explanations of bodily changes or symptoms generate a dominant, normative reality; this becomes the framework or lens people use to interpret their own physical sensations (Lyons & Chamberlain, 2006). How bodies and health or illness are portrayed in public discussion, and especially the media, plays an important role. This goes beyond the provision of factually correct information; these public representations mediate and shape how people "hear", make sense of, and respond to "the language of [the] body" (Corbin, 2003, p. 258).

Social meanings and social reception

The widely accepted meanings of illnesses shape the social reception of particular illnesses in specific contexts—that is, how others respond to people with different conditions (referred to as **social reception**), sometimes negatively (Gibson et al., 2017; Werner et al., 2004). Some illnesses have better social reception, while others carry social stigma. Although all illnesses represent a deviation from the norm of the healthy, able body, and potentially carry stigma (Radley, 1994); the level of stigma varies. This variation is related to factors like who is seen as responsible for this deviation, whether the illness is contagious, the source of infection, if the illness negatively affects bodily appearance or odour, and so on.

"The difference between illnesses that carry high versus low levels of stigma", Olafsdottir (2013, p. 43) points out, "illustrates that there is nothing inherent in some conditions that naturally leads to stigma." Rather, the issue is the **social meanings** that are associated with different illnesses, such as dirtiness, sexual immorality, laziness, poor self-control, and so on. Let us consider two examples to illustrate this, those of (1) HIV/AIDS and (2) cancer (see Textbox 4).

Textbox 4. Social meanings of illness: shame and blame, responsibility and stigmatisation

The widespread stigma associated with HIV/AIDS, especially when it was first identified but not well understood in the 1980s and -90s, offers a striking example of how illnesses become stigmatised. Globally, the medical narrative of AIDS was linked to sexuality, particularly homosexuality. In fact, the condition was even referred to as "gay-related immune deficiency" (GRID), until it became apparent

heterosexual people were also being infected. The condition was widely characterised as a “homosexual disease” or more pejoratively, as shown in the newspaper headlines below.



Figure 2.2.4 Headlines from British newspapers in the 1980s placed blame for the epidemic firmly on gay men. (The Mail on Sunday, January 6, 1985. Retrieved from [‘Gay plague’: The vile, horrific and inhumane way the media reported the AIDS crisis](#))

This misconception fuelled widespread panic and prejudice, isolating those affected and further

marginalising an already vulnerable social group. In Australia, a 2022 national enquiry found that media coverage of the early years of the HIV epidemic contributed to the high level of violence against gay men and lesbians, particularly a 1987 “AIDS awareness” [television advertisement](#) featuring the Grim Reaper, which appears below (McKinnell, 2022). The stigma also hindered public health efforts, delaying effective responses and exacerbating the epidemic due to reluctance to seek testing and treatment (Tsampiras, 2008, 2014).



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/critical-health-psychology/?p=283#oembed-3>

Cancer is not similarly reviled but carries different connotations related to the form of cancer. Gibson et al., (2017, p. 986) explain that “not all cancers are equal—instead, they are a series of illnesses that are varyingly constructed through moral framings and ascribed varying degrees of agency and even individual responsibility”. These researchers conducted a study of Australian women’s experiences of living with cancer and focused on social reception (i.e., how others responded to their disclosures of having cancer). The participants reported that the compassion others showed them depended upon their type of cancer. This “conditional compassion” is linked to assumptions about different forms of cancer and broader cultural norms surrounding the disease (Gibson et al., 2017, p. 991). As part of this, some participants discussed how they were often held to blame for forms of cancer (like lung cancer or cervical cancer) that are associated with “lifestyle choices”, such as diet, smoking, and sexual practices.

For example, a participant diagnosed with lung cancer said, “They tell you [to] stop smoking but I never smoked [...] [I] occasionally hear a parent telling their child, ‘See what happens if you smoke?’ ... the parents are really ignorant and rude”. Another recounted, “My daughter made a comment to the children ... she said, ‘Nan’s got lung cancer, because of the smoking’ ...I don’t like to hear it ... but she was trying to educate them” (Gibson et al., 2017, p. 987). These findings echo international research and polls of public perceptions of lung cancer. These studies show that owing to lung cancer’s association with smoking, many people tend to blame those with the disease for causing it and feel less sympathy for them (Chapple et al., 2004; Global Lung Cancer Coalition, 2023; Head et al., 2022; Marlow et al., 2015).

The examples of HIV/AIDS and cancer highlight the moral dimension of illness “concerning shame and blame, responsibility and stigmatisation” (Werner et al., 2004, p. 1036). They illustrate the very real consequences resulting from how illnesses are understood and what they signify in certain cultural settings. There are consequences for individuals’ identity and sense of self (Radley, 1994), the likelihood of receiving social support, and even healthcare delivery (Gibson et al., 2017; Tran et al., 2015), which we delve deeper into in [Chapter 2.3](#). Negative and stigmatising responses may discourage screening or help-seeking, worsening the prognosis (Carter-Harris, 2015).

There may also be wider repercussions. Everyone is at risk when infectious diseases cannot be managed effectively due to social stigma, as in the case of the AIDS epidemic and, more recently, the COVID-19 pandemic of 2020. Health inequities can also be widened, as public funding and financing are channelled

according to perceptions of deservedness, as seen in the case of cancer (see King, 2012). For example, breast and prostate cancers receive more visibility and funding relative to other forms, like lung cancer (Gibson et al., 2017; Tran et al., 2015). In addition to this, “awareness cultures” have coalesced around certain, more “acceptable” forms of cancer. In the case of breast cancer, for example Pink Ribbon and similar awareness efforts often reinforce highly gendered assumptions about how (cisgender) women with cancer should look and behave in response to their illness (Gibson et al., 2014, 2016). This can have the consequence of alienating or overlooking people who do not fit within the narrow confines of these gendered depictions and expectations (Gibson et al., 2016), exacerbating the challenges that people face in relation to their health.

Symptom interpretation as socially negotiated

The examples provided thus far should make it evident that recognising bodily sensations and interpreting them as symptoms is not something people do in isolation from others (Rosendal et al., 2013). One aspect of this is getting help from others to interpret symptoms. For instance, others can offer advice and help decipher the meaning of an ambiguous bodily sign, such as whether a headache is a sign of a serious medical condition or related to less serious causes like tension, dehydration, eye strain, or caffeine withdrawal. This kind of communication involves gauging one’s experience against the views or experiences of others (Head et al., 2022; Rosendal et al., 2013).

However, critical scholars highlight that symptom interpretation involves more than just exchanging information. People do not just react to someone’s symptoms once they are disclosed; they also have a major impact on how physical signs come to be seen as “real” symptoms warranting medical treatment (Kugelman, 2016; Radley, 1994). Determining “whether one is or is not ‘really ill’ is often a matter of social negotiation” (Radley, 1994, p. 78).

This negotiation is perhaps very familiar to those who have ever attempted to be allowed to stay home from school due to illness. In fact, this scenario offers a simple but effective way of explaining the social mediation involved in symptom interpretation, essentially, whether others recognise one’s symptoms as a legitimate sign of illness. For example:

Priya nervously approaches her parents, clutching her stomach and putting on a tired, feeble voice. “I don’t feel well,” she says, rubbing her forehead as if checking for a fever. She knows the school swimming gala is today, and she wants to avoid it without disappointing her classmates. Claiming to be sick seems like the perfect excuse, but she has to make it convincing. She slows her movements, pretends to struggle to eat breakfast, and coughs faintly, trying to match her symptoms to what she imagines will appear believable. Priya’s goal is simple: secure a sick note and stay home guilt-free.

When My Kid Fakes an Illness

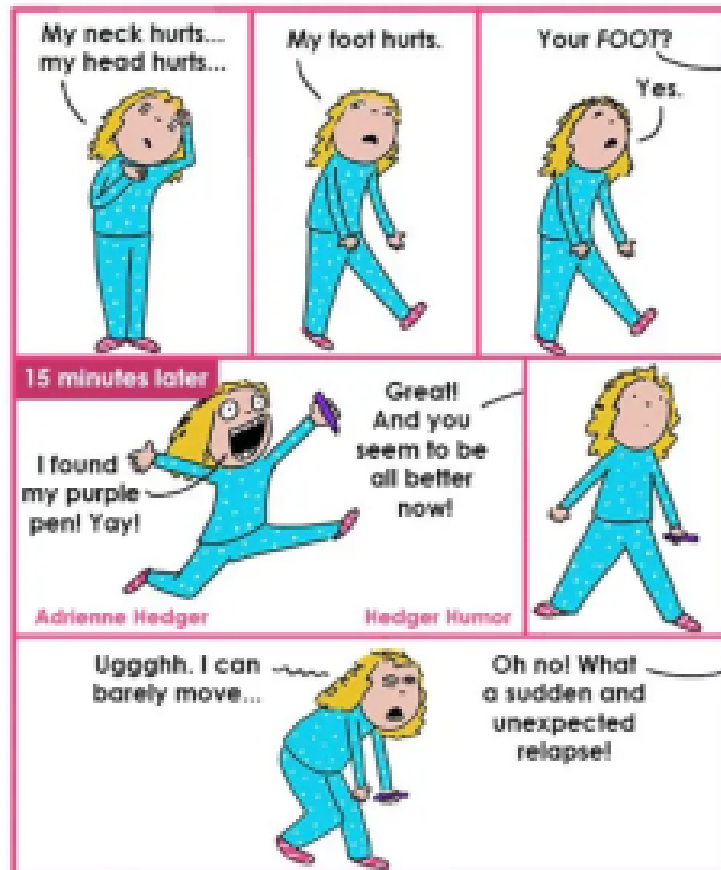


Figure 2.2.5. [When my kid fakes an illness](#), Adrienne Hedger.
(Reproduced with kind permission by cartoonist Adrienne Hedger. All rights reserved.)

This familiar scenario illustrates how symptoms are presented and enacted for others, and the importance of others' responses. It highlights three core concepts in the social negotiation of symptom interpretation, namely: (1) **the sick role**, (2) **social sanctioning**, and (3) **credibility work**.

The sick role

Presenting symptoms to others involves making a claim to be ill and thereby being allowed to take up and benefit from what is termed “the sick role”, in this instance, the benefit of being able to stay home from school. The concept of the sick role was first proposed by sociologist Talcott Parsons (1975) and is explained in more detail in the *CrashCourse* clip below (watch until the 6:02 time mark). This concept has since been developed, but the basic idea remains useful.



— One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/critical-health-psychology/?p=283#oembed-4>

Social sanctioning

Since illness has significant social consequences, bodily sensations must be sanctioned as symptoms by society. Essentially, others must agree that one is indeed ill (Rosendal et al., 2013). How others respond plays a significant role in seeking help and receiving care and support. So, just as the child in our example presents her symptoms to her parents, so symptoms are presented and enacted for others. Like the parents in our example, these others are often authority figures with the power to act as gatekeepers to care and resources (Head et al., 2022; Rosendal et al., 2013).

Credibility work

The concept of credibility work describes the efforts people make to convince others that their symptoms are legitimate and warrant medical attention. As in the case of the school child having to put on a believable show of being unwell, those who claim to feel unwell must perform in particular ways to legitimise their illness and be permitted the sick role (Kugelman, 2000; Werner et al., 2003). Being allowed the sick role and exempted from social responsibilities, like going to school, relies on having the presentation of one's symptoms confirmed and believed by others (Rosendal et al., 2013). "The degree to which a person's experience of illness is accepted by his or her surroundings is tied to ... the degree in which it becomes socially meaningful" (Glenton, 2003, p. 2244). In other words, how people present themselves as ill must be intelligible to others. The "work" done by the ill person to be believed, understood, and taken seriously, or to appear as a credible patient, includes what they say and do, and even their appearance.

Illness narratives are an important aspect of credibility work (Head et al., 2022; Yamasaki, Geist-Martin, & Sharf, 2016; Werner et al., 2004). As Bülow (2008, p. 137) explains:

In the medical encounter, as well as in everyday conversations, illness has to be "storied" to "exist." The story and in what way it is heard could be the difference between receiving a certain diagnosis or not, or between becoming confirmed or doubted. Unless one tells a convincing story, illness becomes contested.

This is evident in classic analyses of illness narratives. These narratives show how people try to account for their illness experiences in recognisable ways, working to represent themselves as legitimately ill and deserving of care or treatment (Frank, 1995; Murray, 1999).

People who feel ill, therefore, actively engage in relational negotiation and disclosure with other people in their life. Sharing bodily experiences with others is shaped by the roles one occupies and one's relationships with others. Both are contoured by power relations. This entails "credibility work"—attempts to present to others as a convincing and believable patient—in order to gain "social sanctioning" (Head et al., 2022). For those who fail, there are wide-ranging consequences, particularly if the illness is serious and ongoing, as illustrated by Arementor's (2017) study of women living with the contested illness of fibromyalgia, described in the case study in Textbox 5 (below). Cases of contested illnesses raise the question of what happens when others do not recognise one's symptoms as a legitimate sign of illness.

Unintelligible illness: failing to achieve social sanctioning

Individuals who suffer from bodily ailments but fail to gain social acceptance for their suffering often find themselves in a liminal state—experiencing illness but not recognised as “sick.” This lack of recognition can lead to two significant consequences: (1) delegitimation and (2) stigmatisation (Glenton, 2003).

Delegitimation occurs when individuals are denied the “sick role.” Without clear medical evidence or a definitive diagnosis, their illness may lack a name, leading others to question or challenge the legitimacy of their suffering. This denial undermines the person’s right to be seen as ill and, therefore, deserving of support and empathy (Gibson et al., 2017). Dumit (2006, p. 577) describes this as a situation in which “everyone—the patient’s family, friends, health insurance, and in many cases the patient—comes to think of the patient as not really sick and not really suffering.” This social invalidation often leaves individuals feeling that others cannot hear or acknowledge their claims, reducing them to feeling “crazy” rather than legitimately unwell (Armentor, 2017; Åsbring & Närvänen, 2002; Werner et al., 2004).

Conditions classified as “invisible illnesses” (e.g., autoimmune conditions managed through medication) or those with no clear medical explanation (e.g., post-Lyme disease) are particularly prone to this kind of delegitimation. These illnesses are often characterised by uncertainty regarding their causes, diagnosis, treatment, and prognosis, making them “unintelligible” in medical, legal, and popular discourse (Dumit, 2006). As a result, individuals with such conditions struggle to establish their suffering as legitimate or to receive appropriate recognition and care (Armentor, 2017).

Stigmatisation adds another layer of difficulty. Disclosing a contested condition involves considerable risk for the individual. If the person fails to convince others of their credibility and the legitimacy of their illness, their moral character may also be questioned (Åsbring & Närvänen, 2002). In such cases, not only is the illness doubted, but the individual themselves may be viewed as untrustworthy or lacking integrity.

Experiences of delegitimation and stigmatisation compound the social and emotional burden of living with a condition that is already contested and poorly understood, as illustrated in the following case study.

Textbox 5. Social negotiation in action: the example of contested illness

The role of social negotiation in recognising an individual’s symptoms is exemplified in **contested illnesses** like chronic fatigue syndrome and fibromyalgia. These conditions have partly overlapping symptomatology, including fatigue and exhaustibility, muscle pain and weakness, and sleep difficulties. Both often face stigmatisation owing to their invisible nature, characterised by elusive aetiology, diagnostic uncertainty, and unclear treatment strategies (Armentor, 2017; Åsbring & Närvänen, 2002; Werner et al., 2004). Such indeterminacy can raise questions about the legitimacy and veracity of people’s claims to illness, positioning them in socially devalued ways, such as “hypochondriacs.”

To combat this, people sometimes try to re-establish a valued social identity by modifying what they share with others, to seem as though they are not unwell or not suffering from a stigmatised condition (Head et al., 2022; Plage et al., 2018). This strategic disclosure is illustrated in Armentor’s (2017) research, “Living with a contested, stigmatized illness: Experiences of managing relationships among women with fibromyalgia”. The researcher conducted a qualitative study with 22 US American women diagnosed with fibromyalgia. The participants were asked about how they go

about talking about their illness with other people and reactions to their experiences. Participants commonly encountered disbelief from others, for example:

Everybody kept saying, "Oh nothing's wrong. You're depressed." I kept getting, "You're depressed. You're depressed." I was like, "No." (Diane, p. 467).

It's very difficult because you look fine. You don't—nobody sees that there's anything wrong with you. It's hard for them to accept that you do have this difficulty. If you have a broken leg, and it's in a cast, then your family doesn't expect you to get up, and clean house, and do dishes, and run five miles. When you look perfectly healthy, it's hard for them to accept that there's anything wrong with you. In the beginning especially, they don't understand. Still today, they don't understand because you look fine. (Brenda, p. 469.)

Armentor (2017, p. 467) concludes that this kind of disbelieving response "reflects the contested nature of the diagnosis among physicians and the general public" (p. 467).

She also asked participants about managing stigma and found that stigmatisation manifested in two ways for them. First, the invisibility of the illness resulted in reputational stigma, with the women's character being questioned, due to behavioural changes that deviated from societal norms. For instance, activities like napping and reducing social engagements were met with scepticism and distrust. For example:

...when I had my oldest daughter, he [father] would get mad at me because I was sleeping a lot. This was long before I was diagnosed. He was like, "You're sleeping too much. You're sleeping too much. You're sleeping too much." He would tell me that I was being irresponsible, I was a moron, and things like that. (Marie, p. 468.)

Second, while a diagnosis sometimes alleviated stigma, stigma also intensified in cases where medical practitioners did not recognise the illness, reinforcing scepticism from others. Despite attempts to educate and seek support, scepticism, and lack of understanding often led participants to stop disclosing to others and withdraw from social interactions to avoid the stigma associated with their condition. These responses lead to social isolation and a lack of much-needed support, as the following participant quote shows.

I don't reach out to anybody; I just kinda suck it up and deal with it on my own. I just kinda shut the world out until it passes ... when I'm not feeling good I won't reach out. Just stay in my own little bubble, basically. (Jennifer, pp. 469-470.)

This case study clearly shows that in addition to the benefits of taking up "the sick role," there can be negative social outcomes from others knowing about one's illness. The chance of stigma arises when an illness or condition becomes known to others (Armentor, 2017).

Conclusion

In this chapter, we explored the body as the central site of health and illness, emphasising the culturally situated and relational nature of symptom interpretation. Identifying signs as symptoms involves more than individual judgment; it is a socially mediated process that relies on interactions with others, including family, friends, and medical professionals. Presenting symptoms is a moral claim, seeking validation and treatment

from those around us. However, the process is also shaped by the authority and expertise of healthcare providers. As Glenton, (2003, p. 2244) highlights,

In Western society, a key player in the legitimization of illness is the medical doctor, a gatekeeper function that is justified with reference to the medical profession's ability to identify objective biological or pathological findings, that is, signs of disease.

In the next chapter ([Chapter 2.3](#)), we examine how symptom presentation unfolds in healthcare contexts—as an important site of the social negotiation of symptoms—focusing on the diagnostic process as a powerful form of social sanctioning that grants individuals “permission to be ill” (Nettleton, 2006, p. 1167).

Summary of main points

Some key takeaways from this chapter:

- People's interpretations of bodily changes influence whether they seek medical help or ignore symptoms.
- Bodies carry social meanings that affect how signs are understood and communicated as symptoms.
- Symptom interpretation is not purely individual; it is shaped by social and cultural factors.
- Understanding this complexity can improve interactions with healthcare providers and lead to better health outcomes.
- Traditional health psychology approaches focus on individual decision making, while critical health psychology perspectives highlight social context and cultural norms.
- Recognising symptoms involves negotiation with others who may support or dismiss the individual's illness claims.
- Lacking a formal diagnosis or visible signs can lead to delegitimation and stigma.
- Social values, norms, and power dynamics (including medical authority) influence how symptoms are interpreted and validated.
- Gender, culture, and social class all affect how symptoms are expressed, perceived, and acted upon.
- A socially embedded view of symptom interpretation helps explain why some conditions are taken seriously while others are doubted.

Learn more

Key scholarship in critical health psychology

- **Jane Ussher** has written extensively on various issues in Women's Health Psychology. Her book, [Managing the Monstrous Feminine](#), deals with the issues of regulating women via the body, the production of knowledge about reproduction, and women's resistance.

- **Robert Kugleman** is a U.S. American psychologist who has worked on the topic of pain. His open-access book, [Constructing Pain](#), provides a good overview of his work on this topic.
- **Alan Radely**'s work has been influential in establishing health psychology. He drew on insights from social psychology to investigate the social and psychological aspects of health and illness. His 1994 book, [Making Sense of Illness: The Social Psychology of Health and Disease](#), can be considered a classic and is very accessible.

Further reading

- Bourke, J. (2014). *The story of pain: From prayer to painkillers*. OUP Oxford. – An accessible and thought-provoking read for those wishing to explore cultural and historical perspectives on pain in more depth
- Hagège, S. (2020, February 26). *Is menopause a social construct?* Centre for Scientific Research (CNRS) News; Centre for Scientific Research. <https://news.cnrs.fr/articles/is-menopause-a-social-construct>
- Lyons, A. C. (2009). Masculinities, femininities, behaviour and health. *Social and Personality Psychology Compass*, 3(4), 394–412.

Multimedia

- Antonia Lyons discusses youth alcohol consumption and touches on its gendered nature in the following podcast.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/critical-health-psychology/?p=283#oembed-5>

Documentaries/films

- *Unrest* (2017): This 97-minute documentary offers a personal look at invisible illness. A form of illness narrative, Brea turns the camera on herself to share her journey of ME (also known as chronic fatigue syndrome), a misunderstood and highly stigmatised disease. [Available to stream free-of-charge on various platforms, including [YouTube](#).]
- [TED Talk](#) by Jennifer Brea (2016) “What happens when you have a disease doctors can't diagnose?” (16:58 mins)

Questions for reflection and discussion

1. Explain how symptom interpretation differs according to people's different social locations (e.g., culture, gender, race, ethnicity, class etc.). Illustrate your answer by referring to one or more illnesses/conditions.
2. What is stigma, and how is it relevant to understanding people's health experiences? To

answer this question use an example of a disease or condition (like HIV/AIDS, type II diabetes, or chronic fatigue syndrome).

3. **Watch Jennifer Brea's TED Talk about her experience of chronic fatigue syndrome (CFS)/myalgic encephalomyelitis (ME) and discuss the negotiation of symptom interpretation in relation to contested, invisible or medically unexplained illness.** Some points to guide your discussion:

- Apply the concepts of credibility work, social sanctioning, and power relations to Brea's illness narrative, using some example to show these in action.
- Discuss how these dynamics impacted the care Brea received.
- How might awareness of these dynamics in clinical practice change how symptoms are interpreted, negotiated and treated by healthcare providers?

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2.3. Diagnosis as a social and political practice

TRACY MORISON AND CLIFFORD VAN OMMEN

Overview

In this chapter, we examine diagnosis not just as a process of labelling diseases, but as a practice that establishes a shared understanding of what constitutes sickness—an understanding shaped by values, norms, and biology, and imbued with significant social consequences (Jutel, 2024). We begin by asking, **“What is diagnosis?”**—exploring how naming and framing create diagnostic systems that often struggle with ambiguity.

Next, we examine diagnosis as a social tool. In medical interactions, healthcare providers wield the “power to name,” raising questions:

- **Who benefits from specific diagnoses?**
- **What role do they play in maintaining the status quo** and, hence, social inequity?

We also consider diagnosis in the context of medicalisation, whereby everyday experiences are reframed as medical issues through diagnostic classifications. We discuss the benefits, such as validation and care, and drawbacks, including stigma and oversimplification, associated with this practice.

Learning objectives

By the end of this chapter, readers will be able to:

1. **Describe** the communicative and validating functions of diagnosis.
2. **Distinguish** between diagnosis as a noun (label) and as a verb (process).
3. **Name** the key points of consensus underlying the provision of a diagnosis.
4. **Describe** how the process of diagnosis rests on a knowledge hierarchy that shapes the doctor/patient relationship.
5. **Provide examples** of how diagnoses are historically and culturally embedded.
6. **Describe** how the process of diagnosis is embedded within and influenced by larger institutional and social contexts.
7. **Explain** the sociopolitical consequences of the process of medicalisation.

Introduction

Diagnosis is a fundamental tool in scientific Western medicine (Jutel, 2019b; Radley, 2013) and, therefore, shapes modern understandings of health and illness (Brown, 1995). At its core, diagnosis involves “putting a

name to an ailment” (Jutel, 2019a, p. 290)—a process of labelling an illness that identifies what is abnormal and in need of treatment. This process explains what is happening to the body and guides treatment to restore normalcy. The diagnostic process involves assigning clinical observations about the body (signs) and patient experiences (symptoms) to predefined categories (Brown, 1995; Jutel, 2021). From a critical health psychology perspective, this process is an interpretative practice. It involves labelling and categorising based on judgments of ab/normality, entwining specialist knowledge and power (Durie, 2004; Rose, 2013).



Figure 2.3.1 A healthcare worker measuring a patient's blood pressure using a sphygmomanometer. (Photo by [Thirdman](#) on [Pexels](#).)

The practice of diagnosis is about more than curing; it carries profound personal and social consequences. A diagnosis provides a gateway to treatment and resources (e.g., government-funded care, insurance benefits), but can also reframe an individual's lifestyle (such as eating, physical activity, and alcohol consumption) as symptomatic of a medical condition. For instance, a diagnosis of Type 2 diabetes may validate experiences like fatigue, low energy, and weight changes while granting access to treatment. However, this reductionist framing prioritises lifestyle factors over contextual issues (e.g., access to nutritious food or safe exercise spaces), potentially subjecting individuals to increased scrutiny and blame, reinforcing stigma, and narrowing their identity to “unhealthy” practices.

Thus, diagnostic labelling can also result in diminished social roles, restricted access to resources, or even being denied opportunities, further isolating some individuals in society. Conversely, the absence of a diagnosis may leave those with contested or unexplained illnesses unrecognised and unsupported (Dumit, 2006; Rose, 2013). Beyond the immediate individual ramifications, diagnosis also plays a role in legal decisions, public health planning, and resource allocation, as summarised in Textbox 1.

Textbox 1. The wider social functions of diagnosis (Rose, 2013)

- (i) determining eligibility for medical treatment, insurance coverage, welfare support, and leave from work;
- (ii) legal decisions, such as detention in jail or treatment under state care;
- (iii) resource allocation within medical and educational systems;
- (iv) distributing research funding;
- (v) epidemiological and public health planning; and
- (vi) organising service provision.

Given these far-reaching social and material ramifications, critical health scholars argue for studying diagnosis as a social and political practice (Jutel, 2021; Rosenberg, 2002; Thompson, 2021). To explore this, we follow the sociological differentiation between:

1. **diagnosis as a noun or “thing,”** asking, “**What is diagnosis?**” and
2. **diagnosis as a verb or practice,** asking, “**How is diagnosis conducted?**” (Blaxter, 1978; Jutel, 2021).

This discussion raises some fundamental issues of particular interest to critical health psychologists, including how decisions about normality and abnormality are made, who gets to decide this, and on what basis.



Figure 2.3.2 Diagnosis can be understood both as a fixed label (a noun) and as an active, ongoing process (a verb), highlighting its dual role in shaping health knowledge and practice. (Tracy Morison. [CC BY-NC 4.0](https://creativecommons.org/licenses/by-nc/4.0/))

1. What is diagnosis? Diagnosis as a noun

A diagnosis offers a way to classify and organise various health conditions in ways that are useful to healthcare professionals. Medical diagnosis involves labelling an illness experience using a predetermined set of diagnostic categories (Rose, 2013; Jutel, 2021). Diagnostic categories and classification systems were created for professional communication and to facilitate medical research and teaching. Common diagnostic categories allowed a common language or standard for healthcare professionals to share information, plan treatments, and conduct research effectively and collaboratively. This standardised approach is essential for the organisation and delivery of healthcare services. Standardisation was motivated by public health imperatives, such as tracking the prevalence and incidence of diseases to inform policies and interventions (Blaxter, 1978; Jutel, 2021). Those who experienced the 2020 global pandemic can no doubt attest to this valuable function.

Without detracting from these useful functions, Ward (2019) maintains that while offering a useful way of summarising a pattern, the power of a diagnosis to simplify can be harmful. Drawing on the concept of “terrible simplification (terrible simplificateur)” —which refers to explanations disregarding complexities and the broader context—he notes three problems. The first is potentially neglecting the complexity and nuance of what a person is going through because the diagnostic process narrowly focuses on biological elements (disease) rather than the social meaning of a condition (illness) (Berndt & Bell, 2021).

For instance, Ward argues, “If you are in despair, it might be worse than useless to be told ‘you’ve got depression’” (p. 19). This is problematic because it reduces a multifaceted, deeply personal experience to a simplistic label, potentially alienating individuals by neglecting the unique and complex nature of their emotional distress. This reduction might arguably be less concerning in the context of acute infectious diseases, such as COVID-19, but can have consequences, especially for those with chronic or complex conditions. Such conditions are multifaceted; a simple diagnosis may overlook the interplay of physical, emotional, and social factors, and promote treatments that do not fully address what the patient experiences as a problem.

The second issue with simplification is that diagnostic categories can strip away humanity in medical encounters. Even accurate clinical diagnoses can reduce individuals to mere labels, Ward (2019) argues. This is evident when medical students casually refer to “the heart failure in bed ten,” reducing the person to their diagnosis, or when “Alzheimer’s disease” is assumed to account for everything a person experiences. This reductive approach, characteristic of the biomedical model (see [Chapter 2.1](#)), can strip people of their personhood.

The third and final issue is that when diagnoses oversimplify complex issues, essential aspects can become invisible. The focus tends to shift toward clinical or biological symptoms rather than contributing factors like the underlying social determinants. For example, in the case of obesity, economic deprivation is a crucial factor because limited financial resources often restrict access to nutritious foods, safe exercise environments, and quality healthcare. Neglecting these economic dimensions creates a paradox where illness is simultaneously defined and obscured—a “way of knowing and not-knowing illness” (Ward, 2019, p. 28)—that fails to address the root causes of the condition.

Having explored what diagnosis entails, it is crucial to recognise that the seemingly neutral process of diagnostic classification is, in fact, a nuanced act of interpretation. Although it appears objective, diagnosis involves naming and framing illnesses—organising them into distinct categories with clear boundaries.

Diagnosis as “naming and framing”

Diagnostic categories are most often thought of as simply describing bodily phenomena caused by

biological processes, “real” entities that exist “out there”, independent of the diagnostic process and outside of the socio-cultural realm (Jutel, 2021). Diagnosis is, therefore, taken for granted as a benign medical tool drawing on classifications assumed to be neutral and objective because they are grounded in medical science (Bourdieu, 1991). Jutel (2021, p. 71) cautions that such thinking “can disguise ideology and convey the illusion of neutrality.” Although diagnostic classification appears neutral and objective, as we stated at the start of this chapter, diagnosis is a process of interpretation and categorisation.

Frameworks for diagnosis—like the World Health Association’s International Classification of Diseases (ICD) or the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM) of Mental Disorders—are created by arranging illnesses into groups divided by clear boundaries (the process of framing) (Brown, 1996). This inherently involves judgment and selection as medical experts decide where boundaries should be placed to create useful categories for understanding and treating health conditions (Jutel, 2011). Each classification results from human decision making involving agreement about what should be categorised in what way, rather than being a fact of nature (Jutel, 2021).

Frameworks for diagnosis are thus formed by social actions and consensus among medical experts (Aronowitz, 2001). These actions determine what counts as a disease, how it should be classified and understood, and who has the authority to make these decisions. This consensus involves several key components, as shown in Textbox 2.

Textbox 2. Key components of diagnosis

- **What Counts as a Disease?** Deciding what constitutes a disease involves social judgments about which conditions are considered normal and which are seen as pathological. These decisions are influenced by contemporary medical knowledge as well as social attitudes and cultural beliefs.
- **Classification and Understanding:** Medical science and social contexts shape how diseases are classified and understood. This includes the criteria used to define a disease and the theoretical frameworks that guide our understanding of different health conditions.
- **Authority to Diagnose:** Not everyone has the authority to diagnose; this power is usually reserved for professionals whom societal institutions have granted this role. This gatekeeping role includes giving permission to be ill, which confers legitimacy on the patient’s condition.
- **Social Goods and Benefits:** The act of diagnosing carries significant social implications. Being diagnosed can provide access to social goods and benefits, such as medical treatment, social support, and economic resources. However, it also involves labelling individuals, which can have broader social consequences, as alluded to above.

Thus, diagnoses are never “just” descriptive. They are not neutral reflections of biological facts. Rather, they are entangled with the social and political currents of their time, underscoring the importance of examining diagnoses within their historical and social contexts to highlight the underlying values and norms (Dumit, 2006).

The role of values and norms in creating diagnoses

The creation of diagnostic categories is not purely a scientific endeavour but one embedded within a cultural context. Cross-cultural and historical comparisons draw attention to the social dimensions of diagnosis (Barker, 2010). They show how changes in diagnoses across place and time are not solely due to the evolution of scientific knowledge and medical advancements but also reflect fundamental shifts in how disease is conceptualised. In this sense, diagnoses often reflect the social and moral contexts in which they emerge (Blaxter, 1978). (Recall from [Chapter 2.1](#) how societal values and norms influence which conditions are recognised as diseases and how they are understood.)

Historical analyses of diagnoses show that shifting cultural values around gender, race, and sexuality have played a pivotal role in redefining what is considered “normal” and “abnormal” behaviour (Tyson, 2011). We have alluded already (in [Chapter 2.1](#)) to the classification of “hysteria” in the 19th century as a reflection of Western cultural attitudes toward women’s mental health and social norms of gendered behaviour, which are today largely considered less valid (Marecek & Lafrance, 2021). Two other useful historical examples, drapetomania and homosexuality, illustrate how Western conceptualisations of mental illness have been influenced by cultural and social forces rather than objective medical findings alone (Tyson, 2011; Olafsdottir, 2013). You can read more about these in Textbox 3.

Textbox 3. Two historical diagnoses: drapetomania and homosexuality

Drapetomania, described in 1851 by American physician Samuel Cartwright, was a mental illness that affected enslaved Africans who wanted or tried to flee captivity. Cartwright suggested that this “disease” was caused by enslaved people forgetting their god-ordained role to serve their White masters. While this diagnosis might seem absurd by today’s standards, it was rooted in the racial ideologies of the time (Tyson, 2011). Slavery was normalised and even justified by pseudo-scientific arguments about innate biological differences between “races” of humans that make some superior and others inferior (Böhmke & Tlali, 2008; Tuffin, 2017). Drapetomania thus reflected broader social values that dehumanised African people and enforced their subjugation. It was not scientific advancement but rather changing social norms around race and human rights, facilitated by the abolitionist movement, that led to the abandonment of drapetomania as a legitimate diagnosis (Tyson, 2011).

The classification of **homosexuality** as a mental disorder, included in the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1952, was shaped by societal attitudes towards sexuality. In the 19th and early 20th centuries, homosexuality was pathologised, with psychiatrists like Karl von Westphal and Richard von Krafft-Ebing claiming it was caused by genetic abnormalities or moral deviance. These classifications reflected prevailing moral and religious beliefs that viewed heterosexuality as normative and other sexual orientations as deviant. Homosexuality was removed from the DSM in 1973, not because of new scientific discoveries but due to changing social values and the influence of the civil rights movement, which pushed back against pathologising sexual diversity (Tyson, 2011). Drescher (2015) identifies gay activism as the salient catalyst in provoking debate within the American Psychiatric Association (APA), ending in a vote which removed homosexuality from the DSM. Thus, through a social process (voting), homosexuality stopped being, at least within the APA, a mental illness and millions of US American citizens were almost instantly de-pathologised.

As in history, today, we see significant variations in diagnoses across cultures. For instance, differing beliefs about childhood behaviour and norms are reflected in the recognition and categorisation of psychological conditions like attention deficit hyperactivity disorder (ADHD) (Dew et al., 2016; Fawcett et al., 2020). ADHD diagnoses have mostly been limited to Anglophone countries (Horton-Selby, 2018). Behaviours indicative of ADHD in UK classrooms are given more contextual attributions (e.g., the behaviour being due to classroom and parenting strategies) in Korea, Denmark, and France (Horton-Selby, 2018; Nielsen, 2018).

Even physical illnesses have faced varying degrees of recognition and attributions of legitimacy across different societies (Dumit, 2006). Myalgic encephalomyelitis (ME), also called chronic fatigue syndrome (CFS), is a case in point, showing how cultural context can shape the acceptance and understanding of medical diagnoses (Aronowitz, 2001). Numerous doctors have been found to not diagnose this condition. In Europe, for example, Pheby et al. (2020, p. 6) state that a “high proportion of GPs [General Practitioners], which is likely to be at least 50%, do not recognise ME/CFS as a genuine clinical entity and therefore do not diagnose it”. However, this varies depending on the country and even the particular region within a country. Official state recognition of ME/CFS as a diagnosis also did not mean that a GP would recognise it as a “genuine entity”. Furthermore, recognising the diagnosis as legitimate did not translate into GPs having confidence in diagnosing and treating ME/CFS or having specialist services to which to refer patients.

The subjective human aspect of diagnostic categories becomes particularly evident when considering how diagnoses change over time and across different cultures, as well as in disputes around illnesses, such as contested or medically unexplained conditions. Such cases of contestation or uncertainty also bring “issues of power and control over legitimation of illness ... into sharp relief” (Denny, 2009, p. 998), as we discuss in the following section where we consider the doing of diagnosis, diagnosis as a verb or practice.

2. How is diagnosis conducted?

As much as it is a useful tool, diagnosing is also a social and political act in the sense that it takes place within social relationships. These relationships are imbued with power and perform various social functions in addition to practical medical functions. As we discuss below, diagnosing structures the patient’s relationship with the medical professional, privileging certain types of knowing and consequently placing the doctor in a powerful position. However, doctors also work within a larger social-political context, which includes a range of other stakeholders (e.g., insurance and pharmaceutical companies) who influence the diagnostic process, including by conferring legitimacy and access to funding.

Healthcare interactions, power and knowledge

Providing a diagnosis is an essential process that organises illness, as we have discussed, and structures the medical relationship (Jutel 2019). Diagnosing is, therefore, a critical point in medical interactions, specifically regarding the roles of healthcare providers and patients. The process requires patients to submit to the healthcare provider’s expertise, thus establishing power dynamics within healthcare interactions. These dynamics are underpinned by entrenched hierarchies of knowledge that shape how different forms of understanding are valued in medical settings.

A major reason for power imbalances in medical interactions is the knowledge hierarchy that structures lay-professional relationships (Dew et al., 2016). Patients and professionals rely on different knowledge bases to understand health issues and to engage with each other, with one form typically valued over others. Biomedical knowledge is a formal, professional, and authoritative form of knowledge. Seen as objective, it concerns the disease process and the unquestionable “truths” about medical science. In contrast, “lay

expertise” or “experiential knowledge” is practical knowledge embedded in the patient’s experience of managing and living with an illness (Dumez & L’Espérance, 2024). This form of knowledge is often granted less authority by professional “hearers” (Dew et al., 2016). However, these boundaries are not always clear-cut: movements toward recognising the “expert patient” and the development of detailed “lay epidemiologies” in the context of healthism (Crawford, 2006) challenge the rigid separation between lay and professional knowledge. Even so, in many diagnostic encounters, experiential and embodied forms of knowing continue to be dismissed or devalued.

This divergence was highlighted in the foundational work of psychologist Elliot Mishler (1986). Mishler showed how patients and physicians communicate using distinct “voices.” Doctors use “the voice of medicine”, comprising medical terminology, objective descriptions of physical symptoms, and categorisations of these within a reductionist biomedical model. Patients use “the voice of the lifeworld,” comprising non-technical language and expressing the subjective experience of sickness inside the framework of social relationships and the patient’s daily existence. Mishler’s study illuminated modern Western medicine’s tendency toward paternalism and hierarchy that tend to minimise or dismiss patients’ knowledge of their circumstances and experiences.



Figure 2.3.3 Mishler (1984) highlighted the different frames of reference for patients and healthcare providers. (Tracy Morison. [CC BY-NC 4.0](#))

Given doctors’ greater power to establish the structure of the interaction with patients, patients may experience their voice as being overruled and shut down, with the doctor’s explanations wiped of individual meaning and social context. For example, a patient suffering from chronic pain might want to discuss how the condition affects the ability to work and care for others. At the same time, a health provider might be inclined to focus on prescribing medication, overlooking the broader context of the patient’s life.

Diagnosis often reinforces this hierarchy, privileging biomedical criteria over other ways of knowing. Expert knowledge is grounded in the biomedical model and focuses narrowly on biological, measurable, and

quantitative elements. Accordingly, the expert knowledge health providers hold is considered objective and, therefore, more trustworthy than the subjective, possibly unreliable, information patients bring to consultations. In contrast, patients, as laypeople, are at a disadvantage because the knowledge of biomedicine is largely inaccessible to them. Instead, patients draw on embodied knowledge of illness gained through experience (Berndt & Bell, 2021).

Embodied knowledge develops over time from “knowing one’s body”, as Corbin (2003, p. 258) puts it. These findings are supported by subsequent research highlighting diagnosis as “a point at which medical authority often dominates rather than negotiates” (Jutel, 2019a, p. 290). Health professionals are often found to minimise, dismiss, or even disparage patients’ experiential or embodied knowledge (Dumez & L’Espérance, 2024). At worst, such dismissals can lead to medical gaslighting, where patients’ own experiences are questioned or invalidated, making them doubt the reality of their symptoms. This deepens the power imbalance in clinical encounters and leaves patients feeling further disempowered and isolated (e.g., Fielding-Singh & Dmowska, 2022; Morison, Ndabula, & Macleod, 2023; Penny, Moewaka Barnes, & McCreanor, 2011).

Likewise, Indigenous knowledge is frequently dismissed in diagnostic encounters as no longer relevant today. However, Māori psychiatrist, researcher and activist Mason Durie (2004, p. 1142) argues, “While clinical views will inevitably focus on a particular diagnostic grouping, clinicians must also exercise judgement about the relationship of the disorder to other aspects of healthy living.” The holistic view offered by Indigenous models of health (such as the Māori health model *Te Whare Tapa Whā* discussed in Part One) can, therefore, be helpful when understanding illness experiences. Durie (2004) maintains that Indigenous ways of knowing are not just culturally significant—they are also key health determinants. He cites a study in which older Māori who scored lower on the cultural index (indicating weaker ties to their traditional values and practices) were more likely to experience poorer health outcomes. Such findings challenge the knowledge hierarchy, showing that Indigenous knowledge offers valuable insights into a holistic view of health, and support calls for integrating other forms of knowledge into healthcare practices and policy. Both expert and lay forms of knowledge are, therefore, important for successfully treating patients.

While healthcare providers have the power to diagnose—and thus act as gatekeepers to resources and recognition—they do so within systems shaped by broader institutional and societal power structures (Jutel, 2019b; 2024). Therefore, the power dynamics of diagnosis extend far beyond the doctor-patient relationship and interpersonal interactions in medical settings. Diagnosis is thus both a clinical activity and a socio-political act (Jutel, 2021), as we discuss further below.

The broader politics of diagnosis

Diagnosis plays a crucial role in the social negotiation of illness and access to the sick role (discussed in [Chapter 2.2](#)), as medical experts grant “permission to be ill” (Nettleton, 2006, p. 1167). The act of diagnosing an illness occurs within and is mediated and regulated by the broader socio-political context, including institutions and societal values and norms (Dumit, 2006). For instance, Dumit (2006, p. 587), discussing contested illnesses, points out that various stakeholders—such as insurers, governments, and industry—“have a vested interest in denying and dismissing claims of chronic illness where they can get away with it”. Consequently, the struggle to obtain a useful diagnosis experienced by people with medically unexplained or contested illnesses is not simply about convincing a healthcare professional (Anleu, 2009; Bell et al., 2024; Nettleton, 2006).

Therefore, diagnosis is important for individuals because of its role in the social sanctioning of illness, as highlighted in cases where people fail to receive diagnoses of their physical ailments. Textbox 4 illustrates the effects of diagnostic uncertainty on the social sanctioning of illness and how this impacts individuals with medically unexplained symptoms.

Diagnostic uncertainty refers to the inability to definitively determine a diagnosis due to incomplete, ambiguous, or conflicting clinical information. It is closely related to contested illnesses and **medically unexplained symptoms** because both involve conditions where a clear, widely accepted diagnosis is difficult to establish or remains elusive (Jutel, 2021b).

The term “**medically unexplained symptoms**” describes cases in which people report symptoms for which doctors cannot identify an organic cause. In other words, there is no known medical explanation for the symptoms they are experiencing (Nettleton, 2006). Examples include chronic pain, chronic fatigue, gastrointestinal issues, and other bodily complaints that conventional diagnostic tests cannot explain.

Contested illnesses are conditions where there is disagreement or lack of consensus within the medical community about the existence, causes, or appropriate treatments for the illness. Examples include conditions like chronic fatigue syndrome (CFS/ME), fibromyalgia, and multiple chemical sensitivity (Murphy, Kontos, & Freudenreich, 2016).

Living without a clinical diagnosis or a medical justification of their symptoms has negative consequences for many people. Research highlights an overall experience of struggle and invalidation for people living in “diagnostic limbo” (Nettleton, 2006), due to being met with scepticism and mistrust from both health professionals and other people (Mengshoel et al., 2018; Rossen et al., 2019). Such responses challenge these people’s credibility and dignity. Those with medically unexplained symptoms therefore often experience their identities as threatened (Rossen et al., 2019).

In this regard, a common experience is of having to struggle against the negative characteristics regularly imposed on a person with an unexplained or contested illness. These include, for example, being “whinger” (Mik-Meyer, 2011, p. 36), weak (Denny, 2009), or a lazy opportunist or workshy (Shaefer, 2005; Mengshoel & Heggen, 2004), and similar negative labels that question moral character. As a result, they engage in “constant identity negotiation” (Rossen et al., 2019, p. 551), constantly resisting negative identities and striving to attain one that is socially acceptable. Some even report the sense of having lost their identity, “seeing themselves as a ‘nobody’” (Engebretsen & Bjorbækmo, 2019, p. 1023).

In addition to legitimization for individuals, diagnostic labels also play a role in societal judgments about which conditions count as legitimate illnesses and/or are “worthy” of attention and are used in shaping public policy and societal priorities (Brown et al., 2012). For instance, widely recognised and diagnosed conditions (such as heart disease or cancer) receive significant funding and attention in medical research and public health campaigns, while others (like certain chronic pain or women’s health conditions) do not (Hudson, 2022). These judgements shape public perception and social reception of certain diseases (discussed in [Chapter 2.2](#)) and also play a role in creating healthcare disparities (Brown et al., 2012; Gibson et al., 2017).

The final political function of diagnosis that we consider is social control. As we have argued, diagnostic categories are based on human judgment and consensus among medical professionals regarding what is

considered “normal” and “abnormal” health, judgments that draw on and reflect broader societal values and norms (Smail, 2005). Consequently, the criteria on which diagnoses are based have been shaped by political and social agendas, reflecting and perpetuating dominant ideologies in the interests of the powerful (Hook, 2004; Parker et al., 1996; Shefer, 2004). Given that the power to name what is normal or pathological resides with those in power, diagnoses can be imposed on people and work as a way of delegitimising and controlling individuals and the social groups to which they belong (Olafsdottir, 2013). In this way, diagnosis can serve as a tool of social control by legitimising and reinforcing certain dominant social ideologies and marginalising others (Parker et al., 1996; Smail, 2005).

One of the most prominent examples of a diagnosis wielding power is the DSM, the authoritative guide used by clinicians to diagnose mental disorders. Mental health diagnoses can reframe common emotional experiences, behaviours, or practices as a medical disorder, transforming how society understands and responds to them (LaFrance & McKenzie-Mohr, 2013; Marecek & LaFrance, 2021). By labelling certain behaviours or conditions as pathological, diagnosis can reinforce societal norms and exclude alternative ways of living or understanding health. Those who step outside the bounds of social acceptability can be labelled as pathological and in need of treatment.

This process of pathologisation was evident in the earlier examples of diagnoses of Drapetomania and homosexuality to control enslaved people and gay men, respectively. Other examples include the diagnoses of nymphomania, hysteria, and, more latterly, female orgasmic disorder, used to regulate women’s sexual behaviour (Marecek & LaFrance, 2021; Potts, 2008; Thomas & Gurevich, 2021). Attempts to exercise social control through diagnosis can be most extreme in regimes whose hold on power is explicitly challenged by its citizens. The historical use of psychiatry in the then-Soviet Union to suppress dissent has been well documented (Bonnie, 2002). Far more recently, we have reports of students involved in the “Woman, Life, Freedom” protest in Iran being sent to psychological centres to be “reformed” or forcibly admitted to psychiatric hospitals (Hooshyari, 2024).



Figure 2.3.4 The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (2013) was revised in 2022. (Photo by [Alana Camargo](#) on Pexels. [Pexels licence](#))

3. The double-edged nature of diagnoses

We hope we have convinced you that diagnostic labels are not simply descriptive. They can have profound social effects, influencing everything from personal identity to legal status and the allocation of resources like disability benefits (Dumit, 2006; Radley, 1994). We want to emphasise that the process of diagnosis is in and of itself neither good nor bad. However, diagnostic labels can be used to serve particular interests, and these labels can be double-edged.

Diagnosis is a valuable tool for providing helpful information about populations and advancing medical science. Diagnoses provide explanations of what is happening to a body, the likely progression and outcome of a condition (prognosis), and how to treat it (treatment or intervention). Oftentimes, a diagnostic label points towards a plan of action that might otherwise not have been evident, such as the need for particular care and assessment for suicidal feelings in cases of depression (Ward, 2019). Obtaining a diagnosis makes people's conditions recognisable to others around the ill person and thereby "promises a label that validates patients' embodied experiences and a road map for living with and treating illness" (Boulton, 2019, p. 809). Receiving a diagnostic label can, therefore, help legitimise the experiences of those suffering from illness, affecting not only how others see and respond to them but also how they see themselves and experience their illness (Bülow, 2008).

Diagnoses can help to support and shape an individual's social identity. Receiving a diagnosis can provide meaning to an otherwise chaotic experience, becoming an anchor or turning point in the person's illness narrative (Riessman, 2015; Werner et al., 2003). Diagnosis influences how individuals understand their health conditions and plays an influential role in shaping illness experiences. For example, Lafrance and McKenzie-

Mohr (2013, p. 214) state that a typical response to psychiatric diagnoses is “the expression of relief and validation,” as the labelling of distress by an expert can normalise and legitimise people’s experiences.

At the same time, however, diagnoses can reinforce or challenge social norms and stigmas. In some cases, being diagnosed with an illness can challenge a society’s cherished values and norms. For example, a diagnosis of HIV has historically been associated with significant stigma, particularly in Western societies where the illness contravenes dominant norms surrounding sexuality, health, and morality (GLAAD, 2022). HIV is often linked to behaviours such as non-heteronormative sexual practices or intravenous drug use, which challenge traditional Western ideals of sexual conservatism, bodily purity, and self-discipline. As a result, the illness has frequently been seen as a marker of “moral failure,” reinforcing perceptions that those who contract it have violated societal expectations about acceptable behaviour. This association with norm-breaking behaviours places those living with HIV at risk of moral judgment, and continues to affect public attitudes toward the condition.

Some diagnoses, as discussed previously (in [Chapter 2.2](#)), may carry stigmas that affect how others perceive and treat individuals, leading to discrimination and marginalisation. Continuing the above example, advancements in medical treatments of HIV have transformed it into a manageable chronic condition, but despite this, it remains highly stigmatised in many contexts. This stigma can manifest in discriminatory practices in healthcare, employment, and social relationships, where individuals may be treated differently due to their diagnosis (ViiV Healthcare, 2025). For instance, the persistence of stigma around HIV reflects more profound anxieties in society about illness, morality, and deviance from social norms, illustrating how diagnoses can function for the purposes of social exclusion (Campbell, 2004).



Figure 2.3.5 Diagnoses can reinforce or challenge social norms and stigmas related to illness. (Photo by [Yan Krukau](#) on Pexels. [Pexels licence](#))

On the other hand, diagnoses can also challenge existing stigmas by increasing awareness and understanding of certain conditions, promoting social change and acceptance (Campbell, 2004). For example, the increased visibility and advocacy around mental health conditions such as depression and anxiety have helped to reduce stigma in many parts of the world. Where mental illness was once heavily stigmatised and often seen as a personal failing or weakness, greater public education and the sharing of lived experiences have reframed these conditions as legitimate health issues that require support and treatment.

The above discussion demonstrates the significant social, psychological and material consequences of the practice of diagnosis. It shows also how diagnosis is a medical practice that is deeply embedded in the norms and values of society. For a condition to become an object of interest to medicine, it needs to be interpreted or framed as a medical issue. Diagnosis is the first step in transforming a non-medical issue into a medical one, initiating a process called medicalisation. This process—framing and treating previously non-medical problems as illnesses, disorders, or syndromes—is a notable feature of industrialised, Westernised societies (Anleu, 2019; Olafsdottir, 2013).

4. Medicalisation and the shifting boundaries of sickness

An article reporting on a newly discovered disorder called motivational deficiency disorder (MoDeD) caused a stir when it appeared in the *British Medical Journal*, with news outlets reporting on this in alarm (Mirsky, 2006). The article stated:

Extreme laziness may have a medical basis, say a group of high-profile Australian scientists, describing a new condition called motivational deficiency disorder (MoDeD). The condition is claimed to affect up to one in five Australians and is characterised by overwhelming and debilitating apathy. Neuroscientists at the University of Newcastle in Australia say that in severe cases, motivational deficiency disorder can be fatal because the condition reduces the motivation to breathe (Moynihan, 2006, p. 745).

A campaign was designed to raise awareness about MoDeD, including [this video, "A new epidemic."](#)



Figure 2.3.6 Screenshot of Ray Moynihan, a MoDeD sufferer, discussing his diagnosis with journalist, Amanda Byrne. (Screenshot from [A new epidemic](#), Miranda Burne. YouTube)

After watching this clip, you will no doubt realise that motivational deficiency disorder, or “MoDeD,” is a fictitious diagnosis. The journal article we quoted was published on “April Fool’s Day” and part of a campaign aimed at highlighting “disease mongering”, the widespread practice of exaggerating and promoting non-existent diseases (Mirsky, 2006), including the media’s role in adding credibility to and feeding the worry underlying disease mongering (Cassells, 2008; Germov & Freij, 2019).

The fictitious case of MoDeD humorously illustrates the widening boundaries of what counts as a disease due to changing understandings of health and illness. It shows how diagnoses can medicalise behaviours and conditions that are not necessarily the result of bodily dysfunction or pathogens, bringing these under the purview of healthcare professionals.

Medicalisation is “the process by which conditions, experiences, and situations, which were at one time not seen as medical in nature, come to be seen as medical. They thus come under a medical jurisdiction for treatment” (Dew et al., 2016, p. 95). Medicalisation is widespread, as an ever-widening range of human practices and experiences are classified, experienced, diagnosed, and treated as medical conditions (Barker, 2010). For example, conditions such as alcoholism, menopause, baldness, obesity, and even ageing (Pickard, 2011) have been medicalised (Dew et al., 2016). Table 2.3.1 provides an overview of how different spheres of life are brought into the medical domain, leading to management and treatment.

Table 2.3.1. Types of medicalised phenomena

WHAT'S BEING MEDICALISED?	"Deviance" (behaviour deviating from societal norms)	Natural life process	Everyday problems of living	Enhancements in healthy people
EXAMPLE	Excessive alcohol or substance use	Ageing	Worry	Athletic/cognitive performance, appearance
CONCEPTUAL SHIFT	"badness" → "sickness"	natural processes/life events → medical-technical problem	common, expected feelings → medical pathology	well → better-than-well
WHO/WHAT DRIVES PROCESS?	The state, social interest groups, or movements (treat "alcoholics" rather than punish social "deviants")	Medical specialities (e.g. psychiatry), consumers	Pharmaceutical companies, psychiatry, consumers, patient advocacy groups	Pharmaceutical companies, medical specialities (e.g. cosmetic surgery), consumers
CRITIQUES	Attention on the individual overlooks the social environment & limits solutions	Narrows definition of normality Lay/Indigenous knowledge undermined Increases medical surveillance & control & diminishes people's autonomy	Attention on the individual overlooks the social environment & limits solutions Less tolerance for minor discomfort or problems False promises Homogenises life	Privileges the well-off & undermines social solidarity (between rich & poor) Individualistic: Promotes individual over collective interests Promotes suspect norms

Once an illness is medically classified, pharmaceutical companies and entrepreneurial influencers can develop and market treatments, driving the expansion of diagnostic categories (Moynihan et al., 2019; 2020). For instance, the diagnostic expansion of conditions like ADHD or depression has coincided with the development of corresponding medications, leading to lucrative markets (Horton-Selway, 2018; Nielson, 2018). Diagnosis is, therefore, not just about identifying disease; it is also a gateway to treatment and profit, where medical and economic interests intersect. Commercial interests frequently drive medicalisation, from companies manufacturing cures to advertisers and media outlets reporting on sensational health issues (Moynihan et al., 2019, 2020).

In recent decades, the "machinery of medicalisation" has mushroomed, involving medical professionals, allied health organisations, social movements, consumers, biotechnology, the insurance industry, and the pharmaceutical industry (Moynihan et al., 2019; 2020; Tiefer, 2008). Pharmacological solutions have abounded in recent years for a host of "conditions" (Marecek & Hare-Mustin, 2009), for example, those related to ageing (e.g., baldness, hormone replacement therapy), emotional distress (e.g., depression, anxiety), and sexuality (e.g., erectile dysfunction, labiaplasty, female orgasmic disorder). The authority of diagnostic systems is thus deeply intertwined with the economic interests of industries such as pharmaceuticals (Moynihan et al., 2019; 2020), prompting critiques of disease mongering for financial gain, as highlighted by cases like MoDeD and protests against Pink Viagra (Moynihan, 2010; Tiefer, 2006; see Textbox 6 further below).

Medicalisation has legitimised branches of medicine, such as psychiatry—a subfield of medicine—extending its influence and conferring greater authority on associated disciplines like clinical psychology (Shorter, 1997). For example, alcohol use or problematic gambling can be “diagnosed” as stemming from addiction, personality disorder, or depression, and psychiatrists may even be involved in matters related to legal norms, such as child abuse or rape (Anleu, 2019). Consequently, psychiatry—and the psy professions more broadly—now oversees a range of aspects of life, including sexuality, eating, substance use, and recreational practices like gaming or gambling. Certain practices can be framed as mental illnesses or disorders based on classifications of normality, like the DSM. The manual is widely used as a diagnostic reference worldwide (Marecek & Hare-Mustin, 2009; Marecek & LaFrance, 2021). It provides standard criteria for diagnosing mental health conditions.

The DSM can also reinforce the medicalisation of human distress by framing a wide range of emotional and psychological experiences as disorders. This solidifies a biomedical approach to mental health, often sidelining alternative understandings such as the role of socio-cultural or environmental factors (e.g., unemployment due to financial crises) in causing distress and a sense of helplessness (Riddle, 2024). In this way, psychiatry and psychology may play powerful roles in the medicalisation process and the social control of deviation according to legal, moral, and even religious norms (Marecek & LaFrance, 2021).

The advantages and disadvantages of medicalisation

The medicalisation of various aspects of life has both advantages and disadvantages. There are, on one hand, arguable benefits to medicalising some issues. This was highlighted in Conrad's (1975, p. 18) foundational work in the 1970s:

Clearly there are some real humanitarian benefits to be gained by such a medical conceptualization of deviant behaviour. There is less condemnation of the deviants (they have an illness, it is not their fault) and perhaps less social stigma. In some cases, even the medical treatment itself is more humanitarian social control than the criminal justice system.

Conrad refers to the conceptual shift from badness to sickness (in Table 2.3.1), arguing that being diagnosed as ill rather than socially deviant may allow a more sympathetic response from others, including healthcare providers. This may be especially so when a condition or disorder is seen as outside of individual control, as in the reframing of socially unacceptable behaviours such as frequent intoxication as an addiction and disruptive behaviour as hyperactivity. Medicine may also offer tangible, sometimes straightforward, and more affordable solutions for complex problems (Schmidt, 2011).

As discussed earlier, receiving a medical diagnosis may allow people to take up the sick role and any advantages attached to it. A good example is the medicalisation of problems of living (as in Table 3.2.1). For instance: working-class Brazilian women use the idea of “suffering from nerves” to explain troubles—like worry, sadness, and sleeplessness—that stem from precarious living conditions. The subsequent diagnosis of “nerves illness” frames these troubles as a medical issue rather than a socio-economic one. This medical label allows them to evade the social stigma associated with poverty as well as potentially giving access to resources and care they might not otherwise have received.

This brings us to one of the primary disadvantages of medicalisation: focusing on the individual. In the case of “suffering from nerves,” women may receive medical treatment and support. However, the root causes of their suffering (economic inequity, lack of state support) remain unchanged (Traverso-Yépez & De Medeiros, 2005). The issue is that “framing suffering in psychiatric terms may depoliticise problems by individualising and disconnecting suffering from the contexts in which it has arisen and is maintained” (Degerman, 2020, p. 1010). Instead, everyone is treated individually and tasked with taking personal control of their own wellbeing, without attempts to improve social conditions that cause suffering (Anleu, 2019).

Treatment often involves medication, an attractive and simple solution in the form of “a pill for every ill”. Medication may offer many sufferers relief and treatment options. Still, it can lead to an overreliance on pharmacological treatment for difficulties whose origins and alleviation may be better understood as societal rather than individual. Moreover, medications themselves are also not always risk-free (Moynihan, Doust, & Henry, 2012). In this way, medicalisation is supported by healthism with its emphasis on individual responsibility for health and the pursuit of health as a primary value (Crawford, 1980; 2006; see [Chapter 1.4](#)).

Another important concern related to medicalisation, also noted above, is that of social control. The ever-widening authority and influence of psycho-medicine grants authority over more parts of people's lives. Medical professionals have increasingly been tasked with applying mechanisms of social control by treating deviance from dominant societal expectations of how certain people ought to behave (as we saw above in the vivid example of the enforced psychiatric treatment of women protesters in Iran). Their job is to induce conformity with agreed social norms or at least help to minimise or manage behaviour portrayed as deviant, be it a disruption of the social order, violation of appearance-related norms, or other kinds of disruptive, unacceptable, or supposedly immoral behaviours (Anleu, 2019).

This process is known as the “medicalisation of deviance” (or the “medicalisation of social ills”), which can mask moral judgements behind the façade of epidemiological and scientific evidence (Barker, 2010; Heally-Cullen et al., 2024). Practices previously considered simply as morally inappropriate or “bad” (but at some point, within the range of normality) are reclassified as sickness: the conceptual shift from badness to madness (as referred to in Table 3.2.1).

The relatively recent concept of “addiction” provides a familiar illustration of the medicalisation of deviance. The emergence of this diagnostic label highlights how certain morally controversial or unacceptable behaviours are reframed in pathological terms rather than as (primarily) sinful, illegal, or immoral. Hence, sexual activity or alcohol and drug use that is considered excessive is diagnosed as sex addiction, alcoholism, and drug addiction respectively. The socially undesirable behaviour moves from being understood (primarily) as moral issue (sin or crime) to a medical one (illness, condition).



Fig 2.3.7 *The Drunkard's Progress* (1846) by Nathaniel Currier frames alcohol use in moral terms and warns that moderate drinking may progressively result in moral decay and, eventually, suicide. (*The Drunkard's Progress*, by Nathaniel Currier, via Wikimedia Commons. Public domain)

Moreover, according to each framing of the issue, the behaviour is differently controlled: through moral sanction (e.g., excommunication from church, gossip), legal punishment (e.g., imprisonment, hard labour, fines), or psycho-medical expertise (e.g., institutionalisation, medications, therapy). Nevertheless, each is a form of social control through different means (Heally-Cullen et al., 2024). Where before religious or legal authorities were granted authority over certain social matters (like sex or alcohol consumption), medicalisation now brings them under the authority of healthcare professionals tasked with their management (Anleu, 2019). Relabelling an issue as a health issue rather than a moral one, as in the case of addiction, may remove some of the (overt) stigma associated with it by freeing the person from moral blame. However, being labelled as ill or deviant may bring a different set of (less overt) social judgements (Marecek & Hare-Mustin, 2009).

Attending to the social process of medicalisation raises critical questions about the role of medicine in society, the nature of health and illness, and the balance between medical authority and individual experience. As such, it is essential to understand diagnosis not just as a medical act, but also as a complex social and political phenomenon. Designating signs as indicative of disease involves interpretation. This is more than a matter of individual judgment; it involves others. Presenting symptoms constitutes a moral claim to be treated in a certain way by others, both laypeople and professionals. In the following chapter, we explore how this plays out in interactions with healthcare providers specifically, where a key issue is power, primarily associated with knowledge and expertise. (See [Chapter 1.4](#)).

Sexual desire is not simply biological; it is a complex, socially located experience shaped by cultural and gendered norms. Yet the process of medicalisation reduces sexual desire to a set of simple physiological responses. By focusing on quantifying and measuring desire, medicalisation neglects the context in which desire is experienced, treating it as an objective “thing” rather than a culturally constructed phenomenon (Vares & Braun, 2006). Male sexual desire is culturally well understood—men are expected to be virile and always-desiring, with Viagra even used to enhance performance (Vares & Braun, 2006). In contrast, female desire has long been seen as physiologically complex, “hard-to-know,” and variable (Fahs, 2016). Historically, Western medicine has classified women’s sexuality as irregular or deviant (Potts, 2008), arguing that female sexual desire requires control according to the norms and ideals of the time. Medical “experts” turned their gaze on female sexuality, framing it as something to be pathologised and treated objectively (Bancroft, 2002).

Under the “medical gaze” (Foucault, 1963/2003), female sexual desire is managed and regulated in the name of helping women address “problems” with desire (Moynihan & Mintzes, 2010). Diagnoses such as hysteria, nymphomania, and, more recently, female sexual dysfunction are based on dominant societal norms regarding gender and sexuality—that is, on ideals about how women should behave. For instance, Victorian society deemed women should be sexually modest and passive, and those with “excessive” libido could be diagnosed with female hysteria (Jutel & Mintzes, 2018). Similarly, in the late 19th century, nymphomania was recognised as a mental illness in Europe and North America. It was applied to women who exhibited “too much” sexual desire through fantasies, masturbation, or expressing a higher sexual appetite than their husbands (Marecek & LaFrance, 2021).

Today, in Europe and North America, a woman displaying more sexual desire than a man is less likely to be pathologised, but the opposite. Changes in gender norms now render low sexual desire problematic. The development of Masters and Johnson’s human sexual response cycle contributed to the view that women with comparatively low sexual drive are disordered (Potts, 2008).

Consequently, variable or low sexual desire may be diagnosed as female sexual dysfunction—specifically as female orgasmic disorder or female sexual interest/arousal disorder—and treated pharmaceutically (Potts, 2008; Thomas & Gurevich, 2021).

These conditions are rooted in subjective judgments about what counts as “excessive” or “insufficient” desire for women, based on prevailing values and the patriarchy. Medicalisation, therefore, works to pathologise deviations from societal norms and serves to control women’s expression of desire—and by extension, their sexuality and bodies—in the interests of the patriarchy (Thomas & Gurevich, 2021).

In contemporary Western contexts, women’s desire is negotiated within a double bind. They are expected to embody purity while also being sexually available—“up for it” but not labelled promiscuous (Farvid & Braun, 2014). This contradictory expectation makes the notion of “normal” female sexual desire elusive. Capitalist economies exploit these conflicting discourses, encouraging women to pay for pharmaceutical “fixes” without acknowledging the culturally specific reasons for fluctuations in desire. The creation of medications for variations in desire reinforces the notion that such variations are pathologies needing pharmaceutical solutions (Bancroft, 2002).

“Pink Viagra”



Figure 2.3.8 Flibanserin of “Pink Viagra” was the first drug approved to treat women’s low sexual desire. It is only moderately effective and there are concerns about its safety and side effects. (Photo by [Michal Jarmoluk](#) on Pixabay. [Pixabay licence](#))

So-called Pink Viagra is an example of how a disorder called female sexual dysfunction was constructed by researchers and pharmaceutical companies to market medication as a treatment—what Leonore Tiefer describes as a “textbook case of disease mongering” (Tiefer, 2006, p. 436). The origins of female sexual dysfunction as a disorder are tied to the success of Viagra (sildenafil), approved in 1998 for treating erectile dysfunction in men (Hartley, 2006; Moynihan, 2003). Pharmaceutical companies then sought a similar treatment for women. However, unlike erectile dysfunction, there is no clear physiological condition equivalent for women. In the late 1990s, drug company-sponsored meetings and conferences brought together clinicians, researchers, and industry representatives to define female sexual dysfunction as a medical condition. Diagnostic criteria for female sexual dysfunction—such as low sexual desire, arousal difficulties, and challenges achieving orgasm—began appearing in medical journals, framing female desire firmly within a biological model (Tiefer, 2002).

The quest for “Pink Viagra” has been fraught with challenges. Female sexual dysfunction is difficult to measure and define, and its treatment has faced significant criticism. Flibanserin, the first drug approved to treat low sexual desire in women, has been criticised for safety concerns, side effects, and modest efficacy. Unlike Viagra, which targets a clear physiological mechanism, Flibanserin’s effectiveness relies mainly on self-reported measures of desire, and clinical trials have not consistently shown a tangible benefit over placebo (Jutel & Mintzes, 2018).

It is also important to note that female sexual dysfunction is not applied uniformly across all women. The diagnosis primarily targets cisgender, heterosexual women, thereby erasing the experiences of those of other sexualities and genders. Moreover, female sexual dysfunction is largely

a condition affecting White women who have the resources, such as health insurance, to access specialised care (Battle et al., 2022). In contrast, women of colour, particularly Black and Asian women, often face the dual challenges of the medicalisation of their sexuality and societal hypersexualisation based on racialised stereotypes (Pires, 2024; Sanger, 2009).

The consequences of medicalising female sexual desire

The medicalisation of women's sexuality and desire frames variations in desire as pathologies that require pharmaceutical solutions (Bancroft, 2002). This framing influences how women understand and experience their sexuality—prompting questions of whether they are “normal” or in need of corrective measures. Advertisers and the media capitalise on these concerns, fuelling the anxiety that underpins medicalisation (Cassells, 2008; Germov & Freij, 2019).

While pharmaceutical companies profit from narrow standards of normalcy, women do not benefit when these standards are divorced from their social context. The medicalisation of desire emphasises a “normal” sexual function, imposing strict expectations on women and risking the stigmatisation of the full spectrum of sexual desire. Critical scholars argue that these normative standards are rooted in androcentric views, reducing sexual pleasure solely to genital function and leaving little room for other forms of desire or the choice to abstain (Tiefer, 2001).

These critiques do not deny that biological factors can influence sexual desire. Rather, critical health researchers contend that treating desire as a solely isolated physiological problem is reductionist and yields limited solutions. Flibanserin's modest efficacy illustrates that addressing sexual desire without considering its broader context can lead to ineffective or problematic outcomes. Instead, proponents argue for a psychosocial view of sexual desire that acknowledges its contextual nature, suggesting that “sexual life is contextualized for everyone” (Tiefer, 2004, p. 273). Thus, while physiological factors may contribute to sexual issues, they are only one aspect of a complex picture (Hartley, 2006; Potts, 2008; Tiefer, 2001).

Pharmacological responses marketed as “for women” can also marginalise other research agendas that might genuinely support women's sexual and reproductive health. From a critical feminist perspective, the normalising agenda of female sexual dysfunction ultimately limits women's sexual agency and reinforces problematic cultural expectations surrounding “normal” sexuality.

The example of female sexual dysfunction highlights why critical health psychologists remain vigilant regarding the disciplinary power of medicalisation in labelling female desire as “dysfunction” (see [Chapter 1.2](#) and [Chapter 2.3](#) on power). The medicalisation of female desire is intertwined with societal norms, gendered expectations, and the capitalist motives of pharmaceutical companies that profit from pathologising and “treating” desire. Critical health psychology is well placed to question this process, as it recognises that health and sexuality are socially constructed and advocates for perspectives that honour the diverse experiences of desire beyond biomedical models. Feminist scholars, in particular, emphasise that desire—in all its variations—must be understood as part of a spectrum of socially produced experiences rather than merely a symptom of dysfunction.



An interactive H5P element has been excluded from this version of the text. You can view it online here:

<https://oercollective.caul.edu.au/critical-health-psychology/?p=693#h5p-1>

Conclusion

Many critiques of diagnostic frameworks centre on their failure to address the social determinants of health, such as poverty, discrimination, and environmental factors. By focusing narrowly on individual pathology, diagnostic systems can obscure the broader social conditions contributing to illness and suffering. For instance, the medicalisation of mental health often overlooks the structural inequalities—such as racism, sexism, or economic deprivation—that underlie psychological distress. Critics argue that this narrow focus reinforces systemic inequalities, diverting attention from the need for broader social change. In this sense, diagnostic systems can perpetuate injustice by framing health issues as individual problems rather than societal ones (Marecek & LaFrance, 2021). Such a sustained focus also benefits those with economic and political interests in preserving the status quo.

Despite the various critiques of the biomedical model of diagnosis, it remains deeply entrenched in both medical practice and public understanding. The authority of diagnosis continues to shape clinical encounters, with doctors relying on established diagnostic categories to guide treatment. The public, too, often looks to medical diagnoses as authoritative explanations for their health conditions, reinforcing the power of the biomedical approach. This authority persists even in the face of growing awareness of the limitations of purely biomedical explanations of health, such as their tendency to overlook social and environmental factors. As a result, diagnosis remains a powerful tool that shapes not only medical practice but societal understandings of health and illness.

Summary of main points

- **Diagnosis as a social practice**

Diagnosis is not merely about labelling diseases; it establishes a shared understanding of what constitutes sickness, shaped by values, norms, and biology (Jutel, 2024).

- **An interpretative and power-laden process**

Diagnosis involves assigning clinical observations and patient experiences to predefined categories—a process imbued with judgments about normality and abnormality, reflecting specialist knowledge and power dynamics (Durie, 2003; Rose, 2013).

- **Benefits and drawbacks**

- Provides access to treatment, resources, and a standard language for medical communication
- Can reduce complex, personal experiences to oversimplified labels, potentially leading to stigma, reduced social roles, and neglect of broader contextual factors (Dumit, 2006; Ward, 2019)

- **Diagnostic classification as interpretative**

Although diagnostic categories are often seen as objective, they are the result of human judgment and consensus among experts, reflecting socio-political currents rather than pure biological facts (Bourdieu, 1991; Jutel, 2021).

- **The role of values and norms**

The creation of diagnostic categories is embedded within cultural contexts, where shifting societal values (e.g., around gender, race, and sexuality) influence what is considered “normal” or pathological. Historical examples (drapetomania and the pathologisation of homosexuality) illustrate this dynamic (Marecek & LaFrance, 2021; Tyson, 2011).

- **Diagnosis in healthcare interactions**

Diagnosis structures the doctor–patient relationship by creating a knowledge hierarchy that privileges biomedical knowledge over lay or experiential knowledge, often marginalising patient perspectives and reinforcing power imbalances (Dumez & L’Espérance, 2024; Mishler, 1986).

- **Broader socio-political implications**

Beyond individual treatment, diagnosis plays a crucial role in legal decisions, public health planning, resource allocation, and social control, determining who is granted the “sick role” and access to social goods (Dumit, 2006; Nettleton, 2006).

- **Medicalisation as a process**

Medicalisation reframes everyday experiences as medical issues, driven by economic interests and the machinery of healthcare. While it can humanise deviant behaviour by framing it as illness (thereby reducing blame), it also risks overemphasising individual responsibility and obscuring structural causes (Conrad, 1975; Dew et al., 2016).

- **The medicalisation of female desire (case study)**

The pathologisation of women’s sexual desire (e.g., diagnoses of female sexual dysfunction) illustrates how societal norms, gendered expectations, and capitalist motives drive the medicalisation process. This results in the marketing of drugs like Flibanserin (“Pink Viagra”), which have been critiqued for their modest efficacy and safety concerns (Jutel & Mintzes, 2018; Tiefer, 2006).

- **The double-edged nature of diagnosis:**

Diagnostic labels can validate and provide a roadmap for treatment, yet they also have profound social, psychological, and material consequences—shaping personal identity, social roles, and reinforcing both stigma and social control.

Learn more

Weblog

- The companion blogs [Mad in the UK](#) and [Mad in America](#) publish some thought-provoking posts, like Cromby’s (2025) below.

Blog Posts

- Cromby, J. (2025). *What if being miserable isn't an illness?* [Weblog post]. Mad in the UK. Retrieved February 2025, from <https://www.madintheuk.com/2025/02/what-if-being-miserable-isnt-an-illness/>
- Jutel, A. (2022) *The social life of diagnosis* [Weblog post]. MJA InSight, Available from <https://insightplus.mja.com.au/2022/13/the-social-life-of-diagnosis/>

Journal Special Issue

- *The Journal of Sex Research* published [a special issue on the Medicalisation of Sex](#).

Video

- [Too much medicine](#), TEDx Talk by Ray Moynihan “a researcher, writer and award-winning journalist. The author of four books on the business of medicine, Ray has an international reputation for investigating the corrupting influences within health systems. He’s currently a columnist for the BMJ and undertaking a PhD on how to prevent the modern epidemic of over-diagnosis.”
- **Orgasm Inc.: The strange science of female pleasure** (2009) documentary on the medicalisation of “female sexual dysfunction” ([available on demand](#)): “ORGASM INC. is a powerful look inside the medical industry and the marketing campaigns that are literally and figuratively reshaping our everyday lives around health, illness, desire — and that ultimate moment: orgasm.”

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2.4 Healthcare interactions: Patient-practitioner relationships

ALLY GIBSON

Overview

In [Chapter 2.2](#), we examined how people make sense of their subjective experiences of symptoms, and in [Chapter 2.3](#), we considered what might motivate or hinder them from seeking healthcare. This chapter explores people's interactions with healthcare professionals, including the quality of these interactions and the subsequent care they receive as patients.¹ The latter can, of course, influence the former: bad experiences of treatment or health 'care' might colour future interactions with healthcare professionals.

Firstly, I critically consider how interactions and relationships between healthcare professionals and patients are shaped by power relations and prevailing sociocultural and political conditions. Within this section, I work towards a model of care known as patient-centred (or person-centred) care, which is an ideal approach to aim for in healthcare. Secondly, I discuss the various roles that healthcare professionals can play related to patients, and what functions these can serve in the healthcare professional-patient relationship. Finally, I draw on two case studies of research conducted on (1) sexual and reproductive health provision in South Africa and Aotearoa New Zealand, and (2) cisgender women's experiences of fertility preservation in cancer treatment in Australia. Using these case studies, I examine the nuances and quality of such healthcare interactions, as well as the implications for those seeking or needing healthcare.

Learning objectives

By the end of this chapter, readers will be able to:

- **Identify the roles that healthcare professionals perform** in healthcare interactions with patients.
- **Explain factors that impact the quality** of interactions between healthcare professionals and patients.
- **Critically evaluate the role of power** between healthcare professionals and patients (as lay individuals) and how this has changed over time.
- **Apply a critical perspective** to healthcare interactions by assessing the positive and negative ways in which these can take shape.

1. I use the term patients for clarity and consistency. However, please see section 1 to understand the different terms that can be used to refer to laypeople in the context of healthcare, and the particular meanings of these terms.

Healthcare interactions: from paternalism to partnership

In this section, I use a social constructionist lens to explore the sociocultural, political, and historical factors that have all shaped how healthcare professionals, patients, and healthcare provision have been variably understood over time.

Within the context of **biomedical dominance** (see [Chapter 2.1](#)), healthcare professionals have traditionally been placed (and continue to be) in greater positions of power relative to recipients of healthcare (Mishler, 1984; Parsons, 1951). This is particularly the case for medical doctors, who hold the most power in healthcare, compared to other healthcare professionals. This is primarily because of the prestige and authority attached to the (almost sole) ability of doctors to diagnose illness and disease and to prescribe medication (Britten, 2001; Freidson, 1970; Jutel, 2019), although this is slowly changing to include other healthcare professionals (e.g., nurse practitioners; pharmacists).

In this medicalised context, the term **patient** is most commonly used to refer to those who undergo some form of healthcare provision or treatment within a clinical context (e.g., doctor's office, clinic, or hospital). Historically, in such contexts, patients have been expected to occupy a passive position, namely, **the sick role** (as discussed in [Chapter 2.3](#)) and required to accept the technical expertise of doctors to direct treatment decision making, with little to no prior consultation with them (Parsons, 1975). Part of taking up the sick role requires **patient compliance** or **adherence** by undertaking and completing treatment as directed (be it medical, surgical, or psychological).

Promoting or even enforcing treatment adherence has continued to pose an ongoing challenge to health service provision, owing to either intentional or non-intentional non-compliance on the part of patients (Foley et al., 2021; Stevenson, 2004; Treharne et al., 2006). At times, poor communication, lack of understanding, or other issues can cause patients to unintentionally not follow treatment regimens. At other times, patients choose not to comply (for a host of reasons). Given its central role in determining whether treatment is undertaken and completed, improving patient adherence has therefore long been the subject of medical and health services research (see Foley et al. (2021) for a comprehensive review). Arguments that are made for completing treatment include improving people's health outcomes, increasing their overall quality of life, and decreasing long-term health costs (Foley et al., 2021; Sluijs et al., 2006; Treharne et al., 2006).

Textbox 1: Women at the hands of (male) doctors

A prime example of the paternalistic, traditional doctor-patient power dynamic is the treatment of women through the “psy-disciplines” of psychology and psychiatry, from the 18th century all the way through to the 21st century (Ussher, 1991, 2011). Feminist critical psychologist Jane Ussher (1991, 2011) provides decades' worth of documentation of this phenomenon. She explains that (predominantly male) psychologists and psychiatrists have held considerable power to assess women's symptoms of distress and determine them to be symptoms of madness (variously termed hysteria, neuroses, or mood disorders over time). The social and legal power that is attributed to being a diagnostician in Western society has allowed psychologists and psychiatrists to assign such labels of pathology to women, and consequently be justified in performing ‘treatment’, even and often against women's will, for centuries (Ussher, 2011). Furthermore, this approach has meant that psychological distress has always been positioned within the realm of internal pathology, rather

than as a result of women's socioeconomic circumstances—something that Ussher continues to critique in her work.

While this unbalanced dynamic remained undisputed for a considerable amount of time, the authority and power of doctors eventually started coming into question through several collective social movements, particularly in France, the UK, and the US, from the 1970s onwards. These included the **anti-psychiatry movement** (Crossley, 1998; 2005), the **women's health movement** (Ehrenreich & English, 1978; Morgen, 2002), and the **disability rights movement** (Halpern, 2004), to name a few. Such disparate movements have shared common points of focus and political aspiration in terms of:

- empowering previously disenfranchised groups of people and promoting their access to equitable healthcare
- raising public awareness about the social and healthcare needs of these groups
- and lobbying for greater involvement and legal rights concerning healthcare provision.

These movements have also promoted a rhetoric of **person-centred** healthcare, involving partnership between healthcare professionals and patients, and the repositioning of people from “patients” to “health service users”, “clients”, or other terms that recognise their personhood (Rose & Lucas, 2007).

Alongside such movements was a growing political turn to **neoliberalism** in Western society (as discussed in [Chapter 1.4](#) and [Chapter 2.1](#)), involving governments rationalising and minimising public spending on areas such as healthcare, and further shifting responsibility to individuals (Crawford, 1980). Such a turn to consumerism has been further fuelled by the increasing corporatisation and privatisation of medicine (Lee, 2015). Despite conflicting sociopolitical values, the coalescing of social rights movements with neoliberalism repositioned people needing healthcare within greater positions of power as “service users”, “clients” or “consumers”, and to varying degrees of partnership with medical doctors. This shift enabled—even required—lay people to educate and empower themselves about their health, to ask questions of doctors, to be more involved in decision making, and to exercise a “freedom of choice” (Lee, 2015, p. 137), such as “shopping around” for doctors should they be dissatisfied with the healthcare they receive. Although this consumer-focused approach overlaps with values of person-centred care, it often involves an oversight of the broader structural factors that make health and healthcare more accessible to some than others (Lupton, 2012).

Nevertheless, such a move (towards health service user-/consumer-/person-centred care) signals a major departure from previous doctor/patient relationships and interactions, and has had significant implications for the provision, delivery, and receipt of healthcare since.

Textbox 2: Shared decision making and person-centred care

Shared decision making is integral to person-centred care because it ensures that healthcare

decisions are made collaboratively, taking into account the patient's individual values, needs, and preferences alongside clinical evidence.



Figure 2.4.1 A compassionate healthcare conversation: patient-centred care involves empathy, support, and communication. (Photo by [Thirdman](#) via Pexels. [Pexels license](#))

As Charles, Gafni, and Whelan (1997, p. 687) succinctly describe, shared decision-making involves professionals:

1. **establishing a conducive atmosphere** so that the patient feels that her views about various treatment options are valued and needed;
2. **eliciting patient preferences** so that treatment options discussed are compatible with the patient's lifestyle and values;
3. **transferring technical information** to the patient on treatment options, risks and their probable benefits;
4. **helping the patient conceptualise** the weighing process of risks versus benefits; and
5. **sharing [their] treatment recommendation** with the patient, and/or affirming the patient's treatment preference.

What Charles et al. (1997) describe above ties to the notion of **concordance**, which gained attention in the UK in the early 1990s, serving as an alternative to the concepts of patient adherence or compliance (Marinker et al., 1997) discussed further above. Focus on medical adherence or compliance, in scholarship and practice, has tended to reinforce a binary between doctors as powerful and patients as disempowered—with

decision-making power as something to be wrestled with between doctor and patient. The notion of concordance offers a different perspective, as Stevenson (2004) explains:

The introduction of concordance marks a shift in the thinking in this area as it embraces the notion that the patient perspective should be an integral part of any consultation. As such, concordance reflects a shift from paternalistic practice, and in relation to models of medicine-taking strategies of patient blaming, to a model based on patient-centred medicine and shared decision making, and in relation to the issue of medicine taking, and more generally, the notion of health care practitioners and patients working in partnership (p. 184).

In an editorial to a medical audience, Treharne et al. (2006) demonstrate the utility of the concept of concordance using the example of patients with rheumatic disease—an illness that requires taking ongoing medication to promote patients' longevity and symptom control. This case study is particularly applicable to understanding concordance, given that it is an illness that can be treated in several similar ways, with relatively similar chances of success. Treatment is also likely to offer a range of side-effects (or risk/benefit ratio) for patients. With no clear preferred option, rheumatology physicians are in a good position, Treharne et al. (2006) argue, to work with patients in a collaborative way to reach a point of agreement, or concordance, by weighing up the costs and benefits for each patient, with each patient. Nevertheless, they acknowledge that the degree to which a patient might want to be involved in this process might vary across individuals. Concordance thus involves the patient's buy-in to be involved in this decision making process.

Each of these approaches to treatment, therefore, involves varying degrees of power held between the patient and the healthcare professional. Patients (and healthcare professionals) might hold very different opinions about what degree of involvement (thus, power) they want to have, or should have, within this decision-making process.

It is worth noting that, as an interpersonal interaction, the process of achieving successful treatment-taking is further influenced by the broader sociocultural context in which the interaction takes place. This is evidenced in a study conducted by Hikaka et al. (2020) in Aotearoa New Zealand, where older Māori relayed the cultural beliefs and social dynamics that impact whether or not they take the medication they are prescribed. Dr Hikaka gives a brief overview of her research in the following video.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/critical-health-psychology/?p=884#oembed-1>

Notably, scholars are shifting away from focusing on a dichotomy of power (as something that is held or not held by patients or healthcare professionals) and are instead drawing attention to the nuances of doctor-patient relationships and the roles that healthcare professionals can play (MacArtney et al., 2020), as we explore below.

Roles of healthcare professionals

Regarding people seeking or using healthcare, healthcare professionals (and the care or 'services' they provide) can take up various positions or play one of several roles, and often more than just one of these at

one time. These roles are not limited to doctors but rather identified across healthcare professions to varying degrees, depending upon a healthcare professional's discipline, seniority, and relationship to a particular patient.

Firstly, I present a typology of these roles below. I also critically explore how these roles operate within patient-practitioner interactions, and when they might be accepted, contested, or modified depending on different contextual factors.

Knowledge-provider

As discussed above, healthcare professionals have historically been positioned as experts in treating illness and disease and continue to hold this role in Western society (Freidson, 1970; Jutel, 2019; Lupton, 2012). They are socially recognised as possessing specialised forms of knowledge, primarily gained from professional training, their practical experience, and with oversight through registration with professional boards (see Freidson (1970); although this can vary amongst complementary and alternative medicines.

It is this professional knowledge and social standing that enables healthcare professionals to be in a position to provide explanations to patients regarding what they might be experiencing subjectively. Medical doctors (amongst other healthcare professionals) additionally have the moral and legal right to diagnose conditions based on these symptoms. This knowledge is given further credence and legitimacy based on physical or psychological assessments they can conduct with patients (with their consent) (Britten, 2001; LaFrance & McKenzie-Mohr, 2013).

Textbox 3: Contextualising interpersonal dynamics in the healthcare encounter

In an educational webinar on conducting culturally safe medical consultations in Aotearoa New Zealand, Dr Sarah Sciascia discusses “whakawhanaungatanga”, a Māori concept of getting to know one another in a meaningful way prior to any engagement in a consultation.



One or more interactive elements has been excluded from this version of the text. You can view them online here: [https://oercollective.caul.edu.au/critical-health-](https://oercollective.caul.edu.au/critical-health-psychology/?p=884#oembed-2)

[psychology/?p=884#oembed-2](https://oercollective.caul.edu.au/critical-health-psychology/?p=884#oembed-2)

Dr Sciascia touches on some appropriate models of care and gives some practical advice on how healthcare professionals can better connect with patients (see particularly section 7:05 to 32:13). This video again emphasises the humanistic element of the healthcare encounter – that it involves (at least) two human beings coming together with their own sets of values, beliefs, life experiences, and so on. These sociocultural factors all come together in shaping how the interaction will then take place and be experienced.

The role of “knowledge-provider” can serve a *comforting function* to patients, who might be seeking reassurance and support for what they are subjectively experiencing. Similarly, as discussed in the preceding chapter, diagnoses themselves can have a legitimising effect for patients, in giving a name to any peculiar or unusual symptoms (LaFrance & McKenzie-Mohr, 2013). Indeed, healthcare professionals might even detect signs (e.g., elevated heart rate, blood test results) that give support to a patient’s felt symptoms, to support their sense they are not “making it up” (although see LaFrance & McKenzie-Mohr, 2013 for a discussion of stigmatising labels). This need for legitimacy is, furthermore, strongly tied to the broader social capital attached to diagnostic labels (Jutel, 2010a).

There are, however, also limitations to the knowledge and ability of healthcare professionals, as well as to any assessment measures, not to mention any differences in opinion, or invisible or undetectable symptoms that could be at play. Dealing with uncertainty can be a challenging experience for healthcare professionals, as it contradicts the role of knowledge-provider, as being seen to be experts or diagnosticians (Fox, 2000; Parsons, 1951). Likewise, the experience of invisible symptoms can be littered with tensions between a patient and healthcare professional, when they are not recognised and legitimised by the healthcare professional, or discounted as “psychosomatic”, “undifferentiated”, or “not otherwise classified” (Jutel, 2010a). This can have a *damaging function* for people seeking help, leaving them feeling silenced or stigmatised (Armentor, 2017).

Treatment-provider

Subsequently, as knowledge-providers, healthcare professionals are in a position to offer patients options (where applicable) or instructions for treatment to consider. Healthcare professionals can thus also play a role as “treatment-providers”.

This role is traditionally characterised by healthcare professionals taking up a relatively directive approach, acting in a position of power in relation to patients, while patients are expected to take up a position of compliance or adherence, as discussed above (Parsons, 1951; Stevenson, 2004). Taking medicine as directed, changing one’s behaviour, undergoing surgical treatment, and so on, all require a patient accepting and adhering to such instructions in an ongoing way. As acknowledged earlier, this uneven power dynamic is frequently justified from a medical or health services perspective as being necessary for achieving successful health outcomes for patients and healthcare services (Lutfey, 2005; Sluijs et al., 2006; Treharne et al., 2006). Medical (and psychological) treatment—especially curative treatment—also holds the promise of relieving a patient’s suffering (Cassell, 1983), and therefore serves as further justification for the *directive function* of treatment-provision. Indeed, patients and their families can be seen to accept or take up the role of following treatment directives in the hope of surviving, or even out of a sense of moral responsibility to do everything possible to get better (Tate & Stivers, 2025).

Textbox 4: Tips for engagement

Treatment is, of course, the point at which opportunities arise for discussion and shared decision making, to improve concordance between healthcare professional and patient. [An article in The Guardian](#) (Phillips, 2025), for example, outlines the ways in which people can bring personal concerns and questions to the medical encounter.

More nuanced analyses of patient-healthcare professional interactions are starting to demonstrate how treatment provision involves a complex negotiation between healthcare professionals and patients to achieve concordance. Drawing on interviews with cancer patients, MacArtney et al. (2020), for example, illustrate the way patients can position themselves *ambiguously* relative to their doctors, as seemingly having less power than their doctors while still presenting themselves as feeling “cared for” or having a positive relationship with them. This complicated power dynamic is well illustrated in one of their participants’ comments:

I think once you put yourself into the hands of the experts, let them get on with it and follow their advice. [er] That’s what I have [erm] learned all my life and certainly in medical terms [erm] it, it seems absolutely clear to me that [erm] they know what they are doing... And they are at pains to [er] at the end of each discussion so when “Have you got any questions at all?” They are at pains to have their brains picked, so there was absolutely, there was no problem whatever about not being kept informed. At no point did I feel I was being somehow not taken notice of. People were very concerned to make sure that I knew exactly what was going on at every stage (MacArtney et al., 2020, p. 850).

MacArtney et al. (2020) argue that patients’ interactions with their doctors—and what they want from their doctors—depend on the interpersonal and contextual factors of any interaction (which can change over time and place). For example, participants in their study indicated they wanted doctors to exercise good interpersonal skills, to demonstrate care and respect toward them, and to hold space for their questions or emotional responses to the diagnosis or treatment (much like what is suggested in *The Guardian* article). This did not necessarily equate to doctors giving them equal partnership. Instead, patients positioned doctors as still responsible for gauging the appropriateness of information sharing (when it was too much/too little), and of directive behaviour (of needing to “nanny” or to share decision making), and to act on their expertise and make—or even direct—decisions when appropriate (MacArtney et al., 2020). As they conclude:

*To be cared for was not understood as an imposition upon a person’s freedom when it was part of a healthcare process in which the patient feels engaged as a human in the right way. Moreover, being **affected, but not directed**, by their doctors was often desired by the patient as a way to lessen the emotional and practical burdens of the process of a cancer diagnosis (MacArtney et al., 2020, p. 856, emphasis added).*

This study demonstrates the need to move away from understanding the patient-healthcare professional relationship as a dichotomy of power, and rather explore the way both parties might experience this as a negotiated, complex process of interaction.

Gatekeeper

Healthcare systems are complex in the stratified levels of the disciplines and seniority of healthcare professionals of which they are made up. Most typically, however, they are structured in terms of **primary** and **secondary care** through a process of **gatekeeping**. Members of the public are (only) able to access primary care by directly making an appointment, for example, with a clinic or health service. Primary care is usually made up of general practitioners (GPs), psychologists, nurses, nurse practitioners, midwives, health improvement practitioners, and other allied healthcare professionals (e.g., physiotherapists). Healthcare professionals working in this space are required to have relatively generalised knowledge to be able to assess, diagnose (where applicable), and/or treat a host of problems that people can experience in relation to their health.

Because of the scarcity of specialists in healthcare systems, healthcare professionals within primary care (most often GPs) are positioned to act as gatekeepers (Loudon, 2008), determining which patients present as severe or concerning enough to require a referral to secondary care, or who might require referrals

to specialist tests or screening. The arguments for this gatekeeping role are most often made based on promoting lower hospital use, ensuring lower healthcare spending, and better quality of care—although this has been found to occur to varying degrees of success (Sripa et al., 2019).

At both primary and secondary levels of healthcare, healthcare professionals also act as gatekeepers to medicine or treatment of some kind. It is only through the recognition of a patient's symptoms (through diagnosis) that a patient can ordinarily receive pharmaceutical, medical, or surgical treatment (Jutel, 2010b). Furthermore, as Jutel (2010b) points out, it is through diagnosis that doctors (and other relevant healthcare professionals) can grant patients certain allowances, such as sick leave, disability parking permits, and so on (p. 6). Having access to these allowances, however, requires recognition that a person needs—or even (in neoliberal terms) “deserves”—them.

Broker

Central to the role and values of being a healthcare professional is the sense of being a patient advocate (Schwartz, 2002). Healthcare professionals are often in a position to act on behalf of patients, to advocate for them, but borrowing the term from Broom et al. (2016), I use the term “**broker**” to capture the dynamic negotiation this role requires. As Stovel and Shaw (2012) originally put forward:

*...people situated between distinct social worlds collect and channel scarce information **in ways that make things happen**. When people—and occasionally organizations—make introductions, help us find jobs, advocate on our behalf, or make sense of the world for us, they act as brokers (p. 139, emphasis added).*

In other words, it is not always simply a case of a healthcare professional putting the needs of a patient forward, but sometimes *actively* working to negotiate towards a deal, an outcome that works in the interests of their patient. Stovel and Shaw (2012) explain:

The crucial characteristics of brokers are that (a) they bridge a gap in social structure [where something is wrong or missing] and (b) they help goods, information, opportunities, or knowledge flow across that gap (p. 141, words added).

In their Australian study of antibiotic use in hospitals, Broom et al. (2016), for example, examined the role that nurses play in challenging or re-directing physicians' antibiotic decisions to start, continue, or stop their use. This is discussed by nurses as occurring all within the context of new guidelines to rationalise antibiotic prescribing, the professional hierarchy within the hospital setting, and their sense of advocacy for patient wellbeing.

The work of MacArtney et al. (2020) similarly demonstrates moments of brokerage—where healthcare professionals are seen to broker access to secondary care (seeing a specialist, having further testing) at the request—or persistence—of patients. This is demonstrated in this extract from MacArtney et al. (2020):

The participant was a hospital doctor, whose story started with a description of the difficulty that she had getting a referral for further investigation from her GP. She had seen the GP twice, who had suggested the bleeding she was experiencing was due to constipation. Frustrated, and facing a third appointment with her GP, the participant spoke to a surgical colleague when at work, who was able to help her,

So then he takes – exactly what one loves – he takes over... So he took me and we went straight out to the nurse who you make appointments with, and so I got the [laboratory] referrals and so I got the appointments – everything I needed (p. 854).

In this example, it is evident there is a sense of breakdown within the interactional process of referral, between the participant (as patient) and her GP, of feeling discounted and frustrated, to the point of

circumnavigating the usual referral pathway, resulting in a colleague reportedly brokering this access to further testing on her behalf.

Another example is provided by a GP in the US, who describes himself as acting as a “quarterback” for his patient, a woman who was highly anxious and unfamiliar with accessing the healthcare system but required it for assessing a breast lump.



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In this example, the GP notably presents himself as going above and beyond to allay a woman's fears, primarily by continuing to advocate for her access to secondary care services and to follow her through the process, rather than losing contact after the point of primary care. Earlier, the referral made between primary and secondary care was discussed in terms of healthcare professionals acting as gatekeepers. Here we can see the term gatekeeper is not always appropriate, nor meaningfully captures what occurs between patients and healthcare professionals in the pursuit of healthcare.

Exercise 1

Can you think of other examples of brokerage in healthcare?

The role of broker also brings up questions of power and who holds it within the healthcare professional-patient relationship. As evidenced in the example drawn from the study by MacArtney et al. (2020), this is not always simply doctors using their positions of power to benefit patients. What we saw in that example was the way the patient presented herself as actively playing a role in acquiring the support (a hospital physician) to broker the gap between her experience and the healthcare service she needed. Of course, like any interaction, any examples of such interaction need to be examined within the particular social context in which they play out. In this case, the patient could be seen to already hold significant social capital, as a doctor herself, with contacts (colleagues in the hospital) to benefit from such brokerage. This opens up interesting opportunities to explore how patients and healthcare professionals might negotiate decision making in the pursuit of improving a patient's health and access to healthcare.

Negotiating decision making in healthcare

For the rest of this chapter, I explore the relationships and interactions between healthcare professionals and people seeking healthcare, using the example of sexual and reproductive health framed through a lens of reproductive justice.

Case study 1: Intersectionality matters: reproductive justice through healthcare interactions

For our first case study, I draw on the work of Morison and colleagues (Morison & Lynch, 2016; Morison, 2023a, 2023b; Morison & LeGrice, 2023; Morison, Lynch & Macleod, 2022). Specifically, they offer a lens of “reproductive justice” to examine patients’ experiences of interacting with healthcare professionals in reproductive healthcare settings (Morison, 2023a; Morison & LeGrice, 2023). Using this conceptual lens brings attention to how **intersectionality**—where social identities such as sexuality, race, class, gender, and age overlap and interact—shapes patients’ healthcare experiences. Intersectionality enables a deeper understanding of the diverse ways that power dynamics shape healthcare encounters and affect reproductive agency (Morison, 2023a; Morison & LeGrice, 2023).

Morison and colleagues’ work highlights how significantly pervasive heteronormativity shapes sexual minority experiences of sexual and reproductive healthcare (SRH) in South Africa. LGBTQ+ people have described multiple ways that their identities intersected to shape their healthcare encounters negatively (Morison & Lynch, 2016; Morison et al., 2022). For example, participants recounted experiences in public SRH care ranging from overt hostility—such as refusal of care following sexual assault—to subtler forms of invalidation or ignorance of their unique SRH needs. Their accounts refer to public, government-subsidised services, which in that country are generally used by those who cannot afford private care, further adding to the power imbalances between patients and healthcare providers.

For instance, one bisexual African man described being publicly humiliated by public healthcare providers who asked intrusive and irrelevant questions about his sexuality, demonstrating how he was positioned as culturally unintelligible within healthcare systems that privileged heterosexual norms (Morison & Lynch, 2016). In other words, it was seemingly unimaginable for a bisexual African man to exist in such a space. Similarly, a lesbian (also Indigenous African) participant explained her attempt to seek care after experiencing sexual violence:

The nurses said we are acting like men while we are women. I explained this is the way I am, but they still ended up dismissing me, so I left without receiving help (Morison & Lynch, 2016, p. 16).

These accounts vividly illustrate how intersecting stigmas—based on gender nonconformity, sexuality, and economic marginalisation—intersect in healthcare interactions, effectively marginalising sexual minority patients and eroding trust in public health services.

In another strand of Morison’s research on contraceptive care, undertaken in South Africa and Aotearoa New Zealand, intersectionality was similarly highlighted (Morison, 2023b; Morison et al., 2022; 2025). Here, contraceptive providers’ accounts of their interactions with patients highlighted how power relations related to race, class, and age intersected to shape reproductive healthcare experiences. Despite widespread commitments to patient-centred care, many providers implicitly positioned women from particular groups as less capable of responsible reproductive decision making and thus better suited to long-acting, reversible contraceptives (LARCs). Providers described using persuasive tactics and selective counselling practices, framing their actions as “protection” or even “empowerment”, rather than coercion. This is illustrated below:

Gavin (specialist gynaecologist in public hospital, Pākehā/White man):

I had this lovely lady a while ago, a young girl, and I asked my standard question: "Are you in a committed relationship?" She said, "Yeah, yeah, yeah". So, I thought I had better just ask how long your committed relationship is, and she said, "Six weeks"! ((laugh)) [...] So, the copper coil might have been brilliant for her, but a Mirena [intrauterine device] would be safer for her, for protecting her against life and from herself (Morison, 2023b, p. 545).

Such accounts highlight how intersectional profiling becomes an unquestioned aspect of clinical decision making. Providers also frequently depicted marginalised women—especially younger, racialised, and economically disadvantaged women—as at-risk and simultaneously risky. Consequently, healthcare encounters subtly reinforced controlling practices under the guise of protection or empowerment—which links to the earlier discussion on paternalism. Some providers explained:

Renee (nurse in public clinic, Māori woman):

We have drop-in clinics every day during the week, so it's definitely possible for someone to go away and have a think about it and come back. There's just some apprehension (.) that for someone higher RISK—because, you know, we find that sometimes you just get the one chance ((laughs))—depending on risk factors, whether you'd want to let them go without anything [contraception] or not (Morison, 2023b, p. 545).

Janet (gynaecologist in public hospital, Pākehā/White woman):

...some women have just had enough, and then they don't want to [continue]. I think if you think you can push them a little bit, they (.) I'd often say, "Well, we'll give you a set time. If things aren't better by that point ... " [...] I suppose what we don't like seeing is women who get to the mid-to late-teens; they've tried everything and say that nothing works. I think then you've got to try and say to them, "Which causes the least problems? You can't just not use anything" (Morison, 2023b, p. 542).

As these quotes illustrate, even providers who appeared to endorse patient rights and autonomy were seen to simultaneously limit those rights when patients were perceived as socially marginalised or risky. In other words, by doing so, they reinforced historical paternalistic attitudes in healthcare interactions. Consequently, intersectionality exposes the complexity of reproductive healthcare and the limitations of standard rights-based approaches.

Accounts from service users who participated in their research—cisgender women—underscored the paternalism noted in the providers' accounts. These participants similarly represented decision making as directed by their healthcare providers:

Kiara (Pākehā/White, student, age 22): It really was a lot of doctor/nurse-led:

They said, "This is what we think is gonna be best for you. You should give this a go." [. .] Like, if I had said to my doctor, then, "No, I want to be on the jab." They would have been like, "Well . . . We don't think that's the best option for you." And when a doctor says, "We don't think that's a good option," you kind of just nod and agree (Morison et al., 2022, p. 234).

These examples clearly show how reproductive healthcare interactions are shaped by intersectional identities, resulting in unequal access and constrained autonomy. As shown above, even when patients like Kiara can exercise some power based on their class or ethnic/racial identity, their age

and their standing within the interaction (as a patient) can limit their ability to act in their own interests.

Morison and colleagues' work shows how a commitment to patient-centred care can be undermined by ingrained, taken-for-granted power relations. We therefore cannot ignore intersectionality. Using the lens of reproductive justice—which is increasingly being adopted in global policy and guidelines (e.g., UNFPA, 2024)—sheds light on how structural inequalities (e.g., poverty) and intersecting forms of oppression (e.g., sexism, racism) shape healthcare interactions. This calls for a rethinking of healthcare professionals' education and training, in a way that does not just address individual patient rights, but also issues of broader social equity, historical contexts, and systemic injustices that shape reproductive healthcare access and interactions (Morison, 2023b; Morison, Macleod, Ndabula, 2025).

Through this case example, I have illustrated how examining intersectionality improves our understanding of patient-healthcare professional interactions. The reproductive justice framework that Morison (2023a, 2023b) and colleagues (Morison & LeGrice, 2023; Morison et al., 2022) put forward challenges us to transform not only how we study healthcare interactions, but also how we engage in them, to truly advance health equity and patient empowerment. Using their work, we can therefore see the possibility and value of creating a more inclusive, critical, and socially just approach to reproductive healthcare.

I now turn to reproductive decision making in another healthcare setting, oncology treatment in Australia. The case study has been adapted from an article by Rowlands et al. (2024), highlighting key arguments they make concerning women's experiences of treatment decision making for gynaecological cancer in Australia.

Case study 2: A case of competing priorities between fertility and cancer care

When faced with a diagnosis, as Rowlands and colleagues (2024) comment, the process of treatment decision making in oncology is not always clear-cut. This is particularly highlighted in the case of cisgender women in Western countries, who are increasingly being diagnosed with a form of gynaecological cancer (vulval, vaginal, cervical, ovarian, or uterine cancer) before having conceived a child—or even having had time to consider whether or not they wish to do so (AIHW, 2022). Notably, global incidence rates of cervical cancer, as one form of gynaecological cancer, rank it as the third most common cancer to be acquired by women under the age of 45 (Arbyn et al., 2020). Treatment for gynaecological cancer most often requires total removal of reproductive organs, which negates the option of most fertility-preserving treatment that women without cancer could ordinarily access (Schüring et al., 2018).

As Rowlands and colleagues (2024) point out, the inability to have children carries considerable weight psychologically and socially for cisgender women living in a “pronatalist” society that favours, even celebrates, childbearing (Rich et al., 2011). Having children is additionally intertwined within pronatalist societies (such as Western countries) with gendered constructions of, and

expectations placed upon, (cisgender, heterosexual) women. To be a woman is to be a mother is the normative assumption. Any woman who chooses not to pursue this life trajectory, or who is unable to, risks facing considerable ostracism and questioning from others, to have to account for this apparent deficit (Canada & Schover, 2012; Rich et al., 2011).

At the same time, Western society is also marked by highly recognisable and predictable responses to cancer—namely, cancer being an enemy that needs to be fought and conquered (Bell, 2010). People's responses to cancer are therefore strongly shaped by a discourse of survivorship, whereby the person with cancer is positioned as needing to do everything possible to overcome the illness, to generate sympathy and support from others (Gibson et al., 2015, 2017; Staneva et al., 2019; Tate & Stivers, 2025). This discourse can be understood as embedded within the broader Western discourse of healthism (see [Chapter 1.4](#) & [Chapter 2.1](#)), in that considerable responsibility is placed on individuals to be proactive concerning their health and their survival, much like general neoliberal approaches to maintaining one's health.

In the following interactive section, I explore the tensions that women can find themselves experiencing: between the value and critical timing that is placed on fertility decision making and on cancer treatment, the active negotiation (reported) between women and their oncologists in this process, and the difficulties of trying to manage competing priorities within a particular sociocultural context that values both survivorship *and* motherhood.

Exercise 2 – based on Case study 2

1. Write down or highlight the words and phrases in the following three extracts (from Rowlands et al.'s (2024) article) that support or appear to make up the pronatalist discourse:

Extract 1 (p. 7)

Erin: ...I would have to have either a partial or a full hysterectomy um which means that I'd never be able to have children [...] I just felt very like I had no other options [...] I don't have children and they're talking about taking away, the one opportunity I have to have children [...]

Interviewer: And how did that feel um, being faced with that?

Erin: Um I was shattered I felt like my world was gonna fall apart ... (33 years old at diagnosis, 1 year post-diagnosis, endometrial cancer).

Extract 2 (p. 6):

...we hadn't um really got around to having children yet um we'd bought a house and everything like that and were just, you know, steadily working and paying it off [...] so it was kind of um you know a bit worrying that we weren't gonna get the chance to do that as it sort of is your normal progression in in life um but yeah so when we found out that I could have the trachelectomy and preserve the fertility that was great news ... (Emma, 27 years old at diagnosis, 5 years post-diagnosis, cervical cancer).

Extract 3 (p. 9):

Mandy: *Like they think, 'What's wrong with her? Why hasn't she got kids?' You know?*

Interviewer: *Gosh and what (mm) how does that feel? I mean getting those sort of responses?*

Mandy: *Ah oh it feels – like I feel like I sometimes need to justify why [...] generally I just say, 'Oh, I was never allowed – never able to have them', and, you know, kind of put some people that are a little judgmental in their place.* (Mandy, 37 years old at diagnosis, 7 years post-diagnosis, endometrial cancer).

2. Drawing on information from question 1, identify what type of role (as discussed earlier in the chapter) the doctor is presented as playing by the participant in the following quote.

...I was struggling to come to terms with the diagnosis and I was probably acting a bit stupid [...] I said, 'If I have a hysterectomy, that means I can't have kids', and he [oncologist] said, 'That's right', he said, um, 'But what's the point of raising children if you're not going to be around to look after them?' (Wendy, 33 years old at diagnosis, 7 years post-diagnosis, ovarian cancer) (Rowlands et al., 2024, p. 11).

- **a)** Thinking about the role you have identified, what argument might be given to justify this doctor's (reported) approach?
- **b)** What argument might serve to critique this approach?

3. Compare the extract in question 2 to the following extract.

...he [oncologist] also asked if um me and my husband if uh what he could do to um help us have kids [...] me and my husband we sat down and we talked and we were like, 'Nah, let's just go ahead and start with the chemo, just in case' ... (Sanushka, 27 years old at diagnosis, 1 year post-diagnosis, ovarian cancer).

- **a)** How do the second oncologist's reported actions differ from the first?
- **b)** What contextual factors need to be taken into account when making evaluative judgments on these interactions?

4. If you were the researcher in this study, how might you apply the lens of 'reproductive justice' to examine these healthcare interactions presented in this case study?

Final Remarks: In the original version of this article, Rowlands and colleagues (2024) explore the tensions that women report experiencing during interactions with their oncologists, how they responded within and in response to these encounters, and made sense of them in light of their cancer narratives. What they demonstrate is that healthcare decision making is not a simple, straightforward process—or even simply a top-down process with doctors in control—but requires careful negotiation, sensitivity, and a recognition of individuals' positionality (their needs, emotional responses, beliefs, etc., be it as patients or healthcare professionals), as well as broader social pressures and structures at play.

Conclusion

In this chapter, I have explored the issue of healthcare professional-patient relationships and how these are

shaped, not only by one-on-one interactions within a particular moment but also by broader and deeper sociocultural, historical, and economic contexts. I discussed how this plays out within a power dynamic between patients and healthcare professionals. This dynamic has historically occurred in a hierarchical, patronising way, with healthcare professionals (particularly doctors) holding all decision-making power. However, with broader sociocultural forces at play, patients have progressively been able to take on more engaged roles concerning their healthcare. Healthcare professionals can also be seen to perform varying roles when interacting with patients, which can involve differing degrees of power and negotiation. I have drawn on several case studies throughout the chapter to illustrate how these interactions can occur. I have also drawn on theoretical contributions in health psychology and related disciplines to help understand their complexity. As I have argued throughout, taking a critical lens to these interactions entails looking beyond individual factors to consider the deeper, underlying context in which they occur, and the implications they might have for people from a variety of sociocultural locations.

Takeaways

- **Healthcare interactions are shaped by power relations:** The relationships between healthcare professionals and patients are not just interpersonal but influenced by wider historical, cultural, social, and political forces.
- **From paternalism to partnership:** Traditional models of healthcare positioned doctors as dominant decision-makers and patients as passive. This has been challenged by social movements and policy shifts promoting more collaborative, person-centred approaches.
- **Person-centred care promotes collaboration:** Person-centred (or patient-centred) care encourages shared decision making, respect for patient values, and mutual understanding between patients and healthcare professionals.
- **Concepts of compliance, adherence, and concordance reflect different power dynamics:** These terms describe how patients follow treatment plans but differ in how much agency they afford the patient—ranging from passive obedience (compliance) to collaborative partnership (concordance).
- **Healthcare professionals take on multiple roles:** These include knowledge-provider, treatment-provider, gatekeeper, and broker. Each role involves different kinds of power and interaction dynamics that can shape patient experiences.
- **Intersectionality matters:** Patients' experiences of healthcare are shaped by overlapping social identities such as race, gender, sexuality, and class. Power imbalances can be compounded when healthcare professionals unconsciously reinforce stereotypes or systemic biases.
- **Reproductive healthcare highlights structural inequalities:** Case studies on contraception and fertility care show how even well-meaning professionals can perpetuate paternalism when they assume authority over patients' reproductive choices, especially for marginalised groups.
- **Shared decision making is context-dependent:** While many patients value being informed

and involved in their care, the preferred degree of involvement may vary. Trust, communication, and responsiveness are central to good care, not just formal equality in decision making.

- **A critical lens is essential:** Understanding healthcare interactions requires more than focusing on individual behaviour. It involves recognising the broader sociocultural, institutional, and political contexts that shape these encounters.

Further learning

Reading

- Coulter, A., & Oldham, J. (2016). [Person-centred care: what is it and how do we get there?](#) *Future Healthcare Journal*, 3(2), 114–116.
- The Health Foundation (2016). [Person-centred care made simple: What everyone should know about person-centred care](#) [PDF].
- Ekman, I., Ebrahimi, Z., & Contreras, P.O. (2021) [Person-centred care: looking back, looking forward](#), *European Journal of Cardiovascular Nursing*, 20(2), pp. 93–95.

Web resources

- [Medicines and older Māori](#): A course comprising four short videos, an independent reflection, and additional resources, produced with pharmacist Jo Hikaka.
- [Healthify New Zealand](#) provides a comprehensive overview for understanding patient-centred care, including links to articles and videos.
- [Ideas on culturally safe consultations – A discussion on communicating to improve medicine access equity | He Ako Hiringa](#)

Multimedia

- Contraceptive access and reproductive justice – Regulating ones own fertility and pregnancy has long been an essential part of women's health and wellbeing, but healthcare providers often act as gatekeepers. In this podcast episode from *ResearchPod*, Tracy Morison discusses her research with contraceptive providers in Aotearoa New Zealand. (Read the original article: <https://doi.org/10.1080/03630242.2021.1927284>)



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/critical-health-psychology/?p=884#audio-884-1>

- In this video, Peter Hopkins at Newcastle University explains **intersectionality** theory very

clearly:



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- The interaction of medical diagnosis has been well captured in a short lecture by Professor Amanda Howe (2013). In this talk, she discusses the intricacies of interpersonal dynamics between the doctor and patient, as well as what each actor brings to the encounter.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/critical-health-psychology/?p=884#oembed-5>

Interactive exercise



An interactive H5P element has been excluded from this version of the text. You can view it online here: <https://oercollective.caul.edu.au/critical-health-psychology/?p=884#h5p-7>

Acknowledgement

Thanks to Tracy Morison for her assistance with formatting the interactive exercises and the chapter layout, and for helping to source additional content.

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Suggested answers to exercises

Exercise 1

Other examples could include:

- doctors advocating for patients to receive non-funded medication;
- doctors supporting patients to go on drug trials;
- healthcare professionals brokering paid sick leave for patients
- nurses brokering second opinions or follow-up checks for patients.

Exercise 2

1. They're talking about taking away the one opportunity I have to have children... shattered... I felt like my world was gonna fall apart... a bit worrying... weren't gonna get the chance to do that as it sort of is your normal progression in in life... so when we found out that I could have the trachelectomy and preserve the fertility that was great news... they think, 'What's wrong with her?... I feel like I sometimes need to justify why... put some people that are a little judgmental in their place.
2. Treatment-provider, in that the doctor is reported by the participant as taking a directive stance, seemingly to convince her to take the option of immediate oncological treatment (instead of fertility-preservation).
 - a.) This doctor's reported approach (which reads as quite blunt or even insensitive) could be seen as justified out of concern for the patient's survival. The doctor could also be seen to be speaking from a place of authority, which allows him to prioritise urgency and radical action at the cost of any sensitivity or ambivalence. From a nuanced, interactional perspective, this doctor could also be forgiven for possibly being caught up in his own affective response to the situation and its perceived urgency, in his concern for his patient's (physical) welfare.
 - b.) From a person-centred perspective, and taking the concept of "concordance" into account, this doctor could be criticised for exercising poor judgement in delivering information about treatment options and their consequences to the patient in a way that did not take into account her psychological wellbeing or broader wishes for her life. As a knowledge provider, the doctor could be expected to know how to deliver such news in a more sensitive manner and in a way that also gives the patient the opportunity to process the consequences without using shock tactics.
3. Firstly, this extract differs from the previous one in that it involves the participant describing her interaction with her doctor as involving her husband. In contrast, the first extract involved the woman on her own.
 - This in itself might result in different interactions between the patient and doctor. For instance, a husband (or partner or other caregiver) might ask questions that could

prompt further input from a doctor.

- The second extract also constructs the consultation as person-centred by portraying the doctor as concerned with the patient's possible hopes to have children and, therefore, as being seen to listen and offer support, which appeared to be missing in the previous extract.
 - One firstly needs to recognise that these are *reported* encounters and cannot be treated entirely at face value, or as having occurred exactly as represented by participants (from a social constructionist perspective).
 - One might consider who was present in the reported interaction, how they were reported as speaking to each other (in tone, words used, emphasis, etc.), and what position they seemed to hold (e.g., as "in control", as "disempowered", as "cared for").
 - One might also think about the social conditions of the encounter—what social capital might the participant have been able to draw on to relate their account in the way that they do, or how might this have shaped how they expressed and interpreted the encounter to the interviewer?
4. If you were the authors of this study, you might first examine the participants' demographic details (age, sexuality, ethnicity). You might then analyse what each participant reported experiencing in light of their particular intersectional positioning (their ethnicity in relation to their sexuality and/or age). Some participants might seem to hold more power—to have the ability to speak openly, or to speak up, or to question decision making—than others, or might hold a sense of power at some points more than at other points (e.g., with a partner present vs when alone, or as a partnered person vs as single). Lastly, much like what Rowlands et al. (2024) report, you might spend time examining the implications of participants' reported experiences in light of broader issues pertaining to reproductive healthcare (and cancer care). This could involve discussing what might be needed to promote decision making in cancer care that promotes patients' longevity while ensuring patients experience the level of care and consultation they need in the face of making a seemingly impossible decision.

PART 3 - APPLYING CRITICAL HEALTH PSYCHOLOGY

Part Three: Applying critical health psychology

KATHRYN MCGUIGAN AND GARETH TERRY

Part Three explores how we might apply critical health psychology principles to our work as practitioners, educators, students, researchers, and activists. In this section we explore the practice of being a registered health psychologist in Aotearoa New Zealand, grounded in Te Tiriti o Waitangi. The section then moves to how students can use application based learning in the process of becoming a practitioner. We move then to promoting health and how we define and intervene in health issues, emphasising the ideological, ethical, and political dimensions of professional practice. Last, we explore critical health psychology through disability theories and use practical examples to demonstrate where we can challenge our personal and professional biases, and embrace lived experience and allyship.

“Psychologist” is a protected title in Aotearoa (meaning only those who are registered with the New Zealand Psychologists Board can use this term to describe themselves; Health Practitioners Competence Assurance Act 2003). In this section, we use “practitioners of critical health psychology” to emphasise that professional registration is just one pathway to practice in our diverse field. Practitioners of critical health psychology work in a range of settings, including in health services as registered psychologists; as members of the broader wellbeing workforce; in health promotion, public health, and policy; in non-governmental and community health organisations; and in research and teaching.

Chapter 3.1 “Frameworks for critical health psychology practice in Aotearoa” presents an overview of ethics, cultural safety, and reflexivity as frameworks to guide emerging practitioners in the discipline of critical health psychology. These frameworks are grounded in Te Tiriti o Waitangi and sit within a broader frame of social justice. The chapter illustrates the interconnected nature of ethical, cultural, and reflexive frameworks, which practitioners must understand and apply in relation to one another.

Chapter 3.2 “Becoming a critical health psychology practitioner” brings us back into the student space. In this chapter, Terry discusses the value of practice placements (practicum) and how they might differ for the critical health psychology practitioner. Students are given practical exercises to help them move from thinking about theory and social justice to working with these. This section loosely uses assemblage theory to help students think about “becoming” through application-based learning within an assemblage of supervisors, skill acquisition tasks, placement locations, and university systems.

Chapter 3.3 “Defining health ‘problems’ and shaping interventions in critical health psychology” introduces us to how we might apply critical health psychology to maintain and improve health at the individual, community, and population levels. Morison explores how health psychology practitioners define and intervene in health issues, examining the values and assumptions underlying intervention choices, the potential unintended consequences of interventions, and the role of reflexivity in mitigating harm. Case studies, including participatory health initiatives such as the SiRCHESI Project in Cambodia and the Sonagachi Project in India, illustrate how different theoretical and intervention approaches shape outcomes.

Chapter 3.4 “Disability and critical health psychology: Applications for work and everyday life” starts to address the lack of attention to disability. Graham and McGuigan first explore the history of disability and review different models of disability. The chapter then moves to defining ableism and consideration of how taking a critical health psychology approach provides opportunities to address ableism. Following this, the chapter focuses on Aotearoa New Zealand and contemporary disability practice. Indigenous approaches are discussed with examples from Aboriginal and Torres Strait Islanders and Māori. Last, the chapter reflects

on the intersections with marginalised groups and provides examples from specific disability communities (Blind/low vision, Neurodivergent, chronic illness, and Rainbow communities).

Overall, Part Three offers possibilities for practitioners, educators, students, researchers, and activists to not only say they are critical, but know what this means in practice. Our aim is to move us forward into becoming reflexive, ethical, relational, and culturally humble practitioners of critical health psychology. The other aim is to give examples of how research and theory can be translated well into and for the community—giving us tools to be activists for social justice.

3.1 Frameworks for critical health psychology practice in Aotearoa

GLORIA FRASER AND ALEX WALKER

Overview

Practitioners of critical health psychology work in a range of settings, including in health services as registered psychologists; as members of the broader wellbeing workforce; in health promotion, public health, and policy; in non-governmental and community health organisations; and in research and teaching. “Psychologist” is a protected title in Aotearoa (meaning only those who are registered with the New Zealand Psychologists Board can use this term to describe themselves; Health Practitioners Competence Assurance Act 2003). Here, we use “practitioners of critical health psychology” to emphasise that professional registration is just *one* pathway to practice in our diverse field.

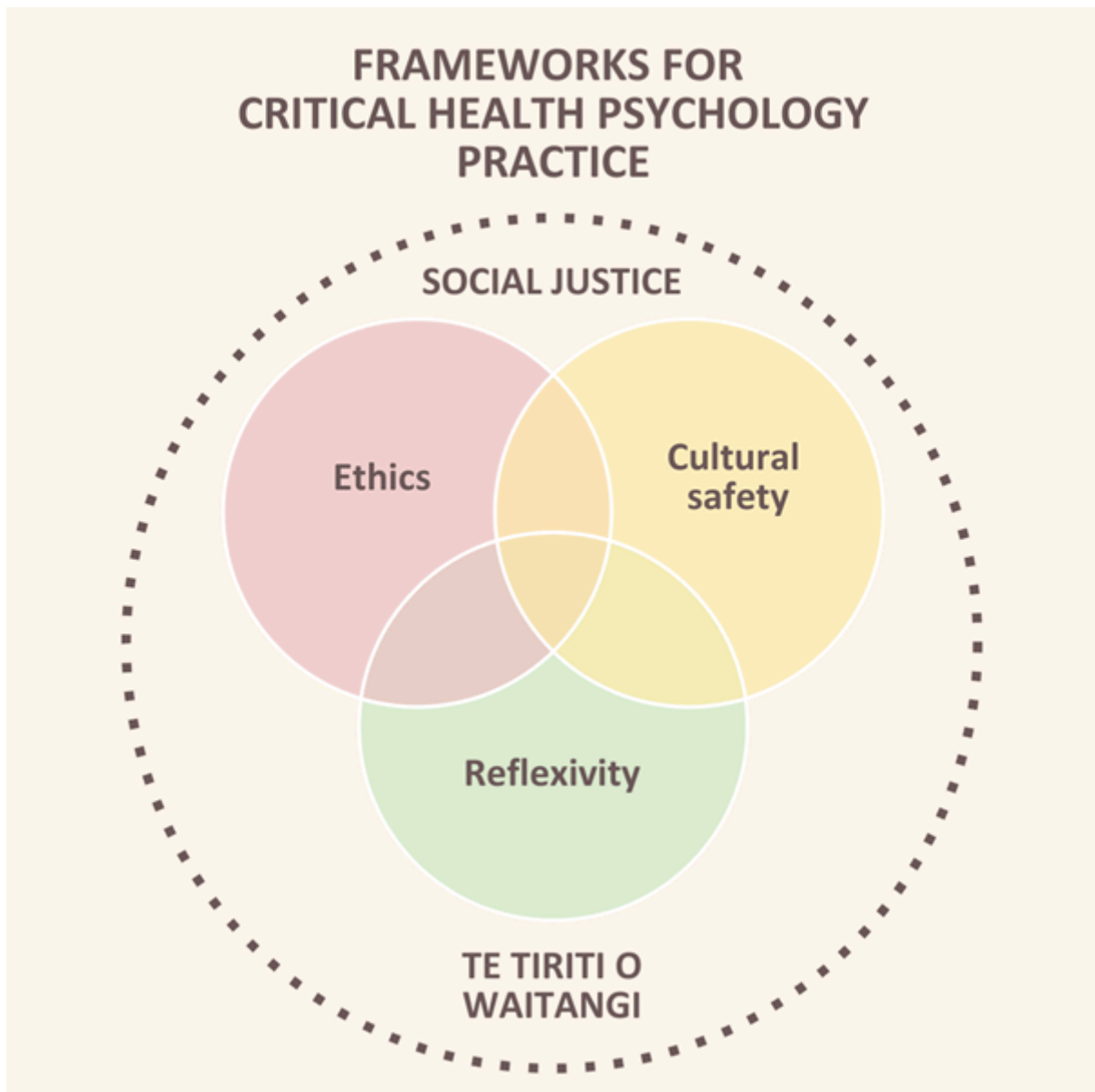


Figure 3.1.1 Frameworks for critical health psychology practice. (Gloria Fraser. [CC BY-NC 4.0](#))

In this chapter, we present an overview of ethics, **cultural safety**, and **reflexivity** as frameworks to guide emerging practitioners in the discipline of critical health psychology. These frameworks are grounded in **Te Tiriti o Waitangi** and sit within a broader frame of **social justice**. Figure 3.1.1 illustrates the interconnected nature of these frameworks, which practitioners must understand and apply in relation to one another.¹

1. Our writing is informed by our experience of teaching professional practice skills and cultural safety with Masters students in health psychology. We acknowledge the whakapapa of the frameworks we discuss, as well as our previous work and conversations with our tuakana, Chloe Parton and Denise Blake. Ka nui te mihi ki a kōrua.

Learning objectives

This chapter addresses the following learning objectives:

1. Articulate the significance of Te Tiriti o Waitangi for critical health psychology practice.
2. Describe critical reflexivity and the relationship between reflexivity and action.
3. Understand how the psychologists' Code of Ethics principles can be used to guide decision making in critical health psychology practice.
4. Describe cultural safety and distinguish between cultural appropriation and cultural engagement.

Putting the 'critical' in critical health psychology practice

Health psychology as a discipline explores how psychological knowledge and ways of working contribute to understanding the development and maintenance of health and illness, the relationship between health and illness, and the interaction of mind, body, and sociocultural determinants of health (Chamberlain & Murray, 2009; Matarazzo, 1980; Snooks, 2009). Critical health psychology does this with a particular focus on issues of power, equity, and benefit, asking: What definition of health and illness are we using? Who benefits from dominant discourses around health, and who is harmed? Who gets to access “healthy”, and who is excluded? Who is blamed for ill health? As Chamberlain et al. (2018) note, “critical scholars are therefore concerned to ensure the application of knowledge for the benefit of society, often with a particular concern for the oppressed and disadvantaged, and with a strong agenda for social justice” (p. 457).

Practitioners of critical health psychology question the individualism often associated with mainstream health psychology; that is, the tendency to assign responsibility for promoting wellbeing and preventing ill health to individuals, and to understand psychologists as expert, objective practitioners using technical solutions to solve functional problems (Bolam & Chamberlain, 2003). However, we should not confuse an *individualistic approach* with *working with individuals*. Prilleltensky and Prilleltensky (2003) propose that the values, assumptions, and practices of professional helpers (who might work at the individual, whānau, or community level) can work in synergy with those of critical agents of social change to promote both wellness and liberation. To realise the goals of critical health psychology “we need specialized knowledge as much as political knowledge, ameliorative therapies as much as social change, and people working inside the system as much as people confronting it” (Prilleltensky & Prilleltensky, 2003, p. 246). In other words, we can take a critical perspective regardless of where in health systems and settings we practice.

As you read this chapter, we invite you to consider your spheres of influence, both personally and professionally: the places and spaces where you can enact transformative change. It can often feel as if we lack the power to challenge unjust systems that maintain health inequities—particularly for those of us early in our career. However, change is created incrementally, and small actions can have ripple effects. Think about the conversations about the ethical, sociocultural, and political aspects of health psychology that you have with whānau, friends, teachers, colleagues, **tāngata whai ora**, and others in your community. At the dinner table, at the bar, and in the therapy room. We also note that practitioners of critical health psychology must, at times, pick their battles. The pursuit of social justice and health equity takes time and energy, and we encourage readers to consider when to agitate for change, and when to rest and conserve energy.

Te Tiriti o Waitangi

Te Tiriti o Waitangi is a foundational document in Aotearoa New Zealand, and a foundational framework for practitioners of critical health psychology in the pursuit of social justice and health equity. The Code of Ethics for psychologists working in Aotearoa (discussed further in the next section) includes a preamble declaring that “there shall be due regard for... the provisions of, and the spirit and intent of, the Treaty of Waitangi” (Code of Ethics Review Group, 2002, p. 1); the Core Competencies for the practice of psychology in Aotearoa notes that practitioners of psychology must be Te Tiriti “partners” (New Zealand Psychologists Board, 2018, p. 6); and all Crown-funded health providers are obligated to uphold Te Tiriti to achieve better health outcomes for Māori (Ministry of Health, 2024). Despite promises to uphold Te Tiriti obligations throughout health legislation, policies, and frameworks, Te Tiriti o Waitangi breaches continue at all levels of the health system (Came-Friar et al., 2019).

Here, we provide a brief history of Te Tiriti o Waitangi, as well as guidance on further reading for Te Tiriti **conscientisation** and deep learning (see Mutu, et al., 2021). We draw on Freire’s (2000) definition of conscientisation as “learning to perceive social, political, and economic contradictions, and to take action against the oppressive elements of reality” (p. 35). Understanding the historical and contemporary context of Te Tiriti o Waitangi is essential for developing a Te Tiriti analysis for use in critical health psychology practice.

Te Tiriti o Waitangi: a brief history

Te Tiriti o Waitangi is an agreement between Māori **rangatira** and representatives of the British Crown, first signed on 6 February 1840. It was created with the intention of establishing a British Governor in New Zealand, confirming Māori authority and ownership over their land, homes, and treasures (including spirituality and knowledge systems), and ensuring Māori had the same rights and privileges as British subjects (Mutu, 2018). There are two treaty texts—ostensibly different language versions of the same document—however, the te reo Māori text (Te Tiriti o Waitangi) is not a translation of the English language text (The Treaty of Waitangi). Differences between the texts are widely understood as driving conflict between Māori and the Crown, however we challenge this framing. We contend that it is *breaches* of *both* treaties (i.e., widespread land confiscation and violent suppression of Māori language and culture) that have created a legacy of racism and health inequities in Aotearoa and had disastrous impacts on Māori wellbeing (Brown & Bryder, 2023; Came-Friar et al., 2019; Reid, 2019).

Myths (here meaning false but widely held ideas) abound about Te Tiriti o Waitangi, including that Māori voluntarily ceded sovereignty, did not understand the meaning of the document they signed, and that differences between the text were a result of rushed translation (see Burns et al., 2024; McCreanor et al., 2024, for discussion of how treaty myths are perpetuated through historical and educational texts). Analysis from the Waitangi Tribunal (a permanent commission of inquiry established in 1975 to investigate Treaty breaches) concluded that rangatira who signed Te Tiriti o Waitangi in 1840 did not cede their sovereignty (Waitangi Tribunal, 2014), and Jackson (2019) notes that the idea that Māori ceded sovereignty “requires a profound suspension of disbelief” (para. 29). Te Tiriti includes a provision for the British Crown to govern British subjects wherever they are in Aotearoa (**kāwanatanga**) and reaffirms Māori **tino rangatiratanga**. As such, Māori agreed to a relationship with the British Crown, with each (Māori rangatira and the British Governor) holding different roles and spheres of influence.

Over the last 50 years the Crown has adopted a “principles-based” approach, to establish a “middle ground” between the two treaty texts (Burns et al., 2024). These are intended to capture the “spirit and intent of the Treaty” (Ludbrook, 2015, p. 3), however, various lists of treaty “principles” created by Crown agencies (e.g., partnership, protection, and participation; Royal Commission on Social Policy, 1988) are open to interpretation and, at times, conflict with one another (Burns et al., 2024). Tiriti scholars contend that treaty principles “effectively reinterpret Te Tiriti in favour of **Pākehā**” (Came & McCreanor, 2015, p. 28), and have

limited engagement with Te Tiriti o Waitangi. The reliance on these principles also diminishes the status of Te Tiriti o Waitangi as the primary text. Legal frameworks, such as the principle of *contra proferentem*, which resolves ambiguities in favour of the party that did not draft the agreement, further support privileging Te Tiriti (Burns et al., 2024).

We advocate an *article-based* or *provisions-based* approach, which privileges Te Tiriti o Waitangi as the authoritative text and focuses on what was written in this text. Through Te Tiriti conscientisation, practitioners of critical health psychology can develop their Te Tiriti analysis, and, in turn, an ability to take health action grounded in the *text* of Te Tiriti o Waitangi. **Textbox 1** presents an overview of what practitioners of critical health psychology must know about Te Tiriti o Waitangi, to support the development of their Te Tiriti analysis skills.

Textbox 1. Te Tiriti o Waitangi: What practitioners of critical health psychology should understand and explore

Te Tiriti o Waitangi is often portrayed as a historic text, however, we understand it as a living document: new Te Tiriti analysis, evidence, and insights are regularly published (see, for example, the Waitangi Tribunal's Te Paparahi o Te Raki reports, 2014, 2022). Practitioners of critical health psychology must consider Tiriti conscientisation (or critical consciousness) as an ongoing and iterative process. Here, we propose immediate learning priorities for practitioners of critical health psychology, as well as lifetime learning. **To support this learning, we strongly recommend practitioners of critical health psychology attend Te Tiriti o Waitangi training and engage with the recommended reading list of Tiriti resources found at the end of this chapter.** These learning priorities are based in the guidance of political education collective Te Atakura (Society for Conscientisation).

As immediate learning priorities, practitioners of critical health psychology should understand:

- Māori society prior to European arrival as fully formed, with a long history of treaty-making, and governed by cultural concepts and practices (**tikanga**, **kawa**, **mana**, **tapu**, and **noa**).
- the role of the Doctrine of Discovery in sanctioning colonisation and colonial violence.
- the relationship between **He Whakaputanga** **He Whakaputanga o te Rangatiranga o Nu Tireni (He Whakaputanga)** and Te Tiriti o Waitangi.
- the circumstances prompting the development of a treaty, including British lawlessness, international interest in Aotearoa, and the threat of New Zealand Company land speculators.

For lifetime learning, practitioners of critical health psychology should explore:

- the history of Waitangi Tribunal claims in the area of Aotearoa where they live.
- for Pākehā and **tauiwi**, what brought their ancestors to Aotearoa.
- for Māori, whether their **tūpuna** signed (or refused to sign) Te Tiriti, and the history of Waitangi Tribunal claims for their **hapū** and **iwi**.

Te Tiriti o Waitangi and critical health psychology practice

Psychology in Aotearoa New Zealand (including critical health psychology) has its roots in Western thought,

and a history of devaluing and disregarding Indigenous psychologies (Kennedy et al., 2022; Waitoki et al., 2024a). Failing to acknowledge the contribution of **mātauranga Māori** (Māori knowledges) in psychological theory and practice breaches Article Two of Te Tiriti o Waitangi, which promises “te tino rangatiratanga o o ratou ... taonga katoa” (full exclusive and undisturbed possession of their treasures), including Māori healing and wellbeing practices. Importantly, psychology in Aotearoa New Zealand also has a history of strong Māori resistance to racism and epistemic violence, as evidenced by decades of work by Māori psychology, psychiatry, and health scholars (see Bennett et al., 2014; Cherrington, 2003; Durie, 1994; Lawson-Te Aho & Liu, 2010; Levy, 2002; Love, 2008; Macfarlane & Macfarlane, 2019; Masters-Awatere & Nikora, 2017; Nikora, 2007; Pitama et al., 2007; Smith, 1999; Valentine et al., 2017; Waitoki, 2018).

Te Tiriti breaches in psychology were famously highlighted in a 1985 survey exploring mātauranga Māori content in professional psychology courses throughout Aotearoa New Zealand (“A whiter shade of pale”; Abbott & Durie, 1987). At the time, no psychology staff members were Māori, and none of the programmes had Māori graduates in the previous two years. Further, few professional psychology courses incorporated taha Māori (a Māori dimension, or a bicultural perspective). Four decades later, Waitoki et al., (2023) published an update on professional psychology programme responsiveness to Māori. Analyses revealed improvements in the number of Māori teaching staff, Māori-focused content, and consultation with Māori advisory bodies, however, “concerns persist regarding the participation and graduation rates of **tauira** Māori in the programmes” (p. 11), and a lack of meaningful relationships between psychology programmes and Māori organisations or advisory bodies presented challenges for incorporating Māori content in psychology training. There is a notable lack of centrally recorded and reliable data about the overall professional psychology workforce (Levy, 2002, 2018) and, to our knowledge, no available data about the number of Māori health psychologists. Data from the clinical psychology workforce sheds some light on patterns within the broader psychology workforce, showing the total number of Māori clinical psychologists has remained stable at 6% since 2018 (Waitoki et al., 2024b).

In 2018, community psychologist Michelle Levy lodged WAI2575, a claim that the Crown had failed “to ensure psychology, as an academic discipline and profession, adequately meets the needs and demands of Māori” (Waitangi Tribunal, 2018, p. 1). Specifically, Levy argued that the Crown had breached Te Tiriti by failing to ensure psychologists are culturally competent to work with Māori, to increase the Māori psychology workforce, to support the development of an Indigenous Māori psychology profession, and to ensure that the New Zealand Psychologists Board and organisations delivering psychology training upheld their Tiriti obligations.

At the time of writing in 2024, the New Zealand Psychologists Board, the New Zealand Psychological Society, and the New Zealand College of Clinical Psychologists are in the process of preparing an apology to Māori for the harms done by the profession of psychology, as well as an action plan to address identified failings and deliberate harm (Waitoki et al., 2024a). He Paiaka Tōtara, a national rōpū (group) of Māori psychologists, are developing Te Tiriti educator capacity for the psychology profession, with an aspiration to enable Māori psychologies to live and promote Māori flourishing. Practitioners of critical health psychology are well-placed to involve themselves in such discipline and institution-level efforts to honour Te Tiriti o Waitangi. At the individual level, following the learning outlined in Textbox 1, we encourage practitioners of critical health psychology to consider and note down responses to the questions posed in **Exercise 1**. This is the first *reflexive* exercise presented in this chapter. We discuss reflexivity in more depth below.

Exercise 1. Reflexive questions and prompts for honouring Te Tiriti in critical health psychology practice

- what feelings come up for me when talking or reading about Te Tiriti o Waitangi?
- where might these come from?
- what are they telling me?
- what messages or stories have I previously heard or been taught about Te Tiriti?
- where have they come from?
- how does the learning in this chapter relate to previous learning about Te Tiriti?
- what am I already doing to honour Te Tiriti o Waitangi?
- what else could I be doing to uphold Te Tiriti o Waitangi in my personal life?
- what about in my professional practice?
- do my proposed actions map onto each article in the text?
- what gets in the way of me engaging with and honouring Te Tiriti o Waitangi?
- what supports could I seek, or plans could I make to address these barriers?

Reflexivity

Reflexivity has a “self-referential characteristic of ‘bending-back’ some thought upon the self” (Archer, 2009, p. 2). In critical health psychology, reflexivity is a process not just of *reflection* (where we might observe or think about our practice), but of *questioning* the cultural and temporal context in which our practice occurs. It is an ongoing process of self-awareness, where practitioners examine how their own values, assumptions, identities, and experiences shape their work. Whereas reflection is akin to looking in a mirror, we think reflexivity is better represented by surrealist artist René Magritte’s painting [*Not to Be Reproduced*](#) (La reproduction interdite), which depicts a man standing in front of a mirror, and his reflection showing him from behind. Reflexivity builds upon each moment of reflection, as new insights reshape how we see ourselves and our practice, creating a recursive and iterative process that deepens over time.

Reflexivity and critical health psychology practice

Reflexivity is more commonly discussed in research (particularly qualitative research) than in health psychology practice more broadly (see, for example, Jamieson et al., 2023; May & Perry, 2014; Palaganas et al., 2017; Watt, 2007). However, it is an essential tool for practitioners of health psychology aiming to challenge the “unproblematic adoption of a scientist-practitioner model” (Bolam & Chamberlain, 2003, p. 215). Bolam and Chamberlain (2003) argue that reflexive practice is what differentiates critical health psychology from its mainstream counterpart, and describe *light* and *dark* reflexivity as different dimensions of critical health psychology practice. Light reflexivity (akin to reflection) emphasises self-awareness and transparency without deeply challenging the status quo, power structures, or social norms. Light reflexivity focuses on procedural aspects of practice, such as asking, “*What went well in the client session I just had, and what might I do differently next time?*” or “*Why did I experience that emotion when the client talked about...?*” These questions promote self-awareness and enhance the practitioner’s responsiveness to clients but remain relatively contained within the immediate context of the therapeutic interaction. While light reflexivity is valuable, it does not necessarily require practitioners to confront broader social or political issues.

In contrast, *dark* reflexivity involves questioning the fundamental assumptions, social power dynamics, and ideologies underpinning practice. For instance, a practitioner might critically question the cultural roots or origins of a therapeutic approach and explore the ethical implications of using it with clients from diverse cultural backgrounds. Other examples include reflecting on how their own cultural identity

or privilege shapes their interactions with clients, or examining how systemic inequalities, such as racism or classism, are perpetuated or challenged through their therapeutic interventions. Dark reflexivity requires practitioners to engage with discomfort and uncertainty, as they consider how their work intersects with broader systems of power, marginalisation, and inequality.

Reflexivity is closely tied to the concept of positionality, or where we are located in relation to our social and cultural identities (Savolainen et al., 2023). This might include our gender, ethnic or racial background, age, sexual orientation, class or socioeconomic status, geographical location, ability, religious or spiritual beliefs, and educational attainment. Positionality or reflexivity “statements” (which describe a practitioner’s identities) have become increasingly popular in research, however, scholars exploring reflexivity in research methodology warn against “laundry list” or “shopping list” reflexivity, where social and cultural identities are listed without exploration of their role in shaping the work (Folkes, 2023; Kohl & McCutcheon, 2015). Qualitative researchers also increasingly question binary notions of “insider” and “outsider” relationships in research and practice, as our identities are made up of multiple and intersecting facets (Dwyer & Buckle, 2009; Hayfield & Huxley, 2015). As such, we can typically find points of social and cultural commonality *and* difference with anyone we encounter in our practice. Practitioners of critical health psychology can usefully draw on concepts of “working the hyphen” (Fine, 1994, p. 70) and occupying “the space between” (Dwyer & Buckle, 2009, p. 54). By resisting binary discussion of whether shared identities are “better” or “worse” for our practice, we can instead consider *how* our experience of the world, our temporal and cultural context, and our interactions with others are shaped by (and, in turn, shape) these identities and subject positions.

Critical health psychology questions the (often implicit) directive to be a “blank slate” practitioner seen in other areas of psychology, where practitioners are expected to leave themselves at the door or attempt to practice in an “objective” fashion (Bolan & Chamberlain, 2003). While maintaining clear boundaries and protecting the therapeutic relationship are regarded as good practice across psychology, critical health psychology challenges where and how these boundaries are drawn, particularly when they intersect with culturally responsive approaches. In Aotearoa New Zealand, for example, self-disclosure is a key component of **whakawhanaungatanga** (building and maintaining relationships), essential for engaging with Māori clients in a culturally appropriate way. This practice can, however, conflict with traditional therapeutic views that caution against sharing too much of oneself, fearing it may blur the boundaries of the therapeutic relationship or compromise the safety of both practitioner and client. As we write this, Gloria is reminded of her own psychology training, where she was explicitly discouraged from sharing details about herself with clients that, in the Māori world, would be considered odd not to share.

Critical health psychology encourages practitioners to engage reflexively with the ethical and cultural dimensions of where those boundaries should be placed. This involves asking questions such as: “*When I share of myself, who is this in service of? What is my rationale here?*” In doing so, it promotes an understanding of boundaries that considers the power dynamics, cultural contexts, and relational needs that influence therapeutic practice. From a critical perspective, it is not only impossible to escape who we are; bringing ourselves into our work is often where we have our richest and most genuine interactions. Reflexivity enables practitioners to assess their practice and positionality through methods such as writing, journaling, peer discussions, or structured activities. See **Exercise 2** for questions to help you engage reflexively with your positionality within relational spaces.

Exercise 2. Reflexive questions for practitioners of critical health psychology

- what social and cultural groups do I belong to? How salient are these group identities to me? How do I feel about being part of these groups?
- what does being healthy mean to me? Where did I learn this? Whose responsibility do I believe it is to promote health and prevent illness? What have my experiences of health and illness been like?
- what is the role of power within my life?
- what cultural frameworks do I draw upon to understand the world?

We then invite you to explore a conversation that you had during the past week. It may have been with a friend, whānau member, teacher, stranger, flat mate – anyone! Use some of the below questions as a guide to explore the conversation reflexively.

- what role might power have played in that interaction?
- what role did cultural systems and frameworks play during the interaction?
- how was I feeling during the interaction?

Challenges in reflexive practice

In our own teaching about professional practice, we observe a few common challenges for emerging practitioners of critical health psychology working to develop their reflexive practice. One challenge arises from the inclusion of the word “critical” in “critical health psychology” or “critical reflexivity”, which some students interpret as an invitation for “self-criticism”. This often leads them to focus on perceived mistakes, overlooking successes or the contextual and systemic factors at play. This tendency may also reflect a broader belief that demonstrating competence requires identifying problems, or a desire to pre-empt external critique by showing self-awareness about shortcomings. For instance, in classes on active listening and emotion validation, students often emphasise moments where they interrupted or rushed to problem-solve, rather than sitting with difficult feelings. While this kind of noticing is important, it can remain surface-level if not taken further. We encourage students to move beyond identifying problems to reflect on their emotional and embodied experiences during interactions. How does it feel to sit in silence during discomfort? What societal or cultural factors, such as the “happiness imperative” (Hyman, 2019), might drive the urge to resolve discomfort quickly? Reflexivity involves exploring these deeper layers and connecting personal insights to broader social, cultural, and systemic contexts.

The second challenge we observe in developing reflexive practice is differentiating reflexivity from rumination. Although rumination and reflexivity have some commonalities (they both entail considered thought on an experience or issue), rumination tends to be *cyclical* in nature and negative in focus (Lengelle et al., 2016). As such, rumination rarely results in action or problem solving. When ruminating, we tend fall “into a bottomless pit of reflection upon reflection” (Lengelle et al., 2016, p. 101). Reflexivity, in contrast, should always end in taking action. Wear et al. (2012) note that action can involve “taking a risk, redressing a wrong, or, at the very least, resolving to do things differently the next time” (p. 605).

We use Mitchell’s (2017) Six Step Spiral for Critical Reflexivity (see Figure 3.1.2) as a visual depiction of the process of moving from an experience, to analysing our response to the experience, to taking reasoned action grounded in our analysis. Mitchell’s (2017) spiral ends with several smaller spirals, signalling the ongoing and iterative nature of critical reflexivity. Rather than being “one and done”, we move through the critical reflexivity spiral continuously over the course of our health psychology practice. As practitioners located in Aotearoa New Zealand, we see our own *tohu* of a *koru* in the spiral, which conveys growth and the idea of perpetual movement. We are reminded of the whakataukī “Ka mua, ka muri” (walking backwards

into the future), which emphasises the importance of looking to the past to inform the future. In our next section on ethics, we introduce ethical frameworks that practitioners of critical health psychology can draw on to inform their reflexive practice.

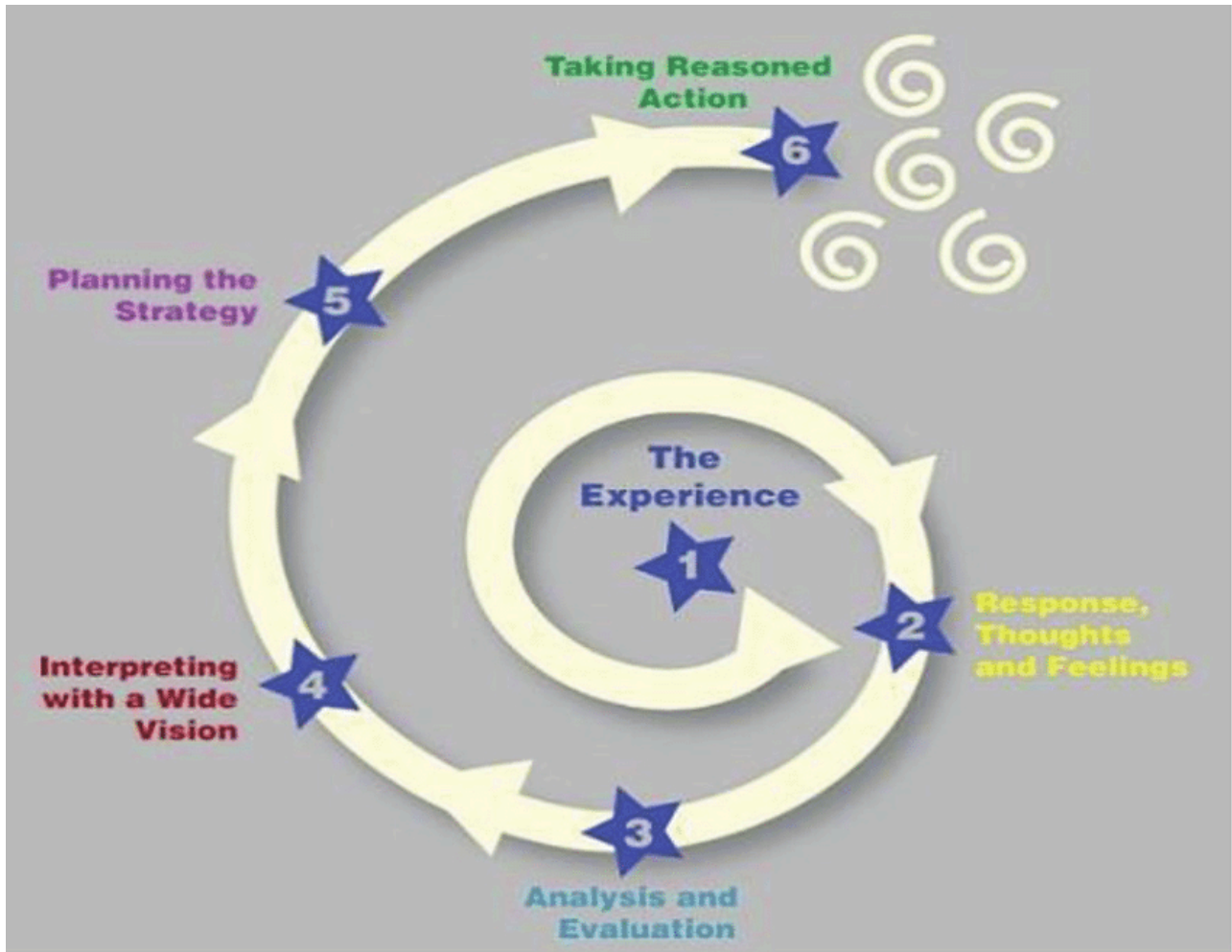


Figure 3.1.2 Six Step Spiral for Critical Reflexivity ([SSS4CR](#) by Veronica Mitchell, 2017. [CC BY-SA 4.0](#))

Ethical decision making

Ethics are a system of moral principles, and a philosophical discipline concerned with moral right and wrong. Professional ethics offer a set of guidelines or principles for use in a workplace or professional setting. Practitioners of psychology in Aotearoa are guided by the *Code of Ethics for Psychologists Working in Aotearoa/New Zealand* (the Code of Ethics); a document jointly prepared by the New Zealand Psychological Society, the New Zealand College of Clinical Psychologists, and the New Zealand Psychologists Board (Code of Ethics Review Group, 2002).

The Code of Ethics for Psychologists Working in Aotearoa New Zealand

The Code of Ethics applies to all members of both the New Zealand Psychological Society (NZPsS) and the

New Zealand College of Clinical Psychologists (NZCCP), as well as all other psychologists registered with the New Zealand Psychologists Board. As such, the Code of Ethics applies not only to registered psychologists, but to NZPsS and NZCCP members involved in “research, teaching, supervision of trainees, development and use of assessment instruments, organisational consulting, social intervention, administration, and other workplace activities” (p. 2). The Code of Ethics is intended to:

- unify the practices of the profession of psychology.
- guide psychologists in ethical decision-making.
- present a set of guidelines that inform the public of the professional ethics of the profession of psychology.

We think of the Code of Ethics as a roadmap to guide practitioners of psychology. The current version, published in 2002, is the second iteration of the Code of Ethics in New Zealand (the first was published in 1986), and the first to directly reference Te Tiriti o Waitangi (Fitzgerald, 2021). It is based in the same four principles found in the *Universal Declaration of Ethical Principles for Psychologists* (International Union of Psychological Science, 2008) and helps us to articulate and reflect on our options for ethical decision making. The Code sits alongside other important guiding documents for the profession, including the *Core Competencies for Psychologists* (New Zealand Psychologists Board, 2018), a range of best practice guidelines developed or endorsed by the New Zealand Psychologists Board (e.g., Working with sex, sexuality and gender diverse clients; Informed consent; Supervision), and relevant legislation (e.g., Health Practitioners Competence Assurance Act 2003). **Textbox 2** summarises the psychologists Code of Ethics.

Textbox 2. Code of Ethics for Psychologists Working in Aotearoa/New Zealand

The Code of Ethics identifies four key ethical principles. Under each principle are several values that are in turn linked to practice implications. The Code also presents a six-step process for ethical decision making, which highlights the importance of identifying relevant ethical issues, developing potential courses of action (preferably in consultation with a colleague or supervisor), and analysing the likely risks and benefits of each course of action using the Code’s principles, values, and practice implications.

Principle 1: Respect for the dignity of persons and peoples

Principle 1 emphasises the need for psychologists to show respect and grant dignity to all people, based on their common humanity. This includes recognition of, and sensitivity to, cultural and social diversity. Principle 1 refers to the Treaty of Waitangi as the basis of respect between Māori and non-Māori in Aotearoa New Zealand. It includes specific guidance about:

- obtaining training and advice to support culturally safe practice.
- promoting peoples’ right to privacy and protecting confidentiality.
- obtaining informed consent.

Principle 2: Responsible caring

Principle 2 outlines the promotion of wellbeing as a basic ethical expectation of the discipline of psychology. As such, psychologists should engage in activities that will benefit members of society. It includes specific guidance for psychologists about:

- using respectful and effective procedures, instruments, and interventions.
- attaining and maintaining adequate levels of knowledge and skills to practise.
- practising within their area of expertise, with regular supervision and evaluation.
- providing responsible care to those who may be disadvantaged or oppressed.
- recognising the vulnerable status of children.
- conducting research that meets current ethical standards.

Principle 3: Integrity in relationships

Principle 3 notes that psychologists must seek to do right in their relationships with others, and that integrity in relationships is vital to maintain public confidence in the discipline. It includes specific guidance for psychologists about:

- accurately representing their qualifications, experience, and competence.
- ensuring accurate, complete, and clear communication.
- ensuring their personal values and beliefs do not disadvantage those they work with.
- maintaining appropriate boundaries in their professional relationships.
- avoiding dual relationships where possible and acting to address conflicts of interest.

Principle 4: Social justice and responsibility to society

Principle 4 states that psychologists have a responsibility to promote the wellbeing of communities and society. This includes acknowledging their position of power and influence, and challenging unjust social structures. It includes specific guidance for psychologists about:

- keeping informed about the needs, current issues, and problems of society.
- speaking out when they possess knowledge that bears on important societal issues.
- ensuring psychological knowledge will be used for beneficial purposes.
- bringing incompetent or unethical behaviour of colleagues to appropriate bodies.

The Code is currently undergoing a third revision, in recognition of the changing landscape in psychology practice over the last 22 years, and the need to “ensure it more strongly reflects the profession of Psychology’s commitment to honouring Te Tiriti o Waitangi” (Stewart, 2024, p. 1). The revised Code will sit alongside a new Code of Conduct. Whereas the Code of Ethics guides psychologists’ practice, the Code of Conduct will outline behaviours that are mandated as part of their professional work. In 2021 a Code of Ethics Review Group was established, made up of members from He Paiaka Tōtara (a rūpū of Māori psychologists), Pasifikology (a rūpū of Pasifika psychologists), the New Zealand College of Clinical Psychologists, the New Zealand Psychological Society, and the New Zealand Psychologists Board. All psychologists were surveyed in 2022 for their opinions about the strengths and weaknesses of the Code, and in 2023 feedback from key stakeholders across the discipline was sought and incorporated. As well as reorienting the Code to better reflect mātauranga Māori, the Psychologists Board has indicated that the revised Code will articulate the ethical considerations for the use of new technologies (e.g., artificial intelligence), provide guidance on managing (rather than avoiding) dual relationships (given the small and interconnected nature of many communities in Aotearoa), and explicitly recognise the need for psychologists to practice their own self-care, advocate for their clients, and aim to use empowering strengths-based approaches (Stewart, 2024).

Using the Code to guide ethical decision making

Some ethical decisions in the practice of critical health psychology are relatively straightforward—as a cut-and-dried example, it is widely agreed that practitioners of psychology should not enter sexual or romantic relationships with those they hold power over, such as their clients and students (see Code of Ethics 2.1.10). Often, however, there is no singular “ethical” decision to be made in a particular critical health psychology practice setting; ethical decision-making is context dependent and requires practitioners to weigh up the likely costs and benefits of different paths forward. In our teaching, we use ethical scenarios as prompts for students to develop their ethical reasoning. Sometimes these come in the form of ethical continua, where we will ask students to physically place themselves in the classroom depending on where they fall on a particular issue. Ethical continuum exercises also provide opportunities to explore how our decisions might change in light of specific contextual factors. See **Exercise 3** for a list of ethical scenarios to work through, using the Code of Ethics to guide your decision making.

Exercise 3. Ethical scenarios with prompting questions

Take some time to work through the following ethical scenarios. For each one, note down:

- your initial response about the best path forward. If you answer “it depends”: what further information would you need to make your decision?
- a justification for your initial response with reference to Code of Ethics principles.
- whether you would change your response in light of your analysis of the Code.
- whether you would change your response given the specific contextual factors below.

1. You are a psychologist in a community-based health setting and have been working with Eileen for six months. You are coming to the end of your therapeutic relationship and Eileen wishes to give you a thank-you gift for the time you have spent together. She presents you with a gold watch! Is this gift okay to accept?

Specific contextual factors: (1) How does the monetary value of the gift impact upon your approach? What if the gift were a hand-woven flax basket, instead of a gold watch? What if it was a box of chocolates? (2) Do your views on accepting the gift shift depending on Eileen's socioeconomic situation? For example, would your perspective change if Eileen were a multi-millionaire? What if Eileen were earning the living wage?

2. It's 3:00 PM and time for your first meeting with a new whai ora. The door opens, and to your surprise.... your hairdresser Paora walks in! Is having a therapeutic relationship with Paora appropriate?

Specific contextual factors: (1) How might the setting you live impact on your consideration of dual relationships? For example, what would your approach be if you were living in a city with a population of 1 million, versus a rural town with one hairdresser and one psychologist? (2) Do your views on seeing Paora change depending on your work setting? What if you worked in a service with only one publicly funded psychologist, meaning Paora's only option is to see you?

3. You are a Lecturer in critical health psychology and log on to Instagram at the end of the day for some much-needed mindless scrolling to find your Master's thesis supervisee Daisy has

requested to follow you. You and Daisy have several mutual friends and are only a few years apart in age. Do you accept the follow request?

Specific contextual factors: (1) What if the order of events was the other way around: you knew Daisy socially and followed each other on social media, and she then approached you to enquire about Master's thesis supervision. Would you agree to supervise Daisy? (2) How might the nature of your social media presence impact your decision? For example, what would your approach be if you posted interesting critical health psychology research on your Instagram page, versus photos of you and your friends attending music festivals?

Cultural safety

Culture (the way of life of a particular group of people at a particular time; Cambridge Dictionary, 2024) is central to critical health psychology, as health and wellbeing are inextricably shaped by cultural context. Culture informs health determinants, constructions of meaning, and decision making for practitioners and clients alike, and cultural difference maps on to power and inequality (Hygens & Nairn, 2016). The New Zealand Psychologists' Board Core Competencies (2018) note that culture "includes, but is not restricted to, age or generation, iwi, hapū and tribal links; gender; sexual orientation; occupation and socioeconomic status; cultural and epistemological frame of reference; ethnic origin or migrant experience; religious or spiritual belief; and disability" (p. 6). Culture is closely connected to the concept of positionality, discussed above.

Practitioners of critical health psychology (as well as psychology and health more generally) use a range of terms to conceptualise engagement with culture. The Code of Ethics for practitioners of psychology and Core Competencies for psychologists include references to cultural safety, cultural competence, sensitivity to cultural diversity, cultural knowledge, and cultural appropriateness (Code of Ethics Review Group, 2002; New Zealand Psychologists Board, 2018). We have also encountered the terms cultural humility (Danso, 2018; see also [Chapter 1.1](#)), cultural proficiency (Kosoko-Lasaki et al., 2008), and transcultural competence (Torry, 2005). A so-called "smorgasbord of definitions and conceptualizations" (Danso, 2018, p. 410) has generated significant controversy around culture-related constructs, often with calls to reject one framing in favour of another. We discuss two frameworks (cultural competency and cultural safety) that aim to address health inequities below. Here, we specifically focus on engagement with te ao Māori, given our unique positioning in Aotearoa New Zealand, though we emphasise that Māori are just one of many minoritised cultural groups in healthcare settings. For comprehensive discussion of psychology practice with other cultural groups (including Pasifika and Asian people; migrants and refugees; and Rainbow people), see Waitoki et al. (2016).

Cultural competency (or cultural competence) is perhaps the most widely used framework for cultural engagement in health practice. Originating in the late 1980s and early 1990s, cultural competence typically focuses on acquiring the awareness, knowledge, and skills to work effectively with individuals from diverse cultural backgrounds (see Sue et al., 1982). Cultural competency has been critiqued for conceptualising competence as a static state or skill, rather than an ongoing process, and for a failure to acknowledge the culture of the practitioner or environment, assuming a culturally neutral practitioner, and the recipients of care as cultural 'others' (Curtis et al., 2019; Kumagai & Lypton, 2009).

Cultural safety has emerged as an alternative framework from which to engage with culture in healthcare practice. Developed by Māori nurse educator Irihapeti Ramsden, cultural safety goes beyond cultural competency by focusing on power dynamics, systemic inequalities, and the impact of colonisation on health outcomes (Papps & Ramsden, 1996; Ramsden, 2002). It requires practitioners to develop a *critical consciousness* (see Friere, 1970)—an ability to reflect on their own cultural biases, privilege, and assumptions

to create a safe and respectful environment for individuals from diverse cultural backgrounds (Curtis et al., 2019). Most importantly, whether a health practitioner is culturally safe is determined by those receiving care rather than those providing it (Gerlach, 2012; Papps & Ramsden, 1996; Ramsden, 2002). Curtis et al. (2019) argue that a shift from cultural competence to safety is essential to achieve health equity for Māori in Aotearoa New Zealand, and that health practitioners, organisations, and systems “must be prepared to critique the ‘taken for granted’ power structures and be prepared to challenge their own culture and cultural systems rather than prioritise becoming ‘competent’ in the cultures of others” (p. 1).

Cultural appropriation and appreciation

Calls for a culturally safe critical health psychology practice that honours Te Tiriti o Waitangi prompts questions and discussion about Pākehā and tauīwi engagement in Māori cultural practices. Elana Curtis, a public health physician and academic known for her work on cultural safety, has been clear that widespread investment in practices such as pōwhiri, mihi whakatau, and karakia in healthcare settings has not eliminated Māori health inequities, and warns of the “karakia sandwich”, where healthcare practitioners learn to say a karakia at the beginning and end of a hui, while the middle of the sandwich “stays racist, stays uncritical, stays actually dangerous for Māori” (Te Whatu Ora, 2024, para. 14).

The “karakia sandwich” that Curtis describes is not benign but causes active harm for Māori. First, when health systems, institutions, and practitioners *appear* to be working towards Māori health equity through visible cultural practices, this can shift attention from the structural (and often *invisible*) factors that perpetuate inequity, maintaining the status quo. An example of this is a healthcare service with a Māori name that decorates their space with Māori art but fails to address structural barriers to accessing their service (e.g., inaccessible clinical locations or systemic racism in health screening and referral). A second danger is the potential for Indigenous knowledges to be co-opted or appropriated if Māori practices are approached as a tick box rather than with genuine engagement. Waitoki (2012, p. 60) notes:

For Māori, when language, culture and knowledge of the colonised are used in an un-reflexive way it serves to affirm the group of people who already occupy the position of power (Bertanees & Thornley, 2004). While there is a need for bicultural initiatives and cultural competency training in psychology, what is not needed is a wholesale misuse and lack of understanding of Māori culture and its relevance to psychology.

Indeed, Māori cultural practices are inherently spiritual practices: **karakia**, **waiata**, and pōwhiri are imbued with tapu (which can be translated as ‘under **atua** protection’), meaning they relate to an unseen or intangible realm, as well as the physical world in which we live (see Ngawati et al., 2018). When Māori practices are co-opted in a way that loses connection with their true purpose, this tapu is diluted or diminished and has significant negative implications for Māori wellbeing. Moreover, the giving of Māori culture to non-Māori is not neutral. Māori culture and language have been forcefully taken and violently suppressed through the process of settler colonisation (Moewaka Barnes & McCreanor, 2019). For many Māori, seeing Crown institutions breaching Te Tiriti while using the same language their grandparents were harshly punished for speaking is akin to rubbing salt in a very fresh wound.

Concerns about health practitioners’ cultural appropriation or misuse and misunderstanding of tikanga, **te reo**, and mātauranga Māori can lead to another problem entirely: Pākehā paralysis. Pākehā paralysis refers to a state of inaction or reluctance among non-Māori to engage with the Māori world, often stemming from discomfort, guilt, or a fear of getting things wrong (Citizen, 2020; Hotere-Barnes, 2015; Tolich, 2002). This phenomenon also results in a failure to address systemic health inequities and can mean that Māori do not see their culture reflected in healthcare spaces. Health systems in Aotearoa predominantly reflect Eurocentric knowledge frameworks and ways of doing and being, resulting in a structure that is culturally familiar and accessible primarily to Pākehā (Came-Friar et al., 2019; Waitoki et al., 2024a). The cultural safety iceberg is a tool to help you reflect upon practices or components that are visible to some people (the top of

the iceberg) and less visible or invisible to other people (beneath the surface of the water) shown in **Textbox 3**.

Textbox 3. The cultural safety iceberg

The cultural safety iceberg is a tool to help you reflect upon your practices. Visible components are important, as Māori need to see themselves and their culture respectfully represented in health psychology spaces. However, these should never be seen as sufficient. The less visible or invisible practices that disrupt inequitable power structures are essential for a culturally safe health psychology. Below is an example of how a health psychology team leader might enact cultural safety within their health service.

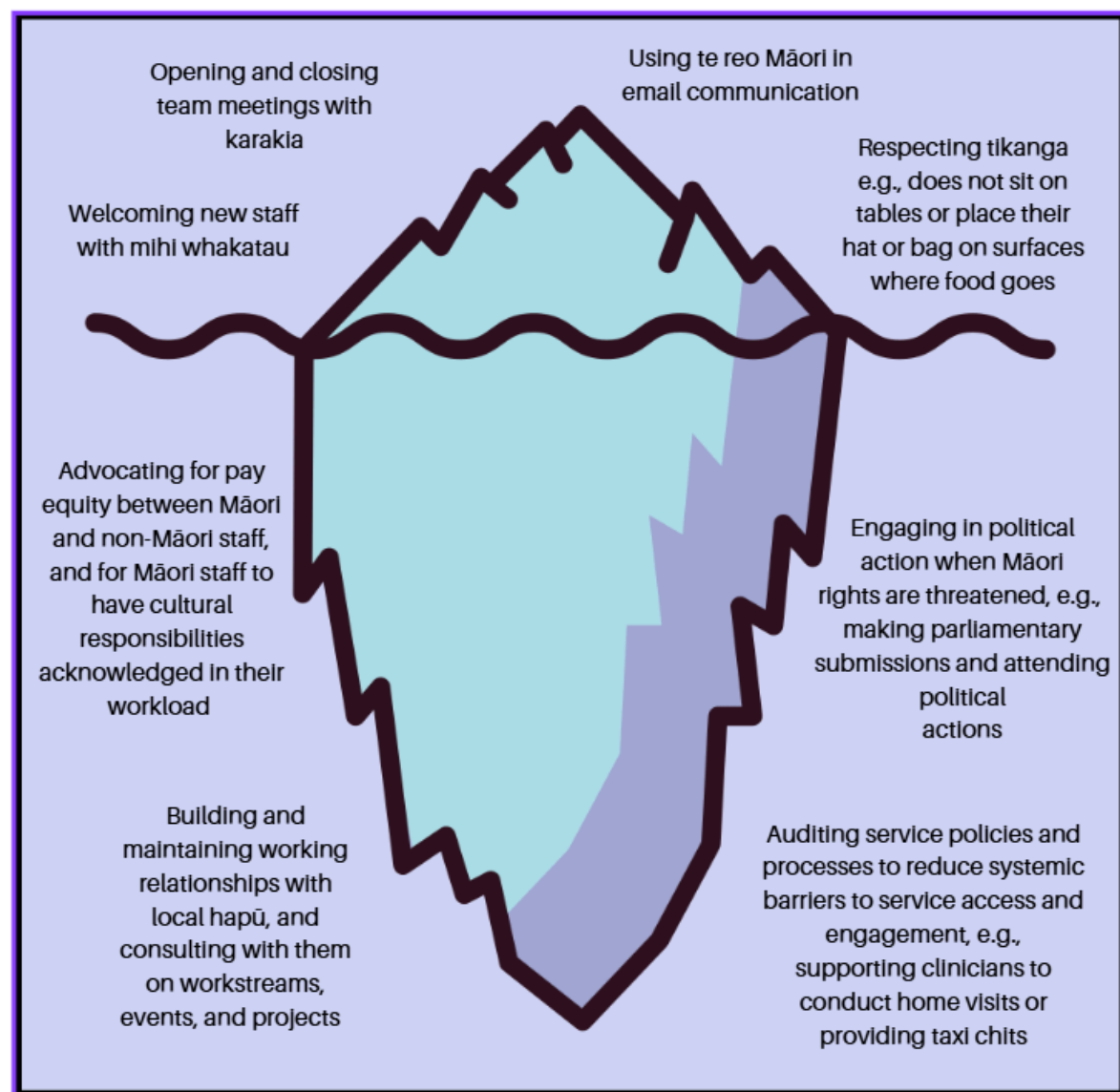


Fig 3.1.3 Cultural safety iceberg with examples. (Gloria Fraser. [CC BY-NC 4.0](https://creativecommons.org/licenses/by-nc/4.0/))

An iceberg model can also be used to reflect upon your own identity and positionality. The surface area contains your qualities and attributes that are obvious and easily identifiable by others. As the iceberg goes deeper, identify the less visible or invisible aspects of yourself that influence how you understand, experience, and navigate the world. These aspects may involve invisible cultural identities, political beliefs, sense of time, relationships and responsibilities to others, and core values. You may then consider how these core aspects interface with your cultural identities. This exercise encourages you to consider the layers of your identity and positionality that you may not have explicitly explored before. It also serves as an ever-timely reminder that all of us—from our colleagues to tangata whai ora to those we pass by on the street—carry hidden depths below the surface that we may or may not ever see.

You will find a blank cultural safety iceberg at the end of the chapter. You can use this to consider

visible and invisible practices to create cultural safety with a particular cultural group, or to further explore your own cultural identities and subject positions.

Cultural appropriation or co-option of Indigenous knowledges on one hand, and Pākehā paralysis on the other, have at times left our own critical health psychology students befuddled, or feeling stuck between a cultural rock and a hard place: how can practitioners of critical health psychology contribute to the decolonisation of critical health psychology, revitalisation of te reo Māori, and emphasise the inherent value and validity of mātauranga and tikanga Māori, all in the spirit of *appreciation* rather than *appropriation*? If I am not going to do it right, they ask, am I better off not attempting to engage at all, to make sure I do not offend anyone? In response, we encourage our students to approach cultural safety in concert with the frameworks previously introduced in this chapter (in particular, reflexivity and Te Tiriti o Waitangi). If you are wondering whether or how to engage in te ao Māori, we recommend starting with the exercises outlined in the chapter so far. We illustrate this approach in Textbox 3 with the “cultural safety iceberg”, a metaphor for the visible and less visible aspects of cultural engagement. Starting with the actions under the surface of the water (including learning more about settler colonialism and how this process is enacted in Aotearoa New Zealand, as well as the history of the land on which you live, and your own whakapapa and positioning in relation to Te Tiriti) provides a foundation to engage more confidently in actions above the surface. We also encourage you to consider the *purpose* of different cultural practices, and how their purpose might be realised in a way that is respectful and authentic (or in Māori terms, tika and pono). **Textbox 4** provides an example with an exploration of the purpose of karakia, along with guiding questions to consider when engaging in karakia in your practice.

Textbox 4. Use of karakia in critical health psychology practice

Karakia are a set form of words (sometimes referred to as a blessing, incantation, or prayer) used to invoke spiritual guidance and protection, or to state or make effective a ritual activity. Karakia can be a set form of words, however, proficient speakers of te reo will compose karakia as they speak. They help Māori to navigate tapu and to acknowledge the mana inherent in all things. Karakia can be formal or informal. They can be used to bless food, before a journey to protect against harm, to start or end the day, to express gratitude, or to ensure a task or activity is successful or runs smoothly.

When used to open and close a hui or gathering, karakia can:

- help us transition from one focus to another.
- bring those present together for a common purpose.
- set an intention for the kaupapa at hand.
- help to centre and ground those gathered.

Reciting Māori karakia is just one way to achieve the purposes outlined above. As practitioners of critical health psychology, we have many ways to bring people together and transition between spaces. Alex often plays music before teaching a class to set the tone and settle students into the teaching room, and he uses this time to connect with students one-to-one with a fun or thought-

provoking question or thought experiment. Gloria has opened sessions in her clinical practice by easing into conversation while making a hot drink and often closes sessions with tamariki using a te reo Māori board game to help transition to a lighter space before she sends them on their way. These practices may not connect us to atua Māori in the same way as a karakia, but are selected intentionally to recognise that invocation of spiritual guidance is not appropriate in every setting or context. At other times (e.g., when presenting workshops about te Tiriti o Waitangi, or when mutually decided with **whai ora**), Gloria does begin and end classes and clinical sessions with karakia. Keep in mind that karakia is extremely important for many (but not all) Māori, and that many non-Māori find karakia helpful and settling too.

If you are planning to use a Māori karakia, check in using the following questions:

- what is the purpose of using a karakia in this context?
- have you chosen a karakia that aligns with your purpose?
- have you explored how this karakia is pronounced?
- do you have a sense of what this karakia means to you?
- what do you know about the origins of this karakia?
- what less visible or invisible actions are you engaging in between opening and closing karakia (in Curtis' terms: in the filling of your sandwich), or outside of the hui, to make your context and practice culturally safe?

If you are unsure of any of the answers to the above questions, this is a prompt to extend your learning about te reo Māori and karakia, or to set aside time for reflexive exploration and action planning around culturally safe practice (for further discussion about use of karakia in practice, see NiaNia et al., 2016; NiaNia et al., 2025).

Conclusion

Critical health psychology practice is about making the world a better place by questioning taken-for-granted knowledge systems and challenging existing unequal power structures. In this chapter, we have taken you on a whirlwind tour of key frameworks to support the (at times, weighty!) aspiration to create a social justice-oriented health psychology practice in Aotearoa, New Zealand. Discussing Te Tiriti o Waitangi, reflexivity, ethics, and cultural safety is a tall order for one book chapter; each of these topics and frameworks are explored with far more nuance and detail elsewhere, and we encourage you to use our reference and Te Tiriti reading lists to guide your further reading. We do, however, hope that we have provided an adequate introduction to these frameworks, and the relationships between them, to start you on your way. Make change in your spheres of influence, be kind to yourself, and keep fighting for social justice and health equity. Toitū te Tiriti!

Blank Cultural safety iceberg

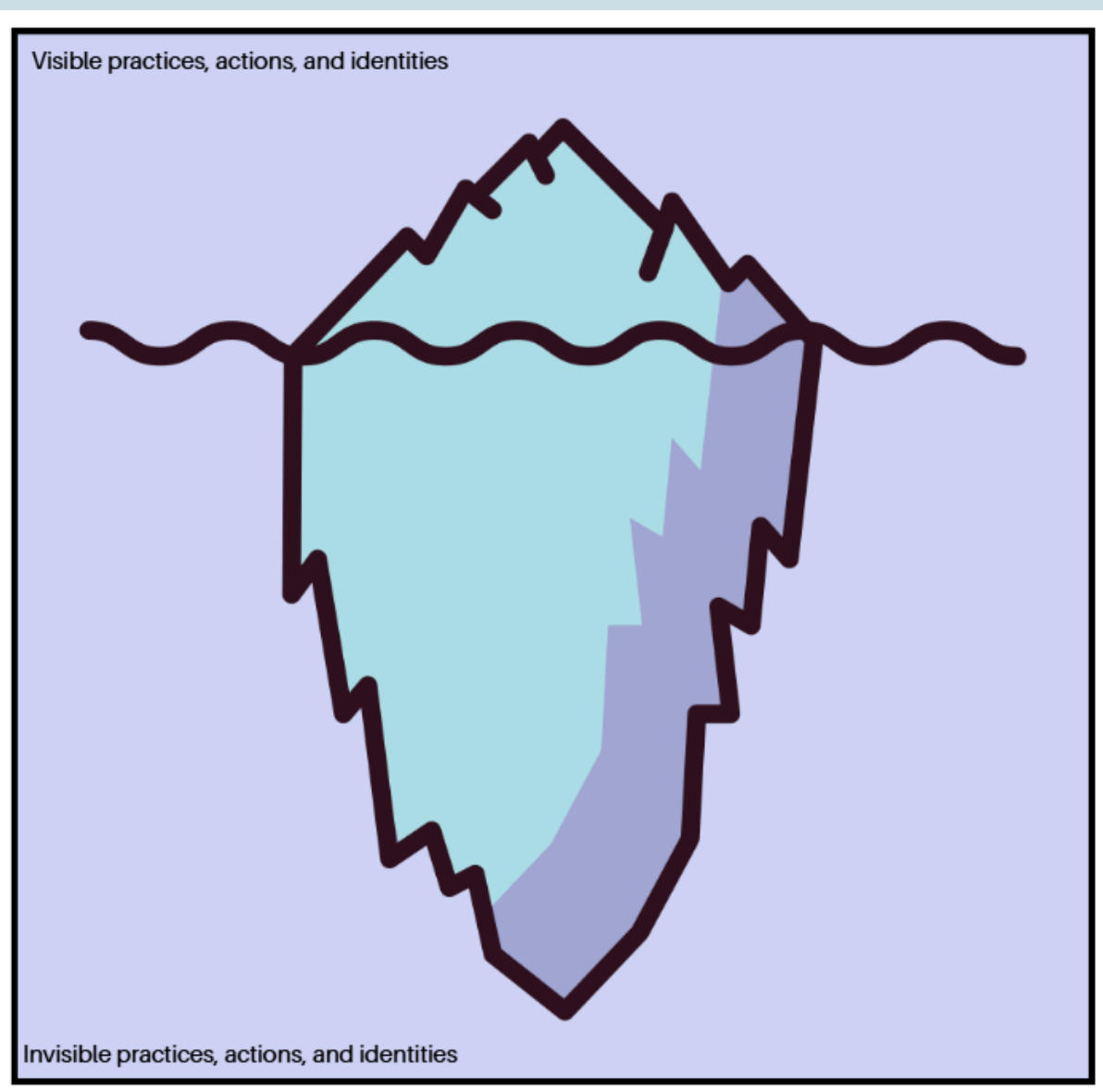


Fig. 3.1.4 Blank cultural safety iceberg. (Gloria Fraser. [CC BY-NC 4.0](#))

Further reading

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Waitangi Tribunal reports, a valuable source of Tiriti evidence, can be found online at <http://www.waitangi-tribunal.govt.nz/reports>

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3.2 Becoming a critical health psychology practitioner: Practicum, internships, placements, oh my!

GARETH TERRY

Overview

In this chapter, I discuss the value of practice placements (practicums) and how they might differ for the critical health psychology practitioner. I will discuss application-based learning beyond the traditional psychological focus on the individual, with a strong emphasis on being theory informed and centring social justice. This lens will be applied not only to the ways that critical health psychology practitioners might work and who they work with, but also to how they might “become” through application-based learning within an assemblage of supervisors, skill acquisition tasks, placement locations, and university systems. This chapter is explicitly written for those who are participating in a process of learning with such a practice-based component. As such, approach it questioning **how you might think about the processes involved in becoming a critical health psychology practitioner through the lens of critical theory.**

Learning objectives

1. Articulate the value of application-based learning within critical health psychology.
2. Understand how to decentre the individual in application-based learning, enabling a stronger focus on context, systems, and relational ethics.
3. Apply theories of liminality, assemblages, and becoming to the context of application-based learning and what this means for the critical health psychology practitioner.

Introduction

Much of what you have been exposed to in this textbook so far are examples of theory, the way theories can manifest in research, and the kinds of things critical health psychology practitioners might be interested in. You have also been introduced to examples of work by researchers and practitioners, who are well-situated within the practice and research space. The readings in the textbook can then act as guides or sources of knowledge about what is possible within critical health psychology and what others have done before you. They are there to help draw you into being part of a new generation of critical health psychology practitioners, engaging in work that continues to challenge inequities through system-levels advocacy and change, enabling better health outcomes for people by focusing on broader social forces, rather than being limited to people’s individual choices and behaviours (Chamberlain & Murray, 2017).

In [Chapter 3.1](#), you have also been given some direction in terms of the kinds of knowledge you need

when moving from a theoretical understanding of critical health psychology to being a practicing psychologist—especially in Aotearoa New Zealand. That chapter focused on the necessary tasks to become a practitioner. As Fraser and Walker note, ethics and **reflexivity** are central to practice, and those are defined by the cultural environment where you want to work. In the case of Aotearoa New Zealand, the centrality of **Te Tiriti o Waitangi** is emphasised, because of its role (including breaches across decades) in shaping the cultural and material conditions of people in this country. This chapter takes a slightly different path, exploring the ways that you can take the knowledge you have gained from being a student (alongside theoretical material from other parts of this book) into the realm of application-based learning—the **liminal space** between study and practice.

To further understand this pathway, the chapter starts with an introduction to some of the theory and history of application-based learning within psychology. I will then turn to the ways that critical health psychology practice might be conceptualised differently from *mainstream* forms of practice—in particular, critical health psychology’s focus on the **pou** discussed in full in the [textbook introduction](#):

- valuing theoretical and conceptual thinking.
- challenging taken-for-granted understandings.
- paying attention to issues of power and equity.
- moving beyond the individualism that characterises much of (Western) psychology.
- considering knowledge as produced in social context.

It is worth noting here that many of the *procedures* of application-based learning in psychology, whether mainstream or critical, might look the same. However, the theoretical content and focus of critical work can sometimes run counter to the expectations of various mainstream systems, which may be primarily interested in training workers in a defined subset of skills or competencies. It is important for those wanting to become practitioners of any kind, but who are still interested in remaining answerable to critical concerns, to take these differences into account. This is necessary to managing a set of tensions they may not have expected to encounter in moving from theory to practice. To help frame this conversation, I will draw on the theoretical constructs of **liminality**, **assemblages**, and **becoming** to highlight the *value* of disruption and instability to the development of a critical health psychology practitioner. I will argue that reflexive engagement with discomfort is a key strategy in the process of transitioning from student to practitioner. Before moving to the next section, it is worthwhile engaging with **Exercise 1** to begin your process of reflexive engagement with the ideas in this chapter.

Exercise 1: What kind of practitioner are you becoming?

Pre-practicum thinking

Understanding what has led you to where you are and what that means for who you might become are a good starting point for reflection.

Take some time to reflect on what is producing your (current) sense of direction.

How do relationships (friends, family, lecturers, supervisors), affects (passions, anxieties, expectations, ambivalences, hopes), limitations (grades, capabilities, interests, histories) and systemic issues (ethnicity, gender, income, colonisation) make certain pathways feel possible or impossible?

What does a practicum add to these? What kind of practicum are you likely to experience given your context? What possibilities might it open up? What uncertainties are there for you?

Application-based learning and the practicum

Application-based (or practice orientated) learning is different from most tertiary study the average postgraduate student has experienced. There is a significant jump from reading about something to doing something, especially in workforce roles that are dedicated to the kinds of things critical health psychology practitioners are interested in. This is both exciting and intimidating! You may have experienced discrete moments of application-based learning in your study to this point, associated with course assignments or other course-based activities. However, in postgraduate study and moving toward employment in psychology and psychology-adjacent roles, application-based learning can become a key ingredient in helping you move toward “workplace readiness” (whatever this means to you).

The recognition that becoming a practitioner involves exposure to and repetition of practices, skills, and development of particular competencies has resulted in an orientation to bringing students through an intermediate stage of development—practical application of knowledge (Callahan & Watkins, 2018; Cooke, 2018; Nicholson Perry et al., 2017). For some, this might be limited to research as they work through a research “apprenticeship” doing an Honours, Masters, or doctoral level project. For others, professional pathways (clinical psychology, clinical health psychology, counselling psychology. etc.) might be formalised in a programme. **Textbox 1** outlines some of the possible application-based learning opportunities you may be exposed to in a university postgraduate setting.

Textbox 1: Different kinds of application-based learning opportunities

Internships, placements, practicums, and research degrees offer opportunities to gain experience of practice within carefully bounded frameworks.

Internships – typically associated with clinical pathways to professional psychology, often defined as a programme of study. You will likely be enrolled in an accredited university programme for a term that may cover multiple placements. There is a good chance you will be performing as a psychologist, under close supervision, with around 1500 hours of placement-based learning, alongside study. The internship may be associated with a professional doctorate.

Research pathways – these are application-based learning opportunities built around postgraduate research degrees, but may also include paid work as a research assistant or research associate—normally following a period of qualifying study. You are more likely to be supporting a research project or projects in the early stages, moving toward seniority and independence. Within the context of academic study, a PhD requires you to make an original contribution to knowledge in a given area, potentially leading to an academic career (Mpofu, 2016).

Practicum – usually a limited course of study (e.g., a single placement in one semester) located within a wider programme of study. It involves supervised application of theory in an applied

setting in a much more limited fashion than in an internship. You may be practicing as a psychologist in some contexts, but in a much more limited way than might be expected in an internship. The literature will often use the term practicum to refer to any [work-integrated learning](#). This chapter will follow this practice, treating the practicum as a manifestation of extended application-based learning within the context of a programme of study.

Placements – location of an internship or other training process, but usually within the context of an existing programme of study. Placements may be single with clear boundaries or multiple with different training experiences in each (e.g., working in a pain unit, followed by another placement in a rehabilitation setting).

Development in application-based learning is typically generated through a) practices and skills that reinforce some of the theoretical or even hypothetical knowledge developed prior, and b) making reflective change to practice in ways that enhance competence and help produce identity (Callahan & Watkins, 2018). For the practice of applied forms of psychology this makes perfect sense, as people need skills-based learning to embed and develop knowledge gained from reading and completing assignments. In these cases, programmes explicitly orientate to training professional psychologists, navigating tensions between scopes of practice outlined by the discipline's organising body (in Aotearoa New Zealand, the NZ Psychological Society), educational requirements of the university and government (in Aotearoa New Zealand, the Ministry of Education via the Tertiary Education Commission), and the skills and knowledge required by the sector a given role is located in (e.g., the health sector). The ultimate purpose of application-based learning in these instances is to take someone from beginner level knowledge of practice to a particular expression of expertise (Nicholson Perry et al., 2017; Skovholt, 2012)—assuming everything goes well!

Within mainstream psychology, particularly the clinical subdisciplines, application-based learning has a long history (Palitsky et al., 2022) and is now extremely common in professional subdisciplines of psychology (Callahan & Watkins, 2018; Carless & Taylor, 2006; Mpofu, 2016; Palitsky et al., 2022). Core to this are the needs of a healthcare workforce, ensuring particular roles are filled to meet (increasing) demand for psychological services. Prior to the 1990s, much “real world” training in psychology was done *after* the movement into the workforce, through in-service based on the job training (Cooke, 2018; Mpofu, 2016). However, for various reasons, this is something that now falls within the domain of higher education programmes, where universities manage the shift from theory to application within the context of a wider programme (Mpofu, 2016). In these contexts, placements “host” students for short periods of time allowing them to practice under supervision. Consequently, much of the value of these experiences relies on good quality training, placements that expose the practitioner to “real world” practice, and developing the competencies of the student to make them workforce ready (Callahan & Watkins, 2018; Kaslow, 2004).

In the Aotearoa New Zealand context, professional doctorates and other formal programmes containing practical experience have been the norm since the 2000s (Mpofu, 2016), with various tiers of practitioner being established, including the recent development of an assistant psychologist category (Shearer & Chadwick, 2024). These programmes are often designed to create professional identity and train autonomous practitioners with a clear scope of practice within a desirable set of competencies. Often these programmes define good training as orienting to “evidence based” or “empirically validated” therapies with an explicitly individualised orientation. They are therefore answerable to concerns of consistency—producing a certain kind of practitioner within a constrained period of time that will enable the workforce to be bolstered and replenished. The application-based learning components within these programmes (often in different locations) are designed to meet the expectation of a certain number of hours of supervised practice – in Aotearoa New Zealand, this is set at 1500 hours (New Zealand Psychologists

Board, 2023). This period of time has been determined as sufficient for a practitioner to develop the needed competencies of the role.

For those of us wanting to extend our understanding of critical psychology into our practice, the process is likely to be different to this programmatic approach. As Fraser and Walker note in [Chapter 3.1](#), there are many places a critical health psychology practitioner might end up working. Further, while a practitioner might be informed by critical theory, many features of the programmes they engage in might be entirely “mainstream” (including the kinds of work they end up in). Consequently, one of the key ingredients to success in application-based learning for a critically oriented practitioner is a willingness to engage with the tensions between their programme of study, their desired working environment, and the theory and values one has gained through engagement with critical psychology theory. These elements are not always congruent with the articulated values of a profession or work environment, and so “fit” might not always be obvious. **Textbox 2** describes a broad typology of different kinds of environments you might be expected to participate in a practicum. Some of these involve more adaptation than others, either being more mainstream than you might want or more critical than the environment is able to facilitate.

Textbox 2. Typology of practicum in relation to critical theory and practice

Fully mainstream: orients to the priorities of the health service and/or university training. Typically, individualistic and framed as supporting “evidence-based” practice. Will likely be accounting for a “scarcity paradigm”—where resources, both human and financial are constrained despite significant demand (Maxwell, 2009). Health psychologists here are likely to be clinically trained drawing on theory such as the biopsychosocial model. This can be built around a professional doctorate, but it is also typical within a Masters degree, followed by a diploma of clinically oriented courses and practical work.

Partially critical: orients to the priorities of the service and/or university training as well as containing social justice elements within course material and expectations in practice (e.g., a clinical psychology position wrapped around with critical theory). An example of this is the doctoral programme at Canterbury Christ Church University in the United Kingdom (Cooke, 2018), where clinical skills are taught alongside critical theory in an integrated fashion. Roles in public health or community organisations might also be possible, where a mix of theoretical perspectives are drawn upon.

Fully critical: orients to producing critical health psychology practitioners as a priority. Invested in seeing our five pou (or an equivalent) manifest in the practices of practitioners in any setting (but often community or NGO-based). There is a clear focus on challenging systemic issues through hiring and training of critical practitioners, in critically informed roles, drawing on critical theory. The role may involve activist-scholar work that helps challenge inequities and injustice in areas such as policy and public health. The practicum in Massey University’s Health Psychology programme (see Textbox 3) is an example of a fully critical, placement-based opportunity set in the context of a critical health psychology programme.

Irrespective of the practicum (or programme) type, the movement towards becoming a practitioner is one where transition and tension are commonplace. Given that placement locations may or may not be familiar

with critical theory, or invested in approaches that emphasise notions of equity, power, systems orientations, etc., a practicum then becomes an *opportunity* to explore how these ideas might work (or not!) in a given workplace environment. There is no question that this is also *unsettling* for many students as they seek to develop new skills and apply material they have been absorbing in their courses. For the student, questions of who they are, what they might become, and what is needed to support this “becoming” become essential to development. These characteristics are markers of what the literature describes as a “liminal occasion” (Greco & Stenner, 2017). Reflexively engaging with this theory and its importance for reflexivity (see Fraser and Walker, [Chapter 3.1](#)) are the focus of the next section.

Practicum as a liminal occasion

Within the context of a practicum, it is worth adding to the reflections from Exercise 1 that you are likely not (yet) a critical health psychology practitioner. Rather you are in an in-between state, somewhere between “student” and “professional” (Callahan & Watkins, 2018; Mele & Marsico, 2019), with all the possible subject positions available within and between these two categories. Some people may have already been in the workforce for some years before taking up postgraduate study, while others may have moved, from school to study, with limited experience of the workforce. Irrespective of the pathway taken, the movement from education to work can be understood as one associated with **liminality**:

“-far from smooth or linear and is instead marked by considerable rupture, delayed entry and navigation of a complex range of potential pathways” (Tomlinson, 2024, p. 1079).

These kinds of liminal zones are often marked by a sense of vulnerability, anxiety, and a lack of confidence in abilities (Mele & Marsico, 2019). In other words, if you are feeling those things coming into your practicum, that’s not unusual!

It is also worth noting that while periods of transition can feel more intense than others, liminality is a defining feature of human experience—it is normative. We are always moving through change, even in our day to day lives, and this means we change and become something different in different contexts—people are always in process (Turner et al., 1969). You will have experienced this in various ways already. For instance, our home spaces demand different ways of being and acting to other spaces (such as work or school) and we transition into something different and even “become” someone different when we move between them. Some transitions are considered socially important, like childhood to adulthood, or moving from being otherwise healthy to experiencing a chronic health condition.

Greco and Stenner (2017) described liminal occasions as important moments in time and space where someone moves from one way of being into another through a process of (potentially) valuable transformation.

Greco and Stenner contrast this with the liminal hotspot—where there is risk of getting “stuck” between two mutually exclusive alternatives. To illustrate the differences between valuable and problematic outcomes from liminality, Greco and Stenner (2017) use the mundane example of responding to a phone call from a parent in the midst of hosting a social event. Using a phone has the potential to take us “elsewhere”, so we

cannot be fully present with our friends who are physically in the room with us. Nor can we fully attend to the conversation on the phone. These moments have the potential to “transform” us, perhaps through us apologising and moving into another room and becoming deeply connected to the person on the phone. They can also involve us shifting our identities, from host and friend to being a dutiful child attending to a parent on the phone. However, if we stay in the room, and try and engage with our parent while staying within the social event, we remain trapped in the in-betweenness, offering limited value to ourselves or either possibility.

The in-between space of **becoming** a practitioner, yet still (and always) a student, might also be seen as a **liminal occasion**. Some mainstream responses to this occasion might seek to manage its uncertainty and complexity through focusing on “training”—where you gain a set of workplace skills and competencies from a trainer experienced in those skills. These skills and competencies can then be tested as a way of validating the movement from student-who-needs-supervision to practitioner (Kaslow, 2004). This sort of training process is seen to (positively) constrain the number of pathways available (through skill specialisation) and reduce the risks of “rupture”, “uncertainty”, and “delayed entry”. In this way, liminality is *managed* but very much treated as a problem. It is a problem that can be mitigated through a “rite of passage”—such as training and then registration as a psychologist. Many students seek to resist the intensities of liminality, and can become invested in a particular kind of work as an outcome of their study, hence the strong appeal of professional programmes that help develop a sense of professional identity and practice (Mpofu, 2016). However, this kind of approach, while “safe”, might miss opportunities to engage with tensions that stimulate growth and depth as a practitioner. It might also involve missing out on critical understandings of people and health (Part 1 of this textbook). It also might mean ending up persisting with simplistic approaches to diagnosis and treatment (challenged in Part 2 of this textbook) and not embracing complexity and people-in-their-contexts.

Lyons and Chamberlain argue, “Resistance to professionalisation is also part of an overall critical stance... professionalisation can produce external pressure on what is taught and how it is taught... this could produce restrictions on our multidisciplinary approach to fostering a critical stance on health” (p. 463).

While engaging with a mainstream programme can be a strategy to mitigate the uncertainties of liminality, it does not always allow students who have taken up some critical theory, including its ethical orientations and values, to integrate these ideas into practice. There are certainly ways to be and become critical as professional psychologists, and many of the recommendations that Fraser and Walker (Chapter 3.1) offer will support this—especially with reference to notions of reflexivity and cultural safety. However, this approach risks always being subsumed by the expectations of professionalism, as a practitioner’s answerability to scopes of practice and the systems that they work within dominate their practice. In this way “being critical” can risk becoming tokenistic, without consistent reflexive practice and a willingness to understand and resist individualistic and pathologising practices.

Another approach to mitigate the “risks” of liminality is by engaging in a programme that supports critical theory. A partially critical or fully critical programme (see Textbox 3) might enable you to work with theory but also gain some of the experience of working in a placement that gives you confidence about your readiness for the workplace. For instance, the programme at Canterbury Christ Church described in Textbox 2 would allow you to “fit” within a health sector role, where there is high demand for practitioners with mainstream skills, while keeping open to social justice orientations and critical theory (Cooke, 2018). These kinds of programmes exist in a wide number of contexts, due to increasing demand for social justice informed theory and practice (see, for instance, Hage et al., 2020).

You might also see the value of a programme such as the one at Massey University, which offers a best of both worlds approach (see **Textbox 3**). Such programmes are designed around critically informed courses, including a practicum element that supports critical reflection and broad, health orientated placements that expose students to a greater range of possibilities than offered in mainstream programmes. As such, they provide some of the sense of liminality mitigation that other formal programmes provide, while also scaffolding the student with a supportive practicum experience, that emphasises critically informed practices and supervisors.

Textbox 3. Exemplar of a practicum – Massey University/Te Kunenga ki Pūrehuroa, Aotearoa New Zealand

The health psychology programme at Massey is defined by its explicit integration of critical health psychology into practice. The purpose of the programme's practicum is to allow students to gain experience applying the knowledge acquired through foundational studies in critical health psychology in work placements. This operates to increase the potential for employability within the health sector (broadly defined), and also to emphasise and demonstrate (for employers and students) the value of students trained in critical approaches. In this context, the practicum is a 120-hour, single semester course as part of the first year of a Master's degree in health psychology. The following extract from Chamberlain et al (2017) describes the practicum's history and purpose:

"We were keen to include a workplace practicum component as part of the programme, which we established in 2003. This has had various iterations, depending on the requirements of the University and the national Tertiary Education Commission but is currently a 15-credit course required within the programme (see [Health Psychology Practicum, 2017](#)). The practicum placement involves students working in a health-related organisation, completing a project of value for that organisation and bringing their academic learning to bear on real-world issues. These placements are supervised by academic staff and local practitioners and have been located in very diverse settings, with the only proviso being that the project undertaken must have a health focus" (p. 463).

This practicum does not result in the necessary levels of practice required for professional registration (e.g., 1500 hours in the Aotearoa New Zealand context) but rather sets a foundation for two pathways: 1) employment within the health sector, or 2) foundation studies that can be added to with a Postgraduate Diploma in Psychological Practice (PGDip PP), a year-long internship-based programme of study that meets registration requirements. Host placements and employers all note the value of Massey student contributions to organisations and the kinds of skills and knowledge they bring to roles.

Embracing uncertainty and the in-between

All pathways involve a **liminal occasion** in the in-between space of becoming a practitioner, and thus some risk and uncertainty. Mitigation pathways, such as the features of a particular programme, might reduce some of the uncertainty in the liminal occasion of a practicum and are understandable as a choice. However, relying on a programme to do all of the mitigation of uncertainty as a strategy may end up limiting some of the benefits of *embracing* liminality and the opportunities it produces for all involved. Students who are supported to embrace various uncertainties and adapt to their work environments can bring important

skills and resources to practice (Mele & Marsico, 2019), as well as a different kind of growth as a developing practitioner. Further, there is increasing evidence that the values that inform practitioners' work can be as important, and sometimes more important than the skillsets many mainstream programmes train people in (Callahan & Watkins, 2018; Cooke, 2018; Skovholt, 2012; Terry & Kayes, 2019; Toporek & Vaughn, 2010). Certainly, students and new practitioners working in psychology and other practice-based roles continue to emphasise the importance of critical theory (especially social justice informed frameworks) to their development, and to inform their practice (Callahan & Watkins, 2018; Cooke, 2018; Hoover, 2016; Lewis, 2010).

Mechanisms that support a pathway through the liminal occasion of a practicum can bolster particular values and knowledge, enabling a depth of practice and effecting change for both the developing practitioner and even the placement environment. At a minimum, exposing yourself to the liminality of "becoming-a-practitioner" and understanding its impacts, can give insight into the kinds of difficulties people can experience in relation to health and ill health. Reflecting on how uncomfortable you might feel in a given liminal occasion (no matter how small) may support your empathy for those dealing with complexity and disruption, including restrictions and limitations on access to support and culturally safe environments (e.g., Curtis et al., 2019; Terry et al., in press). To further extend this, there is a risk that ideas of social justice and critical orientations might become superficially layered onto otherwise mainstream skills, practices, and ethics in unhelpful ways. Good examples of how to resist this superficiality have already been raised regarding Te Tiriti o Waitangi in [Chapter 3.1](#), appreciation of Hauora Māori in [Chapter 1.1](#), and engaging with disability and disabled people in Chapter 3.4. In all of these cases reflexivity is an important tool to manage the multiple liminal occasions found within practice (e.g., offering cross cultural care).

"The word 'reflexive' means 'to bend back upon oneself'" (Finlay & Gough, 2003, p. ix) where "the mind observes and examines its own experiences and emotions, intelligent self-awareness, [and] introspection" (Sherry, 2013, p. 283).

Reflexivity is not just a navel gazing exercise, but rather a process of reflecting deeply on the environment you are in. You should ask yourself the following questions:

- how are you being changed by it?
- how are you changing it?
- is there any observable change or are you simply going through the motions in your practicum, concerned only with "passing" (whatever that entails)?

Tools like reflexivity should be *central* to the practices of a critical health psychology practitioner, irrespective of the work or placement environment. Whatever transition you are making—through a formal programme, through a practicum experience, or even through a shift from study to the workplace without a formal scaffolding, reflexivity can help make sense of the vulnerability you experience and complexity of the transition in important ways. Beginning early with reflexive practices (such as the one advocated for in **Exercise 2**), and continuing to reflect on and integrate new learning, will expedite growth in your capacities and potential. Reflexivity can provide you with creative solutions to problems and thoughtful integration of theory with practice. It can also mean you are always willing to understand what you can contribute through advocacy and allyship, as well as in the kinds of care you offer through your practice.

Exercise 2: Reflecting on your practicum

Early phases: Planning and beginning a practicum

In order to support becoming a critical and reflexive practitioner, it can be a great idea to journal your reflections on your experiences and practices (however that might work for you—you could use a notebook, a [Miro board](#), the note app on your phone). This kind of reflection activity can inform your thinking, enabling you to *benefit* from a time of uncertainty and flux. Use the following questions as a starting point to help get into the process of reflecting at the early stages of the practicum. These are not simply about understanding and recording your reflections, but how to make use of them. How can you continuously become *better* at what you do? How can your values develop in relation to the knowledge you have gained?

- as you think about your transition from study to work, what do you imagine that to look like?
- what are the expectations of your course of study?
- what are the expectations of the placement?
- how does thinking about your own sense of vulnerability and uncertainty allow you to reflect on those of people experiencing ill-health? How does it allow you to think about others marginalised within society?
- what does your current life look like (is it already filled with uncertainty and disruption)?
- what can you take with you from your study into the placement environment (skills you have already learned)? What needs to be left behind?
- are you fighting uncertainty by making “safe” choices? What are you doing (or have you done) to embrace or mitigate the effects of liminality? Are these effects necessary at this time (and why)?
- take some time to reflect on periods of deep uncertainty and disruption in your own life (outside of a practicum!). What did you need during these times? What was offered by people? How would you have preferred to be supported? What practices and values can you see that might be worth bolstering as part of your “skillset”?
- what does being a “values informed” practitioner mean to you?

Taking time to reflect on your reactions, your limitations, and your strengths, as well as the needs of the placement and the people you might interact with there, can turn a potential liminal hotspot into positive transformation—what Greo and Stenner (2017) call a **pattern shift**. These kinds of shifts might involve recognition of where our own experiences of privilege and marginalisation occur, and the implications of these to how we might practice and with whom. For example, for those of us who are in the Aotearoa New Zealand context, and identify as Pākehā (or New Zealand European), it might mean a shift from a privileged state of Pākehā paralysis (Hotere-Barnes, 2015; Tolich, 2002) to one of allyship. Within the former, maintaining a “safe” and neutral relationship to Te Tiriti based on a fear of engaging with Māori on their own terms can give way to the latter approach, which is informed by active anti-racism or “the ability to modify and eliminate racist behaviours, beliefs and outcomes... an active and conscious process of increasing harmony, social justice, equity and human rights” (Kidd et al., 2020, p. 388). In this way, practices might become more informed by values and relational ethics, rather than tick-box “competencies” that can be switched on or off.

While much of this section has focused on your own navigation of a liminal occasion, this does not mean you

are becoming a practitioner in isolation. You do not “become” solely in relation to your own limited resources and capabilities, and your reflexivity does not simply apply to your own inner thoughts. Rather you-as-becoming-practitioner are produced through the intra-action of various human and non-human actors. You are one element in a symbiosis of moving parts, with different demands, needs, expectations, practices, resources, and thinking contributing to your development. In the next section, I will lightly reintroduce some of the theory of assemblages and becoming from earlier in this textbook, to think about the production of you-as-becoming-critical-health-psychology-practitioner.

Practicum as an assemblage

There are a variety of theories available to make sense of the “person” or the “subject” within critical psychology. One of these is the idea of **assemblage** from new materialist theory, influenced by Deleuze and Guatarri’s (1987) process ontology. In contrast to our typical (and often) dominant understandings of humans as self-contained and autonomous subjects, these approaches treat “the person” and therefore “the practitioner” as radically open, not defined by static binary categorisations. The subject is considered an *outcome* of generative processes, where humans and their capacities are understood as continually being made and unmade across different encounters (Braidotti, 2006; Gibson et al., 2021). A simple example of an assemblage is a person’s “relationship” to their smartphone—it enables connections and presence in places they are not physically located in, which challenge the boundaries of the individual person’s skin and bones. Social media, social connection apps, people that call us during a social event, television, news, and radio all blur the boundaries between the person and their environment—and all of these interactions are as “real” as any other. Augmented reality and virtual reality technologies only add to this blurring (Al-Ansi et al., 2023).

The practicum might also be understood as a complex assemblage, where the person-who-is-becoming-a-practitioner is only one element. As discussed throughout this chapter, a practicum brings together real-world experience, theory and knowledge drawn from study, and the relationships between a student-becoming-practitioner and supervisors (there are usually more than one!). It also involves the particularities of the placement location and any colleagues you may have there, as well as a cohort of students also doing their practicum in similar kinds of environments. It might involve clients you interact with, or a population that a public health programme seeks to engage with. Human actors can play a part in shaping you-as-becoming-practitioner, but so does the placement location itself. Within assemblage theory, non-human actors contribute as much as humans in helping to produce you as a subject. In this framing, the environment (i.e., a placement) is not simply acted upon by the becoming-practitioner, but also *acts* to produce the practitioner in various ways. The same is true of university systems and support structures (including libraries and Learning Management Software like Moodle, Stream, or Canvas). **Exercise 3** gives you the opportunity to try and map the various elements of the practicum you are participating in.

Exercise 3: In the midst of your practicum

What are the components of ‘your’ practicum assemblage?

Produce a mind map that (as exhaustively as possible), maps all the elements in this assemblage. Think about:

- people (which people and why are they there).

- objects (what things are important to the placement and why you have listed them).
- locations, virtual spaces, feelings and emotions, skills.

Use a tool like Miro to think about the relationships and connections and the various ways each element intra-acts with others.

Write some reflexive notes about the contributions of each and the resources each element brings to the whole assemblage. Return to this mind map through the course of the practicum to add elements, take notes about each.

In this practice, it is good to note that reflexivity extends beyond you as an individual. Try to make notes about how the practicum benefits all elements, and how each element enhances others. What might each element value from others? As an example, and to use a really individualised framing. How might the project(s) you are involved in make a difference to other people? Use this kind of approach with each element in your assemblage map.

Within this framing, it is good to be reminded that you are not the only component of the practicum assemblage, but you may be the newest. So, while the assemblage might feel “new” from your particular perspective, think of the assemblage as existing before you came, changing as you come in, and producing different effects as it forms and reforms. To get the most of this experience is to embrace and learn from what exists, while acknowledging you will become part of the assemblage on your journey to becoming. As such, the “success” of the practicum is not just about you-as-practitioner, but about the assemblage as a whole. All of the elements “desire” success and work together to make that happen. This is one of the reasons why the practicum at Massey is built around pass/fail orientations (rather than a particular grade)—it reflects the assemblage working together to enable something new and valuable. After all, practicums are considered important not just for training individual practitioners! Placement opportunities would not exist, and supervisors would be uninvested in supervising if this were the case. Each element should benefit from being part of the assemblage. The better an assemblage works, the better outcomes for all of the elements involved in it—it is a symbiotic relationship (Alvesson & Sköldberg, 2018).

Practicum as becoming

One of the key features of assemblage theory is that you-as-becoming-practitioner are *always* becoming, never finished, nor settled, and even assemblages form and reform in the same ways. **You will never “be” a practitioner outside of involvement in an assemblage** (despite titles, roles, notions of “expertise”, and even pay checks); **instead you are always becoming**. You will leave the practicum assemblage but then join a new one, where you bring many of the elements of the previous assemblage with you. These act as resources for the new assemblage, and as you-as-practitioner continue to become something new in each instance. Elements of an assemblage may come and go, but they always leave an impact on what remains behind. The mapping exercise above can then act as a useful framework for understanding new roles, new assemblages, new kinds of work. As an example of the value of this kind of activity, I have recently heard of a senior manager who was shifting between departments in their organisation. Her reflexive practice of taking a day to map what she was taking with her, what the new environment would look like, and how it might benefit from her previous assemblage, offered immediate positive effects. Reflexivity can therefore be extended to think well beyond your own understanding, and social position to the elements that shape you continuously—even beyond the term of the practicum.

As a new component in the practicum assemblage, there is a lot to benefit from if you can embrace the

liminal occasion, the uncertainty, and be highly reflexive. The benefit of going into an environment you have not experienced before is also going to result in forms of becoming that, while potentially anxiety producing, are also exciting. Managing emotions will become a significant feature of your practice. **Exercise 4** gives you a set of reflexive questions to ask yourself at the end of your practicum.

Exercise 4: At the end of your practicum

Reflect on what you have gained from this process of application-based learning. Think about the benefits of embracing, mitigating, or resisting liminality.

Look over your assemblage and map and identify how the assemblage (and your understanding of it) have evolved over the course of the practicum:

- what are you grateful for?
- where have your struggles been?
- what would you do differently (or again!)
- begin to think about next stages: What are you becoming, where is the next evolution of your becoming going to occur?
- is there another opportunity to *value* the processes of liminality and becoming?

Be careful about working across assemblages as a student. For instance, some students try to stay within existing work assemblages and “tack on” those of another (the university or training elements, including supervisors). However, this ends up being overly complicated, as the different expectations of each of these assemblages can clash (e.g., an existing role might require you to continue doing a certain kind of work that does not fit with the expectations of the practicum). At Massey, we recommend a practicum that is an entirely different place for this reason. Trusting in the process of becoming within a practicum assemblage, and the kinds of directions the assemblage moves toward are fundamental to its value. There is depth of experience, knowledge, and relationships that can be drawn heavily on as you move from student-who-knows to becoming-practitioner-who-applies.

Conclusion

In this chapter, I have explored the ways that various kinds of theory within critical psychology can enhance our understanding of the practicum experience for future critical health psychology practitioners. At the heart of this is a consciousness that sometimes practicums are unsettling and complicated for students who have largely only engaged with knowledge as something to absorb and then reproduce through essays, exams, and other forms of writing. Moving into the mode of knowledge application is a step on the way to workforce readiness, an intermediate step that can be used to integrate some of your learning into skills, practices, values, and knowledge. This transformation process is one marked by liminality, which can be embraced, resisted, and mitigated, but if managed well can result in positive transformation. Core to that transformation is the importance of the practicum assemblage, which de-centres the student, locating them as one element within a broader configuration of people, practices, and things—enabling the becoming as a practitioner.

Further reading

- [Chapter 3.1](#) of this text – should be read as interrelated chapters
- Bella van Hattum's ISCHP [blog post](#) on person centred care, where she describes the movement from theory to practice.

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3.3. Defining health “problems” and shaping interventions: A critical health psychology perspective

TRACY MORISON

Overview

This chapter offers a critical reflection on health psychology practice, focusing on how practitioners define health problems and intervene to support wellbeing at the individual, community, and population levels. Building on the frameworks introduced in [Chapter 3.1](#)—particularly ethics, reflexivity, and cultural safety—it explores the ideological, ethical, and political dimensions of professional practice. Drawing on the concept of *complex reflexivity*, I examine the often-unspoken values, assumptions, and theoretical frameworks that shape how practitioners decide when, how, and whom to help. Rather than assuming neutrality, the chapter invites a questioning stance: Whose knowledge is prioritised? Whose interests are served? What social conditions are left unchanged? Throughout, I emphasise that health psychology interventions are never value-free. They are shaped by broader social structures, institutional power, and professional worldviews. Case studies such as the SiRCHESI Project in Cambodia and the Sonagachi Project in India illustrate how different intervention approaches—grounded in different values and theories—can lead to different outcomes.

Key questions guiding the discussion include:

- **Who defines what counts as a health issue?**
- **What exactly is considered the “problem”, and what needs to change?**
- **How do values, ethics, and theory shape intervention choices?**
- **How can reflexivity help avoid harm and promote justice?**

Introduction

Health psychology is characterised by a dual focus on research and practice, “devoted to understanding psychological influences on **how people stay healthy, why they become ill, and how they respond when they do get ill**. Health psychologists both study such issues and promote **interventions to help people stay well or get over illness**” (Taylor, 1995, in Prilleltensky & Prilleltensky, 2003a, p. 200). My focus in this chapter is on professional practice: the role of health psychology practitioners in facilitating health and wellness—whether by keeping individuals well (proactive, health promotion) or by treating and managing illness (reactive, ameliorative). I conceptualise *practice* broadly as work in a range of settings (mental health, primary health, workplace, and community, among others), and typically falling into two domains: (1) clinical services and (2) health promotion. Practitioners in these domains intervene to help promote, maintain, or restore people’s health and wellbeing (Prilleltensky & Prilleltensky, 2003a). (These domains are discussed interchangeably in the chapter.)

The aim in this chapter is to examine what it means to be a “professional helper” (Prilleltensky & Prilleltensky, 2003, 2003b) involved in health interventions, and what counts as effective help. Thinking about how professional helpers go about deciding how to intervene in health-related issues is not just busy-work, or

self-indulgent navel-gazing, however. Reflecting on this question brings to mind a much-loved book I had as a child, *Harriet Help-a-lot* (Watson, 1980), which captures what is at stake for helping professionals.

Harriet Help-a-lot: a cautionary tale

The gist of the story is that “Harriet is trying to help, but she is not always helpful.” Eager to help others Harriet often creates more problems than she solves. For instance, one hot summer’s day, she spots a carton of eggs on her neighbour’s doorstep. Her neighbour doesn’t appear to be home as her car isn’t in the driveway as usual. Harriet assumes the eggs must have been delivered while her neighbour was out and decides to help by moving the eggs to a shady spot on the driveway to stay cool and safe. Just after doing so, the neighbour reverses her car out of her garage and, splat, over the eggs! What Harriet hadn’t known is that the neighbour was on her way *out*. She’d parked in the garage for the car to stay cool and left the eggs for *collection*.



Figure 3.3.1 Unforeseen consequences. (Tracy Morison. [CC BY-NC 4.0](#))

The neighbour shouts angrily at Harriet, asking why she hadn’t asked whether help was needed or what she could do. By the end of the story, all her neighbours are cross with well-meaning Harriet, who then has a difficult lesson to learn about helping.

This little story about poor Harriet-help-a-lot illustrates the pitfalls of well-intentioned but misguided assistance and the importance of communication and seeking information to being able to help effectively. It serves as a cautionary tale for professional helpers, no matter how well-intentioned, about the complexities of intervention. Deciding when and how to intervene requires careful consideration, as uninformed or poorly planned actions can leave those we aim to help worse off. Without a clear

understanding of the problem and its underlying causes, interventions risk leading to unintended consequences or, at worst, exacerbating the very issue they seek to address. This phenomenon is sometimes called the “cobra effect”, as explained in **Textbox 1**.

Textbox 1. The Cobra Effect

The term *cobra effect* describes a situation where an attempt to solve a problem results in unintended and counterproductive consequences, ultimately worsening the issue. The term originates from a policy implemented by the British colonial government in India, which offered a bounty for dead cobras to reduce their population. In response, people began breeding cobras to collect the bounty, inadvertently increasing the snake population rather than reducing it. The *cobra effect*, therefore, refers to interventions that produce an unintended outcome opposite to what was intended (Bartholomae & Stumpfegger, 2021).

THE COBRA EFFECT

WHEN WELL-INTENTIONED MEASURES BACKFIRE



INTENTION

REDUCE COBRA
POPULATION

ACTION

A BOUNTY FOR
DEAD COBRAS!

EFFECT

PEOPLE START
COBRA FARMING

sketchplanations

Figure 3.3.2 The Cobra Effect: When an attempt to solve a problem has unintended consequences, making it worse. ([The Cobra Effect](#) by Jono Hey, Sketchplanations [CC BY-NC 4.0](#))

A recent health-related example of this is discussed by Davis (2020) in her podcast episode *Unintended Consequences*, which examines the impact of a government intervention banning tobacco and alcohol sales during South Africa's COVID-19 lockdown. While the ban on alcohol was intended to reduce pressure on hospital trauma units by curbing alcohol-related injuries, the inclusion of tobacco—due to other government priorities—had unforeseen consequences. The prohibition fuelled the illegal tobacco trade, leading to “massive criminal syndicates... enjoying the payday of their lives” (Davis, 2020) as tobacco sales were driven underground.

As Davis's (2020) example illustrates, the *cobra effect* highlights the risks of imposing interventions from a detached, top-down perspective. When those in power set the agenda without consulting relevant stakeholders, well-meaning policies can lead to significant and even more severe unintended consequences.

Critical health psychology requires practitioners (as well as researchers and educators) to actively reflect on

how we collectively define outcomes for others (Prilleltensky, 2003a). Those who seek to help others are part of the same social world they aim to transform. Their biases, values, and worldviews are shaped by the context in which they live and work (Horrocks & Johnson, 2014). Consequently, all decisions about “helping” inherently involve ideological choices. What is problematic is not the presence of ideology, but the failure to make the underlying values, assumptions, and guiding frameworks—or theories—explicit (Raphael, 2000). This makes *complex reflexivity* essential to ethical and effective practice.

In this chapter, I focus on **intervention as a core element of professional practice**, exploring:

- how health psychology practitioners decide *when, how, and whom* to help;
- the role of **values, ethics, and theory** in shaping health problem definitions;
- the concept of **complex reflexivity** as a tool for avoiding harm and promoting justice;
- how theoretical framing influences intervention strategies and outcomes.

By critically analysing how health problems are selected and framed, this chapter highlights the importance of contextual, ethical, and participatory approaches to intervention that centre wellbeing and liberation. In the next section, we take a step back to consider the “why” of critical health psychology practice: what it means to take a critical approach to practice, and how overarching values, ethical commitments, and theoretical assumptions shape how we work in the world.

Learning objectives

After completing this chapter, readers will be able to:

1. **Explain** how health psychology practitioners’ assumptions and values shape choices about what and whom to target in interventions.
2. **Critically discuss** the potential for unintended consequences that might arise as a result of an intervention.
3. **Identify and reflect on** the ethical, moral, and political implications of intervention.
4. **Explain** the importance and implications of reflexive use of theory in planning interventions.
5. **Apply** key concepts from critical health psychology—such as power, cultural safety, and complex reflexivity—to evaluate real-world examples of intervention.

Why do we help? Taking a critical approach to health psychology practice

Critical health psychology requires practitioners (as well as researchers and educators) to actively reflect on how we collectively define outcomes for others (Prilleltensky & Prilleltensky, 2003a; Raphael, 2000). Interventions, by definition, are purposeful attempts to change individuals or groups. As Guttman (2000, p. 27) notes, they inherently involve conflicting values and ethical dilemmas, some of which may be subtle or hidden. Yet mainstream psychology—and by extension, health psychology—has often denied these ideological and political dimensions, instead claiming scientific neutrality (Prilleltensky & Prilleltensky, 2003a; Raphael, 2000).

Critical health psychology, in contrast, insists on what I term “complex reflexivity”, drawing on Parker (1994) and Bolam and Chamberlain (2003). This goes beyond reflecting on personal biases, training, or cultural positioning—what we might call “light” reflexivity, as discussed in [Chapter 3.1](#). Complex reflexivity invites us to see ourselves not only as clinicians or researchers, but as socially embedded actors whose work has moral and political consequences (Fox, Prilleltensky & Austin, 2008).

In this sense, critical health psychology forms part of a broader critical psychology project that “starts from fundamental concerns with oppression, exploitation and human well-being” (Hepburn, 2003, p. 2). Textbox 2 provides an overview of key principles that guide this approach. Importantly, the term “critical” here does not mean being negative or fault-finding but rather denotes an analytical and questioning stance—one that examines not just what we do, but why and how we do it. This includes turning the analytical gaze inward: to psychology’s own assumptions, methods, ideologies, and social functions (Parker, 2015).

Textbox 2. Key features of critical psychology (Parker, 2015)

Critical psychology offers alternative ways of understanding and practising psychology that are socially aware, politically engaged, and ethically grounded. It encourages us to rethink what psychology is, what it does, and whose interests it serves. According to Parker (2015), key features of critical psychology include:

- **Working alongside people, not just observing them**
Instead of separating the psychologist from their “subjects”, critical psychology emphasises *working with* people. It encourages psychologists to turn the gaze back on themselves and their own roles, asking: *How are we part of the systems we study?*
- **Situating individuals in their social and political context**
Critical psychology highlights how people’s experiences are shaped by wider social, cultural, historical, and economic forces. It rejects reductionist approaches that focus solely on the individual.
- **Valuing diverse methods and perspectives**
Critical psychology embraces **transdisciplinary approaches** and **methodological pluralism**. It draws on insights from sociology, anthropology, philosophy, political science, and beyond to understand complex human issues, rather than relying on a narrow set of methods.
- **Recognising that knowledge is interpretive**
Critical psychologists understand that knowledge is always constructed—not simply a mirror of reality. This means being attuned to the meanings people make, and how those meanings are shaped by power.
- **Practising reflexivity, not claiming objectivity**
Critical psychology values *reflexivity*—the ongoing process of reflecting on how our positions, values, and assumptions shape our work, instead of pretending to be neutral or objective.

Together, these principles support a psychology that is committed to justice, transformation, and human dignity, rather than simply adjustment or control.

Within this broader project, critical health psychology offers a distinctive perspective—one that (1) foregrounds the social embeddedness of health and illness, and (2) highlights power and privilege in shaping health outcomes and care (as discussed throughout this book). Its two central goals are **wellbeing** and **liberation** (Prilleltensky & Prilleltensky, 2003b). Critical health psychologists therefore aim to contribute to both emancipation and quality of life (Prilleltensky & Prilleltensky, 2003b). A key premise is that people cannot be truly well unless they are also free from the systems and structures that constrain or harm them. Wellbeing and liberation, in other words, are inextricably linked (Prilleltensky & Nelson, 2017).

From a critical health psychology standpoint, wellbeing is not limited to the absence of illness or individual mental health. It includes physical, emotional, relational, cultural, and community wellbeing, and emphasises the conditions that support human flourishing, dignity, and connection. This means taking seriously the social, economic, and political determinants of health, and recognising the role psychology can play in either supporting or undermining those conditions. Mainstream psychology has been criticised for adopting a narrow view of its ethical responsibilities, often focusing on individual adjustment or minor reform rather than structural change (Fox et al., 2008).

The goal of liberation, meanwhile, calls us to address not just the experience of illness or distress, but also the underlying determinants and systems that produce inequality. This demands critical attention to power relations—within therapeutic encounters, health institutions, and the discipline of psychology itself (Bolam & Chamberlain, 2003). Practitioners are therefore encouraged to question the assumptions underpinning their work:

- **whose knowledge is prioritised?**
- **how are professional practices shaped by—and shaping—broader social structures?**
- **whose interests are being served?**

Dominant definitions of health are typically set by those with the most societal power. In many cases, policymakers and professionals define health problems and solutions, while the voices of service users—particularly those from marginalised communities, such as Indigenous people, are silenced or ignored (Ratima, et al., 2015; Reid, et al., 2019).

Psychology's dominant values and claims to scientific objectivity have also been shown to align with and reproduce social inequalities (Fox et al., 2008; Burman, 2003; Parker, 2015). Feminist and Indigenous scholars have long pointed out that practitioners from minoritised groups—women, gender-diverse people, Indigenous professionals, and people of colour—are often devalued, sidelined, or excluded (Burman, 2003; Came, 2014; Prilleltensky, et al., 1999).

Institutional hierarchies typically privilege the perspectives of dominant social groups, embedding inequity into psychological systems and practices. As Came (2014) argues, racism remains present in health systems and professional spaces, including psychology. This means that psychology, as a powerful institution, can itself cause harm, particularly for those who are already socially disadvantaged (Fox et al., 2008; Prilleltensky & Nelson, 2017).

These dynamics are also visible in the ways problems and solutions are defined. Health interventions often focus on getting individuals, especially those from lower-income groups, to change their behaviour, rather than addressing the structural conditions that produce ill-health in the first place (Mik-Meyer, 2014). (This relates to the **social gradient in health**; Marmot, 1994, 2002, 2003¹).

1. The social gradient in health refers to the well-established pattern that people with lower socioeconomic status tend to experience worse health outcomes than those with higher status—and that health improves at each step up the social ladder. This isn't just about extreme poverty versus wealth: even small differences in income, education, or occupational status can correspond to noticeable differences in health. The gradient is shaped by unequal access to resources that support health—such as safe housing, quality education, secure employment, nutritious food, and healthcare. Chronic stress from financial strain, discrimination, or lack of control over life circumstances

In closing this section, let me return to the idea of wellbeing and liberation as interconnected goals, and show how this lens might reshape intervention.

Imagine a psychologist working with a client who experiences distress about her body and eating habits. A conventional approach might focus on building self-esteem, teaching cognitive-behavioural strategies to challenge negative thoughts, or offering nutritional guidance. These may be helpful—but a critical psychologist would also ask: What cultural messages about beauty, weight, and morality are shaping this experience? How do gendered, racialised, or classed norms contribute to body shame? And what role does the healthcare system itself play in reinforcing fatphobic or exclusionary assumptions?

Even the setting of care matters. Is this client at a private clinic with mostly affluent patients, or a public service where resources are limited and people may feel stigmatised? When disordered eating is treated purely as an individual issue, interventions often focus on teaching people to “cope” or adapt—rather than challenging the conditions that make distress so common in the first place.

This is not to say therapy is not valuable; but a liberation-focused approach invites broader questions—about power, cultural norms, and social transformation. It creates space for interventions that support individuals **and** push back against the systems that cause harm.

This example highlights a central theme in this chapter: that effective, ethical practice in critical health psychology requires careful reflection on the level at which we intervene and the scope of what we aim to change. Interventions can target individuals, relationships, communities, or broader social systems, and they can range from reactive responses to proactive efforts to promote long-term wellbeing and justice.

Table 3.3.1 (below) offers a way to make these ideas concrete and an overview of what is to come. It brings together two key dimensions: timing and scope of intervention (e.g., is the goal prevention or management?) and **ecological level** (e.g., individual, relational, or collective). This table also reflects three sets of values identified by Prilleltensky and Nelson (2017) as central to **critical health psychology practice**, and which can be used to help guide ethical decision-making in critical health psychology practice, ensuring that interventions are aligned with the goals of wellbeing and liberation at personal, relational, and collective levels. As I discuss in the next section, all interventions are shaped by underlying values and assumptions about what counts as a problem, who is responsible for addressing it, and what kinds of outcomes are prioritised.

Table 3.3.1. Timing and Level/Scope of Intervention from a Critical Health Psychology perspective with practice examples

also plays a role. As Michael Marmot (1994, 2002, 2003), a leading researcher on health inequities, argues: reducing health disparities means addressing the broader social and economic conditions in which people are born, live, work, and age. In critical health psychology, the concept of the social gradient is key to understanding how structural inequality—not just individual behaviour—drives many health problems.

TIMING & LEVEL / SCOPE OF INTERVENTION	◇ PRIMARY INTERVENTION <i>Health promotion / preventing onset of health issue</i> Proactive (universal) → prevent adverse health outcomes → pre-empt: risk factor reduction for entire population, usually via large social changes & public policy	◇ SECONDARY INTERVENTION <i>Early detection & response</i> Proactive (high risk) → early detection to diagnose conditions & prompt treatment → slowing progression & minimising impact	◇ TERTIARY INTERVENTION <i>Managing long-term conditions & improving quality of life</i> Reactive (indicated) → lessen negative impact of health condition & prevent complications
MICRO LEVEL – Individual / intra-personal <i>Values for Personal Wellbeing:</i> • self-determination • protecting health • caring • compassion	• Ensuring access for marginalised groups • Advocating for health services in deprived areas	• Assertiveness training for patients • Communication training for professionals	• Self-determination in rehabilitation • Power sharing in treatment for chronic illness
MESO LEVEL – Interpersonal / relational <i>Values for Relational Wellbeing</i> • collaboration • participation • respect for diversity	• Smoking cessation with emphasis on corporate exploitation • Diet programmes with anti-consumerist framing	• Exercise groups for disadvantaged communities • Organisational changes to reduce staff stress	• Self-help groups for caregivers • Community media to address alcohol use & diet
MACRO LEVEL – Collective <i>Values for Collective Wellbeing</i> • community structures • social justice	• Challenging corporate harm to public health • Promoting equity & social cohesion	• Organisational development for better work culture • Rights & responsibilities for patients/ staff	• Self-instruction on breast or HIV prevention via health awareness campaigns

The above table serves as a touchpoint for the remainder of the chapter as we explore how health issues are defined and addressed in practice.

What is the problem, and what should be done about it? Defining health issues

Determining what exactly needs to change is a fundamental aspect of intervention design, yet it is often overlooked. This is a crucial issue because “different problem interpretations lead to different kinds of solutions” (Fox et al., 2008, p. 7). When this issue of problem definition in health psychology is critically examined, several key questions emerge:

- what is considered a **health issue**, and why? / Why is it framed as a **problem**?
- **who determines** what is ‘good’ or ‘bad’ for health, and on what basis?
- who or what should be the **target** of an intervention, and why?
- what is the **desired outcome**?

These seemingly straightforward and often taken-for-granted questions are crucial in shaping how interventions are framed, designed, and implemented. How a problem is defined directly influences who is targeted, the strategies used, and the anticipated outcomes (Stephens, 2008). If these questions are not carefully considered, interventions may not only fail to achieve their intended goals but could even exacerbate the issue, or create new unintended consequences, as seen in the examples of the cobra effect. Thus, Prilleltensky and Nelson (2002, p. 27) maintain that “each time psychologists define problems, assign roles to themselves and their clients, and determine an intervention, they are enacting values with multiple consequences. Problem definition is not just a professional act but a political one as well.”

In this section, I discuss how decisions about intervening are shaped by a variety of social and contextual factors—such as the type of evidence collected (e.g., statistical data or personal testimonies), national priorities (budgets and policies), pressing local issues, and, importantly, the assumptions, values, and ethics of decision-makers (Stephens, 2008). Making determinations about how to intervene is therefore not always straightforward, because, as Seedhouse (2005, p. xix) argues, these determinations are “based on a point of view about the ways people should and should not behave, and ultimately therefore on some notion of the good society. And since the good society can be thought of in very different ways, and since health promoters inevitably hold a wide range of political philosophies, health promotion is riddled with deep theoretical tensions.” This point is illustrated by Seedhouse’s (2005, pp. 68–69) (tongue-in-cheek) example of two “morally controversial health promotion plans” related to smoking, shown in Textbox 3.

Textbox 3: Morally controversial health promotion plans

Plan A: HEALTH PROMOTERS SHOULD *ENCOURAGE* PEOPLE TO SMOKE

RATIONALE

- **Coping:** Smoking can help people deal with stress.
- **Economic Benefits:** (a) boost job opportunities in tobacco industry, potentially reduces unemployment-related health issues; (b) increased cigarette sales raise tax revenue, which governments could spend on health
- **Population Impact:** Smokers tend to have shorter lifespans, and encouraging smoking might lower the number of elderly people with chronic illnesses, potentially reducing state spending on geriatric care
- **Social Belonging:** Many young people see smoking as “cool,” which helps them feel a sense of belonging—a factor that is important for overall well-being.
- **Enjoyment:** Most smokers report that smoking is pleasurable

METHODS TO PROMOTE SMOKING

- Advertising Freedom: Advocate for unrestricted advertising of cigarettes, arguing that any legal product should be freely promoted in a capitalist market.
- Enjoyment Guidelines: Provide comprehensive, research-based advice on how to get the most enjoyment from smoking—such as tips on choosing the right cigarette, using filters appropriately, and determining optimal smoking frequency.
 - Highlighting Benefits: Publicise the mental and social benefits of smoking.

Plan B: HEALTH PROMOTERS SHOULD TRY TO *STOP* PEOPLE FROM SMOKING

RATIONALE

- **Health Impact:** Smoking causes illness, shortens lives, and reduces physical fitness.
- **Economic Costs:** Treatment for smoking-related diseases is expensive, often straining public funds, and contributes to absenteeism and reduced productivity.
- **Wider Harm:** Smoking harms non-smokers through passive exposure and imposes additional economic costs on taxpayers.

- **Aesthetic and Hygiene Concerns:** Smoking is considered unattractive (it stains) and unhygienic (unpleasant odour).

METHODS TO PROMOTE SMOKING CESSATION

- **Education:** Provide clear, comprehensive evidence about the harms of smoking so that individuals can make informed decisions.
- **Training:** Offer accessible and widespread stop-smoking programs and techniques wherever people smoke, ensuring ample opportunities for behaviour change.
- **Indoctrination:** Distribute anti-smoking propaganda to counteract tobacco marketing, using powerful imagery and messages that emphasise the severe health risks and ethical issues associated with the tobacco industry.
- **Legislation:** Implement policies such as banning tobacco advertising, imposing high taxes on tobacco products, restricting smoking in public places, and requiring smokers to cover the costs of their smoking-related medical treatments.
- **Prohibition:** In extreme cases, consider the outright banning of smoking to protect public health and refuse government subsidy for smoking-related healthcare.

Seedhouse notes that while Plan A may seem clearly problematic—possibly even shocking—and Plan B might appear to need less ethical justification at first glance, both plans arise from different interpretations of smoking’s benefits. Hence, both approaches to smoking can be thought of as morally controversial, even if one appears less problematic because it conforms to our widely accepted belief that smoking cessation is inherently “good”. While this may seem self-evident, Seedhouse (2005) reminds us of the importance of distinguishing between objective facts and the value judgments that underpin them. Neither plan is a value-neutral response to the evidence; instead, each is built from a mix of empirical data and value-driven opinions, resulting in a specific health promotion strategy. Seedhouse (2005, p. 68) depicts this as:

Various pieces of EVIDENCE + various sorts of OPINION [based on values] = health promotion PLAN.

The example of these two plans, shows how different political, professional, and cultural standpoints about what is considered “good” or “bad”—and hence what the ideal outcomes should be—generate vastly different approaches to the same issue. In line with these differing sets of values and assumptions, different kinds of evidence are seen as valuable, and interpreted and used to support different approaches and envisaged ideal outcomes. Thus, defining what constitutes a health problem is never a neutral or purely technical process. It is always shaped by human values and assumptions, even intervening in health issues that one might take for granted as obviously harmful or “bad”, and for which there might be a wealth of evidence, as in the case of smoking (Dawson & Grill, 2012; Signal, et al., 2015). Ultimately, “what constitutes a health problem is largely in the eye of the beholder” (Mik-Meyer, 2014, p. 32).

For our purposes of reflecting on health psychology practice, we might then say: **EVIDENCE + OPINION [values and assumptions] = PROBLEM DEFINITION and INTERVENTION APPROACH**. I discuss each of these aspects (evidence; values and assumptions) separately below, but by the end of the discussion it should become apparent how interrelated they are.

Evidence-informed practice (and its limitations)

Understanding the causes of health and disease is essential for effective intervention. Evidence is crucial as it provides justification for specific approaches to interventions—the ways they are planned and designed to be applied by professionals. Evidence of a health issue can help identify its relevant causes, determine whether to intervene, design interventions, and evaluate outcomes. (Carter et al., 2011; Raphael, 2000). Evidence-based practice is therefore often championed. The challenge, however, is that evidence signals that something *should* be done, but not necessarily *what* to do or *how* to do it (Carter et al., 2011). As Carter et al. (2011, p. 456) point out:

“Evidence-informed practice is never straightforward ... not least because it is social and political, involving contests between community, corporate, bureaucratic, and political stakeholders.”

Firstly, what counts as valid evidence might be disputed. For example, some health promoters see quantitative evidence like epidemiological data as more objective and reliable than qualitative data like patient narratives or community needs assessments (Stephens, 2008). Secondly, the determinants of a health issue may be debated. There are frequent disputes over which factors contribute to health outcomes, whether a particular factor plays a role at all, and how significant it is compared to others. These disputes are often related to the value people place on certain factors, and the implications of identifying them as risk factors, particularly in terms of what actions should be taken in response. Finally, regardless of the evidence that is ultimately used, it requires interpretation, inevitably bringing values and worldviews into play. These all influence which causal factors are considered in the design, execution, and evaluation of interventions (Hickson, 2015; Raphael, 2000).

The role of values and assumptions in defining health problems

Defining what constitutes a health problem is never a neutral or purely technical process—it is always shaped by human values. Although health work—like disease prevention or rehabilitation—may seem inherently moral or “good”, closer reflection reveals that every aspect of it is ultimately driven by value judgments (Seedhouse, 2008). As Carter et al. (2011) note, values underlie all health interventions. The example of the morally controversial plans above prompts us to ask: **What values underlie each plan, and how should health psychologists decide between them?**

Values are principles that guide behaviour, and so guide decisions about which issues are labelled as “problems”, who or what becomes the focus of intervention, and what outcomes are prioritised (Prilleltensky & Nelson, 2017). In this sense, values are not just personal preferences about what matters, but broader ideological commitments—beliefs about how society should function, what is desirable, and what constitutes a “good life”. In Western contexts, for instance, a “healthy weight” is often framed through a biomedical lens that emphasises individual responsibility, discipline, and self-control. As Mik-Meyer (2014, p. 31) argues, this framing “praises certain physical measurements of the body, as well as dominant societal values such as self-responsibility and self-control”. It can lead to moralising portrayals of those considered overweight as lazy or psychologically troubled, or even bad parents or partners according to research in this area (Warbrick et al., 2018). Yet these portrayals reflect only one value system. Other cultural or political traditions may define health—and desirable bodies—differently.

Alongside values, interventions are also shaped by **assumptions**—people’s (often unspoken) beliefs about how the world works. These include assumptions about human nature (e.g., whether people are rational decision-makers), about causality (e.g., whether health outcomes are due to individual choices or structural forces), and about professional roles (e.g., whether practitioners are experts or facilitators) (Prilleltensky & Nelson, 2017). Such assumptions influence how health problems are framed, the kinds of explanations that are prioritised, and which solutions are considered viable (Stephens, 2008). For example, assumptions about personal agency often underlie behaviour-change models, whereas assumptions about structural inequality might inform approaches focused on social determinants of health. Some assumptions can appear “natural” or “commonsense”, but all are historically and culturally situated. When unexamined, they can lead to interventions that reinforce dominant ideologies, exclude alternative ways of knowing, or inadvertently marginalise those they intend to help (Metzl & Hansen, 2014; Prilleltensky & Prilleltensky, 2006; Prilleltensky & Nelson, 2017).

How should we help?

Once a health issue has been defined, decisions must be made about what kinds of interventions are appropriate, ethical, and effective. This section explores three interrelated aspects that shape intervention practice in critical health psychology:

- 1. values and assumptions shaping professional responses to health issues;
- 2. ethical principles guiding decision-making; and
- 3. theoretical frameworks informing how problems and solutions are conceptualised.

Together, these elements play a role in how practitioners engage with individuals and communities, and how they strive to promote wellbeing and social justice in real-world contexts.

Values and assumptions shape modes of practice

Values and assumptions are intertwined and produce distinct modes of practice—that is, characteristic ways of understanding problems and intervening in people’s lives (Prilleltensky & Nelson, 2017). Together, they shape what is seen as problematic, what kinds of change are considered appropriate, and who is responsible for achieving it. The interplay between values and assumptions is helps explain why different practitioners interpret and address the same issue in markedly different ways. Consider the contested issue of “teenage pregnancy”², for instance. It is more than a health concern; it is a morally charged topic with multiple, often conflicting framings, each reflecting different assumptions and values and, in turn, different responses to the issue (Macleod, 2014; Pihama, 2011), as summarised in Table 3.3.2.

Table 3.3.2. Framing “Teenage Pregnancy” – Values, Assumptions, and Intervention Approaches

2. I use scare quotes here to signal that this term is contested as morally loaded and problematic, as discussed by Macleod (2014).

Framing	Assumptions	Values	Intervention Approaches
Individual problem →focus on personal responsibility and behaviour	- women are more capable of managing sexual desire than men - women can avoid pregnancy through their conduct; men can't really be held responsible for sexual behaviour	- individual responsibility, choice, and control - maintaining traditional Western gender roles	- abstinence-only sexuality education ("say no") - contraception and assertiveness training for young women
Gendered social issue →emphasis on power, inequality, and structural factors	- sexual responsibility is shared - gendered power dynamics contribute to men's sexual coercion of women	- gender equity - Social justice and transformation	- consent-based relationships and sexuality education for all - men-as-partners programmes and sexual violence interventions - women's shelters and support services

Likewise, in clinical work, for example, practitioners working with people living with type 2 diabetes, may focus on behaviour change—such as increasing exercise or improving diet. While this is often helpful, framing the issue primarily in terms of individual choices or motivation can obscure the broader social, emotional, and economic contexts shaping those behaviours, including factors like food insecurity, the emotional toll of stigma, caregiving responsibilities, and limited access to affordable healthcare. A more holistic approach might involve working collaboratively with clients (and, where appropriate, their whānau) to explore how these wider factors influence their health, and to co-develop strategies that acknowledge both personal agency and structural constraints. This broader framing also invites psychologists to advocate for culturally responsive care and more accessible services, as argued by scholars calling for greater attention to structural and contextual factors in clinical work (Metzl & Hansen, 2014; Prilleltensky & Prilleltensky, 2006; Prilleltensky & Nelson, 2017).

Whether in health promotion or clinical practice, the values embedded in interventions influence not only how support is provided, but **what kinds of behaviours, choices, and ways of living are encouraged or discouraged**. As Mik-Meyer (2014, p. 31) notes, “**health psychology interventions often implicitly prescribe how people ought to live**, based on their ideas of what is good, correct, or worthwhile”. By this point in the discussion, it may become apparent that values and ethics are deeply connected. To illuminate this further, let me return to the earlier example of smoking. Since smoking is known to harm health, it is commonly accepted that it should be discouraged or restricted in certain contexts, and that working toward reducing smoking rates is *inherently ethical* (Seedhouse, 2004). Ethical considerations involve determining what actions best ensure human wellbeing—judgments about what is good or valuable (Carter et al., 2011). Thus, it is crucial to reflect on the ethical dimensions of intervening in people's lives, both for moral reasons and for the practical effectiveness of interventions (Guttman, 2017), as discussed in the following section. This is another aspect of the question about the “how” of health psychology intervention.

Ethics and decision-making in health psychology practice

While values and assumptions shape how practitioners understand and approach health issues, ethical considerations come to the fore when deciding how to intervene. Guttman (2017) highlights key ethical

concerns in health interventions, including the potential infringement on privacy, autonomy, and equity. Some interventions may unintentionally widen social disparities, benefitting those who are already better off while further disadvantaging marginalised groups (Reid, 2015). Additionally, interventions can have unintended psychological and social consequences, such as reinforcing stigma or labelling individuals in harmful ways (Lupton, 2015; Warbrick et al., 2018). They may also shape cultural norms by idealising certain lifestyles (such as being thin, fit, or self-disciplined), and by promoting the idea that being healthy is a moral obligation. This can create pressure to conform and exclude or judge people who do not or cannot meet these ideals (McPhail-Bell et al., 2015). In doing so, such interventions raise questions about whether people are genuinely able to make free and informed choices, and whether public health decisions reflect open, democratic debate or top-down agendas—concerns long raised in critiques of *healthism* (Crawford, 2006). These tensions are particularly acute in areas of health psychology that deal with morally charged issues, such as substance use, sexuality, and reproductive health. In these contexts, values often come into conflict and must be carefully weighed—sometimes even traded off (Carter et al., 2011; Carter, Cribb & Allegrante, 2012). The following two common ethical dilemmas in health interventions help to illustrate these challenges:

Should individual freedom be restricted to protect health?

Interventions related to smoking, alcohol use, or drug consumption reveal tensions between personal freedom and promoting collective wellbeing. Some argue that competent adults should have the right to make their own health choices, provided they do not harm others. From this perspective, harm reduction approaches—such as needle exchange programmes, methadone clinics, or vaping as a substitute for smoking—are considered to offer pragmatic solutions without coercion (Seedhouse, 2005; Guttman, 2017). Others, however, see illicit drug use as a broader societal threat that undermines social safety and stability, work ethics, and legal order. From this standpoint, minimising drug use is seen as essential to protecting society's core values (Seedhouse, 2005).



Figure 3.3.3 The issue of personal rights versus collective welfare became an issue in relation to public health restrictions during the COVID-19 pandemic. (Photo by Liza Poor via Unsplash. [Unsplash license](#))

Is it justifiable to use fear, shame, or disgust to motivate behaviour change?



Figure 3.3.4 Images from a “Childhood Obesity” campaign in the USA. (Copyright holder unknown. Retrieved from [American Society for Nutrition blog](#))

The image above of solemn-looking children labelled as “chubby” or “fat” is from a U.S. campaign on childhood obesity. The campaign targeted caregivers/parents with a combination of messages intended to arouse fear (e.g., “WARNING”, “*Chubby kids may not outlive their parents*”, and “*He has his father’s eyes, his laugh, and his diabetes*”), as well as blame, and shame by positioning caregivers as wholly responsible (“*Big bones didn’t make me this way. Big meals do*, or “*Fat kids become fat adults*”). This messaging was supported by videos featuring children making painful statements about their weight, for example, a boy gravely asking his mother, “*Why am I fat?*” (Perry, 2012). Advocates believed these messages would galvanise parents into addressing their children’s health. However, several critics questioned the ethics of victim blaming and the use of guilt and fear, especially without offering a clear solution (Freeman, 2011).

As these examples highlight, health interventions may require decisions about ethical trade-offs—for instance, between individual rights and collective wellbeing, or between persuasion and coercion. While interventions may offer benefits, they can also cause harm, especially when they reinforce stigma, restrict autonomy, or ignore context. Sometimes a “win-win” solution is possible, but often difficult choices must be made. To guide this kind of ethical reflection, practitioners can draw on specific concepts that help evaluate the implications of different health interventions.

Ethical concepts

Ethical concerns can surface at any intervention level, whether the goal is to prevent the onset of disease (primary), detect and address it early (secondary), or limit the damage and promote wellbeing despite chronic conditions (tertiary). It is therefore critical to remain mindful of how well-intentioned strategies may inadvertently harm individuals, undermine autonomy, or reinforce stigmas. **Iatrogenic outcomes** refer to

unintended harm from interventions. Health interventions can sometimes lead to unintended negative consequences, for example:

- fear-based campaigns may cause resistance, fatalistic thinking, or avoidance rather than behaviour change.
- routine screenings can cause distress due to false positives or overtreatment of slow-growing conditions, such as unnecessary cancer surgeries.
- chronic disease management interventions may increase psychological strain if patients feel pressured into invasive monitoring or rigid lifestyle changes.

Avoiding such outcomes requires complex reflexivity. Explicitly identifying ethical concepts provides the basis for explaining and discussing decision making, monitoring and evaluation, and accountability to stakeholders (Carter et al., 2011; Stephens, 2008). Table 3.3.3 provides an overview of some ethical concepts that arise in health interventions that health psychologists may be involved in (highlighted in Guttman's (1997) discussion).

Table 3.3.3. Ethical Issues in Health Psychology Interventions

ETHICAL ISSUE	Example in Health Promotion	Example in Clinical Practice
Coercion: Restrictive policies infringe on freedom of choice	Banning sugary drinks or trans fats without public input	Involuntary psychiatric treatment without patient consent
Control: May serve as a means of social or organisational control	Employer health screening policies linked to insurance benefits	Monitoring patient adherence through digital tools without consent
Culpability: Unfairly placing blame on individuals or groups	Framing obesity as a personal failure in health campaigns	Blaming patients for their poor outcomes despite structural barriers
Depriving: Denying pleasures that others can afford	High tobacco taxes limiting access for low-income groups	Restricting access to certain treatments based on funding or location
Distraction: Health focus diverts attention from larger social issues	Focus on personal diet distracts from environmental health issues	Focusing on individual resilience instead of workplace burnout causes
Exploitation: Using marginalised groups to deliver services or achieve goals	Relying on community groups to provide services without funding	Expecting cultural navigators or kaumātua to work unpaid
Harm reduction: Supporting non-approved behaviours to reduce harm	Needle exchange programmes	Providing opioid substitution therapies like methadone
Health as a value (healthism): Promotes moralism at the expense of other values	Glorifying health behaviours over community or cultural values	Promoting 'health responsibility' while ignoring trauma or social determinants
Labelling: Harm caused by stigmatising or labelling individuals	HIV campaigns portraying people with HIV as dangerous	Labelling patients as 'non-compliant' or 'treatment resistant'
Persuasion: Persuasive strategies may arouse anxieties or fears, be manipulative, or impinge on individual rights	Graphic anti-smoking ads using fear to change behaviour	Using fear-based messaging to promote compliance with psychiatric medication
Privileging: Benefits unequally distributed based on social power	Medicalising cholesterol levels to prioritise detection in affluent groups	Private services offering better chronic disease care for those who can pay
Promises: Making promises that may not be realistic or beneficial	Messages that imply lifestyle changes guarantee long life	Telling patients treatment will 'cure' them when prognosis is uncertain
Targeting: Strategies may widen inequalities or ignore cultural relevance	Targeting low-income groups with dietary advice that they cannot act on	Cultural tailoring of interventions that overlook Indigenous worldviews

Next, I home in on some common concepts that might be used to evaluate the ethical implications of

health interventions, namely, stigma, paternalism, and victim blaming. Although these often overlap, for simplicity, I discuss them separately.

Paternalism – interfering “for their own good”

Paternalism, according to Carter, Cribb, and Allegrante (2012, p. 10), “gathers several, usually three, meanings into a single word: **interfering with a person’s autonomy or liberty**, doing so **without their consent**, and doing so **for their own good**. It is possible to justify all of these, depending on our view of a good society, and on the particular case”. Paternalistic interventions are often justified as protecting people from harm, for example, through coercive public health messaging, restricting treatment options, or steering patients toward particular choices. While often framed as benevolent, such practices can undermine trust, particularly when people feel excluded from decisions about their care (Brown, 2018). This is especially problematic for socially marginalised groups (e.g., women, Indigenous peoples, and people of colour) whose concerns are often ignored, dismissed, or pathologised (Barnes, 2015; Heard et al., 2020). For example, McPhail-Bell et al. (2015) show how Indigenous health promotion in Australia can reproduce colonial control, despite claiming to promote empowerment. Thus, “disrupting established norms and ‘expertise’ requires taking the perspective of those populations whose social and health realities remain at the margins” (Hankinsky & Christofersen, 2008, p. 278).

Victim-blaming – ignoring structural barriers

Health interventions can sometimes place undue responsibility on individuals while overlooking broader social determinants. This is evident in:

- health promotion campaigns implying that people *choose* ill-health simply by failing to exercise or eat well.
- blaming individuals for late diagnoses due to missed screenings.
- labelling certain clients “non-compliant”, without considering contextual or structural barriers (e.g., poverty, inadequate healthcare access, cultural health literacy differences).

This kind of thinking, often called *victim-blaming*, assumes people have full control over their health and can always make “good choices” if they just try hard enough. Research shows that is not realistic; people’s health is shaped by many factors outside their control, including housing, income, racism, and access to healthcare (Carter et al., 2012). Victim-blaming does not just miss the bigger picture—it can harm the people it is trying to help, and discourage engagement with services. Framing health as a personal responsibility can lead to shame and blame, especially for people living with chronic illness or from marginalised groups (Brown, 2018). For example, mental health workers supporting people with cancer have raised concerns about anti-smoking interventions that focus on individual-level change only. These behaviour-focused interventions create stigma and shame among people with smoking-related illness, even those who never smoked. Some clinicians have, therefore, questioned whether the health benefits of such approaches are worth the personal costs of stigma and blame (Riley et al., 2017). Ethical practice in both health promotion and clinical settings means taking structural barriers seriously and avoiding messages or approaches that suggest people are solely to blame for their health.

Coercion – restricting choice

While coercion is sometimes necessary to achieve public health goals, it can also infringe on individual autonomy. Examples include:

- restricting substances (e.g., sugar taxes or banning alcohol sales).
- pressuring people into screening programmes with urgent-sounding messages that limit informed choice.
- compulsory rehabilitation under the justification of “protecting” patients.

Carter et al. (2011) note that coercion ranges from reasonable to questionable. Of course, what counts as “reasonable” is, as discussed earlier, open to debate. Ideas about what is acceptable or justified often reflect particular values, cultural norms, and assumptions about health, responsibility, and risk. These judgments are not neutral—they are shaped by broader social and political beliefs. Therefore, based on one’s values, unreasonable coercion may involve **encouraging negative self-perceptions** (e.g., labelling individuals as lazy, irresponsible, or dangerous) or **amplifying fear around health risks, even for low-risk individuals**. For example, campaigns targeting body weight often use population-level data to suggest that any increase in waist size leads to serious illness, such as cancer or heart disease. This can prompt fear and self-surveillance in people who are not at high risk, encouraging them to see themselves as unhealthy based solely on weight, regardless of their actual health status (Carter et al., 2011).

Stigma and reinforcing social marginalisation

Interventions can stigmatise individuals by portraying them in negative ways and as responsible for their health problems. For instance:

- anti-smoking campaigns that frame smokers as reckless.
- patients declining screenings or struggling with treatment regimens may be labelled as “non-compliant” or “difficult”.
- repeated hospital admissions may result in patients being seen as lacking insight rather than acknowledging systemic issues affecting recovery.
- health psychology practitioners must be cautious not to reinforce biases or present individuals as burdens on healthcare systems.

Discussing this issue in the context of anti-smoking campaigns, Riley et al (2017) assert, “There is an ethical burden for creators of public health campaigns to consider lung cancer stigma in the development and dissemination of hard-hitting anti-tobacco campaigns. We also contend that health care professionals have an ethical responsibility to try to mitigate stigmatizing messages of public health campaigns with empathic patient-clinician communication during clinical encounters”. These comments apply to other health issues where stigma is used to try to promote behaviour change. Weight management is a good example, as shown in the following example.

An example: Applying ethical concepts to “How do you measure up?” campaign video

The Australian social marketing campaign *How Do You Measure Up?*, which targeted adult weight through mass media messaging, provides a good example of ethical concepts in practice. While social marketing campaigns like this represent only a fraction of health promotion efforts, their high visibility and resource intensity make them particularly worthy of scrutiny (Carter et al., 2011). Below is a television advertisement from the campaign. As you watch it, think about what ethical issues their approach raises.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/critical-health-psychology/?p=832#oembed-1>

Carter and colleagues argue that this campaign relied on coercive and stigmatising tactics—framing weight as a personal failing, appealing to parental guilt, and encouraging self-surveillance. Lupton (2015) critiques this campaign (and others like it) for using what she calls the “pedagogy of disgust,” in which shame and revulsion are deliberately evoked to influence behaviour. These strategies raise serious ethical concerns about autonomy, dignity, and unintended harm, particularly for people already marginalised due to body size, socioeconomic status, or health history (Warbrick, et al., 2019). In this vein, Warbrick et al.’s (2019) work shows how obesity prevention campaigns rely on fat-shaming tactics that disproportionately target Māori, reinforcing stigma and colonial narratives of personal failure. These approaches not only ignore structural conditions like food insecurity or racism in healthcare, but also cause harm by deepening shame and marginalisation.

Similar ethical concerns can also arise in clinical contexts—such as when weight is treated as the primary health concern without considering broader social, psychological, or metabolic factors. Interventions that fail to engage with patients’ lived realities may risk reinforcing stigma or overlooking structural barriers to health. As discussed in [Chapter 2.2](#), this narrow framing can overlook cultural understandings of health and body size, reinforce stigma, and sideline structural issues. Failing to engage with patients’ lived realities may risk undermining trust and causing harm, even when well-intentioned.

Theoretical assumptions: using theory reflexively in practice

In addition to values and ethics, health psychology interventions are shaped by theoretical assumptions—often implicitly. Being reflexive about the theories used helps clarify goals, illuminate the complexity of health issues, and anticipate the social and political effects of one’s work. The reflexive use of theory helps:

- guide practitioners’ understanding of health issues and their targets for change.
- clarify the complexities of health-related behaviours and practices.
- incorporate insights about social systems, structures, and contexts.
- encourage critical reflection on assumptions, professional roles, and responsibilities (Stephens, 2008).

Stam (2000, p. 274) argues that the explicit use of theory “is **one of the most crucial steps of our entry into the world of health, disease and illness precisely because it establishes nothing less than our political, epistemological and moral grounding. It also establishes our responsibility as professionals who intervene in the lives of others.**” The theoretical lens used to understand a health issue—specifically, what is considered to determine good or poor health—shapes the intervention design. Defining intervention targets involves deciding who or what the intervention will focus on (Nutbeam et al., 2010). As discussed earlier (see Table 3.3.1), this corresponds with different **levels of intervention**: individual, interpersonal, community, and societal. For instance, supporting children with diabetes might focus on individual behaviour change, family dynamics, school policies, community resources, or broader policy measures, or a combination of these. The figure below also provides a detailed summary.



Figure 3.3.5. Levels of intervention with examples. [Read the full image description.](#) (Tracy Morison. [CC BY-NC 4.0](#))

To illustrate, consider the following two Australian interventions based on evidence generated using two different theories, as summarised in Table 3.3.4:

1. The **Active Teen Leaders Avoiding Screen-time (ATLAS)** intervention for teen-aged boys (12 – 14 years old) that used socio cognitive theory (Smith et al., 2014); and
2. The **Be Active Eat Well (BAEW)** programme for children (4 – 12 years old) that took a socio-ecological approach (Sangiorski et al., 2008; Waters et al., 2011).

Table 3.3.4. Comparison of health promotion interventions for children's weight

Intervention	ACTIVE TEEN LEADERS AVOIDING SCREEN-TIME (ATLAS) – Smartphone obesity prevention trial	BEACTIVE, EAT WELL (BAEW) – Community capacity-building programme promoting healthy eating and physical activity.
Theoretical basis	Social-cognitive	Socio-ecological
Core Assumptions (based on theory)	• Individuals have choice and control. • Behaviour is made up of independent choices. • Behaviours can be examined in isolation. • People do not always think deeply about health.	• Behaviours are context-dependent • Material/social constraints limit choice. • People (especially children) may lack the power to make changes. • Behaviours interconnect & form a complex whole.
Rationale	If children are informed about negative health effects and given enjoyable alternatives, they will adopt healthier behaviours.	Children's behaviour change occurs by addressing both individual actions and broader social/physical environments.
What must change?	Children's lifestyle behaviours: • Less screen time • More physical activity	Children's behaviours + wider (physical and social) environment: • Decrease screen time; sugary drinks + snacks • Increase water + fruit; active play/transport • Supportive social norms • Community capacity building
Targets	Individual children, teen-aged boys in low-income communities	Children aged 4 to 12 years within their communities (multi-level approach)
Strategies	Self-monitoring, goal setting, and education	Combining behaviour-focused strategies with supportive changes in the physical and social environment.
Key acknowledgements	• Health knowledge and self-efficacy matter. • Social norms influence behaviour. • Individuals can be at different "stages of change."	• the importance of the context – health practices are shaped by the environments in which people live, work, play and learn • environment as having both physical and social dimensions • the importance of "health- enabling social environments"
Limitations	• Behaviours/choices do not occur in a vacuum. • Often ignores socio-economic and environmental contexts.	• Barriers to sustainable change.

Intervention	ACTIVE TEEN LEADERS AVOIDING SCREEN-TIME (ATLAS) – Smartphone obesity prevention trial	BEACTIVE, EAT WELL (BAEW) – Community capacity-building programme promoting healthy eating and physical activity.

This example shows how a **socio-cognitive approach** assumes that health issues stem from individuals' or groups' modifiable behaviours, attitudes, or beliefs. This implies that change can be achieved by altering these factors through education, skill-building, or environmental adjustments. Accordingly, the *Active Teen Leaders Avoiding Screen-time* intervention focused mainly on individuals and interpersonal influences. In contrast, **socio-ecological models** recognise that health determinants operate at multiple levels, from individual behaviours to social relationships, institutional policies, and broader socio-political structures (Signal et al., 2013). Hence, the *Be Active, Eat Well* programme took a multi-level approach, targeting these interconnected layers rather than solely focusing on individual choices.

As Table 3.4.4 highlights, the approaches taken in both interventions have limitations. This is because each theoretical frame offers a particular and *partial* perspective on an issue. No theory is perfectly complete. These limitations are made explicit through reflexive engagement with theory, encouraging critique and improvement. Reflexivity allows practitioners to acknowledge the knowledge and assumptions underlying their approach, fostering openness to alternative perspectives (Stam, 2000; Nutbeam et al., 2010).

The use of reflexive theory can help ensure that the approaches taken align with the values, needs, and experiences of affected individuals, groups, or communities. This is particularly evident in an example of suicide prevention efforts for Indigenous communities. Mainstream prevention models often focus on individual risk factors, neglecting broader cultural and historical determinants of wellbeing. The continued higher rates of suicide among Indigenous communities than their non-Indigenous counterparts suggest a need for more holistic interventions that incorporate Indigenous culture (Sones et al., 2010). Reflexivity is needed in theoretical framing to allow for participatory design and cultural safety and generate more effective and empowering mental health interventions for Indigenous communities. Some examples of such approaches include the culture-based framework for mental wellbeing within Manitoba First Nations communities, which employs community-based participatory research to co-create interventions with First Nations leaders, incorporating relational approaches, land-based healing, and Indigenous governance over mental health services (Kyoon-Achan et al., 2018). Similarly, Australia's Social and Emotional Well-being Model was developed through participatory action research with multiple Indigenous communities, affirming cultural knowledge and promoting collective healing and relational resilience (Dudgeon, 2020).

Summing up

Values, ethics, and theoretical assumptions all play a central role in shaping how health

psychologists understand problems and design interventions. Together, they guide decision making about *what should be done, why, and how*. Being explicit about ethical considerations can help practitioners explain and justify their choices, especially in contexts where decisions may affect marginalised or vulnerable groups. Ethical frameworks must be sensitive to local contexts, taking seriously the material conditions and lived realities of the people most affected. This ensures that interventions are relevant, equitable, and unlikely to cause unintended harm. (Remember the cobra effect!) Similarly, theoretical assumptions—often operating implicitly—shape how health issues are defined and what kinds of change are prioritised. Reflexively engaging with theory helps practitioners clarify their goals, anticipate consequences, and align their strategies with the values and needs of communities (Stephens, 2008; Prilleltensky & Nelso, 2017). Professional competency in critical health psychology, therefore, requires a commitment to ongoing reflection on personal, ethical, and theoretical standpoints. This reflective approach establishes clear, intentional standards for practice—helping to ensure that interventions are not only evidence-informed, but also socially just and contextually responsive (Health Promotion Forum, 2012).

Designing and implementing interventions: turning definitions into practice

Applying interventions in real-world settings requires balancing evidence-based practice, community perspectives, policy constraints, and professional judgment (Stephens, 2008). This section explores how health interventions are defined, planned, and implemented through two case studies of HIV/AIDS interventions: the **SiRCHESI Project in Cambodia** and the **Sonagachi Project in India**. Both illustrate the importance of culturally and ethically informed decision making in community and multilevel health promotion efforts.

Lessons for health psychology and intervention design

Both the SiRCHESI and Sonagachi projects illustrate the value of **contextualised, participatory, and multi-level approaches** in health promotion interventions. They highlight:

- the necessity of **integrating social, economic, and cultural considerations** into health interventions (Kerrigan et al., 2006).
- the **power of community-led strategies**, where those most affected actively shape solutions (Dasgupta, 2009).
- the **importance of structural empowerment**, ensuring sustainable, systemic changes that support marginalised populations (Nag, 2005).

These case studies reinforce that effective intervention occurs at all levels, from individual behaviour change to systemic inequalities, to create enabling environments for lasting health improvements (Signal et al., 2013).

The SiRCHESI Project: a participatory approach to HIV/AIDS prevention in Cambodia

The Siem Reap Citizens for Health, Educational, and Social Issues (SiRCHESI) project exemplifies a participatory framework for addressing community health issues in ways that are meaningful to local populations. Founded as an evidence-driven grassroots NGO, SiRCHESI employed Participatory Action Research (PAR) to combat HIV/AIDS in Siem Reap. Over time, the initiative significantly reduced transmission rates, particularly among high-risk groups such as beer sellers (Lubeck et al., 2014).

Background and health issue

Siem Reap, a major tourist hub in Cambodia, was severely affected by the HIV/AIDS epidemic, with some of the highest infection rates in Southeast Asia. The crisis was fueled by sex tourism, poverty, workplace exploitation, and limited access to healthcare, disproportionately affecting women in precarious employment, such as beer promotion and massage services. At the start of the intervention in 2000, 42% of brothel-based sex workers and 20% of beer sellers tested positive for HIV (Stephens, 2008). The following video (supplied by Ian Lubeck) provides the background to this issue, focusing on the beer sellers.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/critical-health-psychology/?p=832#oembed-2>

The crisis was shaped by historical and socio economic factors. Many young Cambodian men had lost their parents during the Pol Pot genocide, which disrupted traditional marriage customs and led to an increase in visits to brothels (Lubeck, 2008). Simultaneously, women with limited education and employment opportunities were funnelled into the entertainment industry, including beer promotion, where low wages and economic necessity led many to engage in sex work for additional income (Lee et al., 2010).



Figure 3.3.6 The Famous “Pub Street” in Siem Reap, Cambodia, once at the centre of a tourism-driven HIV/AIDS crisis. In response, the SiRCHESI initiative took a multi-sectoral, empowerment-based approach to reduce HIV risk by addressing the structural drivers of inequality, including poverty, gendered labour exploitation, and limited access to healthcare. (*Pub Street* by [Ashley](#), 2015 via Flickr. [CC BY-NC-ND 2.0](#))

Intervention strategies and theoretical basis

SiRCHESI adopted a multi-sectoral, empowerment-based approach that addressed individual, social, and structural determinants of health. Hence, the aim was to reduce the spread of HIV in Siem Reap by tackling underlying social inequalities in literacy, employment, poverty, and HIV/AIDS mortality risks. These aims generated specific objectives at different levels:

- *individual behavioural change*: 100% condom use for those at risk of HIV infection.
- *social development*: peer support, literacy education, and employment opportunities.
- *economic development*: Improving local employment conditions.
- *political change*: Lobbying the government and advocating for corporate responsibility.

Lubeck et al. (2014) described the following strategies used in the programme:

- peer education and health workshops to build knowledge, raise critical consciousness (or **consientisation**), and promote safe practices.
- economic empowerment through literacy training and job skill development (helping women transition into safer employment).
- workplace advocacy to improve labour laws and working conditions for beer promoters.
- challenging negative social, community and global structures (e.g., lobbying multi-national beer companies).

In addition, “SiRCHESI constantly conduct[ed] research, so that programme decisions can be informed

by evidence/evaluations, as part of the PAR [Participatory Action Research] framework” (Lubeck et al., 2014, p. 111).

A key innovation was the Hotel Apprenticeship Programme, which originated from the finding that many Cambodian women had been denied jobs in hotels due to a lack of job skills, Khmer literacy, and conversational English, turning to beer promotion as a result. The programme provided literacy, English language training, and professional skills to help beer sellers secure safer, higher-paying jobs in the hospitality industry (Lee et al., 2010; Lubeck et al., 2014). This initiative highlights the connection between economic security, social empowerment, and health outcomes (Carr, 2019). The video below shows some highlights from the author. (Video kindly supplied by Ian Lubeck. Credit: Ian Lubeck and Brett Dickson.)



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/critical-health-psychology/?p=832#oembed-3>

Stephens (2008) explains how these strategies occurred at various levels of change, addressing both immediate individual risks and broader social and economic conditions that contribute to vulnerability to sexually transmitted infection, as summarised in Table 3.3.5.

Table 3.3.5. Strategies and Levels of Intervention

Individual and community level	Community and local institutional level
• Health education workshops for various groups. • Social behaviour-change strategies and negotiation techniques taught to peer educators working with: ▪ Beer promotion women ▪ Married men ▪ Pregnant women ▪ Young souvenir vendors vulnerable to predatory sex tourists • Workplace safety training for women working as beer promoters	• Hotel Apprenticeship Program (HAP): Training and employment pathway to help beer promoters transition to safer jobs in the hospitality sector. • Health and safety legislation to improve workplace conditions for women. • Formation of solidarity groups among beer promoters to strengthen collective advocacy and support.

The Sonagachi Project: a sustainable HIV/AIDS intervention in India

The Sonagachi Sexually Transmitted Disease (STD)/HIV Intervention Program (SHIP) is a globally recognised community health initiative that transformed the lives of sex workers in Kolkata, India. Originally a small-

scale intervention, it evolved into a sustainable, peer-led programme that empowered sex workers to take collective action in reducing HIV vulnerability (Dasgupta, 2009).



Figure 3.3.7 Sex workers in Calcutta take collective action through the Sonagachi Project, redefining sex work as work and HIV as a community and occupational issue. Their leadership was central to the project's success in reducing HIV rates and increasing rights and recognition. (*Indian Sex Workers* by [Ben Sutherland](#), 2009 via Flickr. [CC BY 2.0](#))

Background and health issue

With high HIV rates among brothel-based sex workers, Sonagachi's intervention sought to reframe HIV as an occupational health issue and empower sex workers to advocate for safer working conditions (Bandyopadhyay et al., 2002). The programme engaged over 4,000 sex workers alongside government and non-governmental organisations to research, design, and implement a comprehensive health intervention (Gooptu & Bandyopadhyay, 2008).

Intervention strategies and theoretical basis

The Sonagachi Project moved beyond individual behaviour change approaches (e.g., condom promotion) to focus on environmental and structural factors that shape health risks (Kerrigan et al., 2006). Applying community development theories, the project redefined HIV/AIDS as a shared community issue requiring collective action and dialogue rather than solely an individual responsibility (Dasgupta, 2009). The focus of the intervention thus shifted from individual sex workers' failure to prevent sexually transmitted infections

to the wider context where they work and the community that this work is part of (Campell & Cornish, 2012; Stephens, 2008).

Accordingly, intervention followed a multi-level empowerment approach, working at individual, group, and structural levels to address the broader conditions contributing to HIV risk (Campell & Cornish, 2012; Dasgupta, 2009; Newman, 2003), as shown in Table 3.3.6. The specific strategies that were used included:

- **peer outreach and participation**, with sex workers leading education and advocacy efforts (Newman, 2003).
- **human rights and labour protections**, positioning sex work as legitimate employment deserving of occupational safety measures (Kerrigan et al., 2006).
- **community development and social solidarity**, fostering collective empowerment through worker-led organisations (Bandyopadhyay & Banerjee, 1999).

Evaluations identified the following strategies implemented by the Sonagachi Project as key to increasing the collective ability of sex workers to reduce their vulnerability:

- facilitating a sense of community among sex workers through community meetings, fairs, and protests.
- increasing access and control over material resources via micro-credit and cooperative banking.
- facilitating social acceptance of sex workers by actively involving sex industry and civil society stakeholders.
- decreasing perceived powerlessness among sex workers through capacity-building workshops and seminars (Bandyopadhyay et al., 2002).

Table 3.3.6. Empowerment Strategies by Level of Change

Individual Empowerment	• Enhancing knowledge & skills, particularly in HIV prevention and treatment. • Building self-worth & fostering conscientisation (awareness of one's social context & ability to create change). • Raising awareness of rights among sex workers
Group Empowerment	• Strengthening cohesion & solidarity among sex workers. • Combating stigma, which disempowers individuals & weakens HIV prevention efforts.
Structural Empowerment	• Engaging key institutions (government, public health agencies, police, local officials) to build institutional support. • Establishing dignified health services tailored for sex workers. • Leveraging respected professionals' status to influence policy and practice changes. • Involving brothel madams & male clients to reinforce safe practices & shared responsibility. • Creating conditions for sustainable, system-wide reform that supports the rights & well-being of marginalised communities

Outcomes and global recognition

The Sonagachi Project successfully lowered HIV rates among sex workers and increased their collective bargaining power. It received international acclaim, with UNAIDS recognising it as a “best practices” model for community-led HIV prevention (Newman, 2003). A crucial factor in its success was the active leadership of sex workers, who played a central role in designing and sustaining the intervention (Bandyopadhyay et al., 2002).

Conclusion

This chapter has explored the complexities involved in defining health problems and designing interventions, showing that professional practice in health psychology is never neutral. It is shaped by **values, power dynamics, ethical frameworks, and theoretical assumptions**—each of which influences who gets help, how, and with what consequences.

By taking a **critically reflexive** approach to practice, health psychologists can make more intentional, ethical, and socially responsive decisions. Reflexivity helps surface hidden assumptions, question dominant models, and create space for alternative knowledges and community-driven solutions.

Ultimately, interventions rooted in critical health psychology aim not just to reduce risk or change behaviour, but to promote **wellbeing and liberation** in ways that are **culturally grounded, participatory, and just**. As the field continues to evolve, practitioners must remain open to discomfort, committed to reflection, and attuned to the broader social and structural contexts in which they work.

Takeaway points

1. **A critical lens advances justice** – critical health psychology encourages practitioners to challenge dominant narratives, promote inclusivity, and work toward structural change.
2. **Defining health problems is not neutral** – the identification and framing of health issues are shaped by cultural, social, political, and ethical factors.
3. **Intervention is never neutral** – all interventions reflect particular values, worldviews, and power dynamics. Recognising this helps practitioners act with greater accountability and care.
4. **Practitioners are not outside the system** – health psychologists are shaped by the same social norms, structures, and power relations they aim to address. Reflexivity involves locating oneself within this context.
5. **Unintended consequences are common** – even well-intentioned interventions can backfire if they overlook context, power dynamics, or the perspectives of those most affected.
6. **The power of framing** – how a health issue is defined and understood shapes decisions about who or what should change and what strategies are considered legitimate.
7. **Reflexivity is essential** – health psychology practitioners must critically reflect on their assumptions, values, and theoretical frameworks to ensure ethical and contextually relevant interventions.
8. **Reflexive use of theory strengthens practice** – applying theory consciously and critically helps practitioners design thoughtful, effective, and accountable interventions.

9. **Ethical practice involves navigating tensions** – practitioners often face competing priorities and must make difficult choices. A critical perspective supports transparent, principled decision-making.
10. **Ethical and cultural safety considerations matter** – practitioners must engage with ethical principles, cultural safety, and (in Aotearoa New Zealand) Te Tiriti o Waitangi commitments to avoid reinforcing inequities or causing harm.
11. **Match the strategy to the level** – effective interventions require clarity about whether change is needed at the individual, interpersonal, organisational, or systemic level—or across multiple levels.
12. **Participation and equity strengthen impact** – interventions co-designed with affected communities—especially marginalised groups—are more likely to be effective, ethical, and empowering.

[Learn more](#)

Further reading

- Ahuriri-Driscoll et al., (2025). *Cultural safety in health: Professional practice, pedagogy & research*. Queensland University of Technology. <https://doi.org/10.5204/book.eprints.25>
- Psychologists are guided by ethical principles and codes of conduct to ensure responsible and ethical practice, encompassing areas like beneficence, fidelity, integrity, justice, and respect for rights. For example, the American Psychological Association (APA) publishes the [Ethical Principles of Psychologists and Code of Conduct](#) detailing aspirational principles and enforceable standards that U.S. American psychologists should use when making decisions. To find your country's code, visit your local professional board's website.

Multimedia

- **Watch** Isaac Prilleltensky's highly engaging TED Talk "[Community Well Being: Socialize or Social-Lies](#)"



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/critical-health-psychology/?p=832#oembed-4>

- **Watch** the following video in which researchers Puhl, Reudicke, and Peterson (2013) systematically assess public perceptions of obesity-related public health campaigns in the USA. Their findings on the effectiveness of using stigma and shame in health promotion communication are discussed in the video.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/critical-health-psychology/?p=832#oembed-5>

Full image description of Figure 3.3.5. Infographic showing three levels of health psychology intervention: Primary intervention (health promotion and prevention): focuses on reducing risk factors and preventing illness through actions like community co-design, peer education, and addressing social determinants. Secondary intervention (early detection and response): involves slowing disease progression and diagnosing conditions early—for example, mental health screenings or support for newly diagnosed patients. Tertiary intervention (managing long-term conditions): aims to lessen the impact of chronic illness and improve quality of life through psychological support, behaviour change programs, and rehabilitation. The infographic notes that these levels are not mutually exclusive, and that programmes working across individual, community, and societal levels tend to have the greatest impact. [\[Back to figure\]](#)

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3.4 Disability and critical health psychology: Applications for work and everyday life

REBEKAH GRAHAM AND KATHRYN MCGUIGAN

Overview

Historically, critical health psychology has not treated disability equitably and has tended to erase disability spaces from texts and exemplars. This chapter is one step towards addressing this oversight. We provide practical suggestions for ways in which practitioners of critical health psychology (and anyone) can apply critical health psychology ideas and approaches in everyday work and home life. It also provides a starting point for addressing systemic changes. Firstly, we explore the history of disability and review different models of disability. The chapter then moves to defining ableism and considers how taking a critical health psychology approach provides opportunities to address ableism. Following this, the chapter focuses on Aotearoa New Zealand and contemporary disability practice. Indigenous approaches are discussed with examples from Aboriginal and Torres Strait Islanders and Māori. Lastly, the chapter reflects on the intersections with marginalised groups and provides examples from specific disability communities (Blind/low vision, Neurodivergent, chronic illness and Rainbow communities experiences with disability). The question we address in this chapter is: **“can critical health psychology practitioners use disability theories and models in practice”?**

Learning objectives

- Explore this history of disability and review three different models of disability.
- Recognise ableism and start to consider how critical health psychology might provide opportunities to address ableism.
- Explore disability in Aotearoa New Zealand including Indigenous approaches.
- Review case studies to explore disability work in practice in the community.

Critical health psychology and disability

There has been a consistent lack of attention paid to **disability** by critical health psychology and psychology in general, with a few exceptions (Quirk, 2022). A focus on the **biomedical** approach to disability has resulted in psychological research undertaken from a deficit-oriented lens and an individualistic approach to disability, tending to exclude disabled people and focusing on overcoming impairment, which can be damaging (Goodley et al., 2017). There has been even less work with Indigenous approaches to disability. In contrast, a critical health psychology approach emphasises the importance of integrating and incorporating disabled people and families throughout. Critical health psychology is also grounded in grassroots activism,

advocacy groups, organisations, and movements, that support work that addresses equity, systemic and structural barriers, and the role of the social determinants of health. Critical health psychology tends to also take an intersectional approach when working in health.

Globally, there have been and remain ongoing calls for disabled persons worldwide to have self-determination with regard to decision making (Charlton, 1998; Wong, 2020). The phrase “nothing about us without us” reflects this clear call from the disability community. Self-determination is a core orientation for critical disability studies, which utilises the socio-political construction of disability in arguing for the full social inclusion of disabled persons (Meekosha & Shuttleworth, 2017). However, while the discipline emphasises the need for social change to challenge systemic inequalities and social exclusion, understandings of disability are from a predominantly Western worldview (Goodley et al., 2019; Smith & Routel, 2010). Both self-determination and dignity are guaranteed rights for disabled persons under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). The purpose of the UNCRPD Convention is to promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity ([UNCRPD](#), n.d).

History of disability in New Zealand

Approaches to disability in Aotearoa New Zealand have been influenced by wider sociocultural trends in Western nations. At the turn of the 20th century the prevailing Western approach to disability was biomedical (Quirk, 2022). Intellectual disability and mental health were poorly understood within this framework. This biomedical framing intersected with and supported the concurrent eugenics-based belief systems (Turda, 2022).

What is eugenics?

Eugenics is a philosophy that advocates controlling reproduction to produce better offspring. It flourished in the early 1900s but lost credibility after the Nazis' horrifically extreme version of eugenics in the Second World War. Organised New Zealand eugenics groups in the early 1900s advocated sterilising those they deemed 'unfit' to breed. They urged upper-class and middle-class women to stop using contraception and to breed more, to stop the country being dominated by 'defectives' (Tolerton, 2011)

Eugenics is a value system that determines a person's value according to biological, social, and cultural boundaries. Insiders, who belong to the valued race-based group, are viewed as separate from outsiders, who are framed as potential enemies of the race (Turda, 2022). In Aotearoa New Zealand, one example of eugenics-based practice in the early 20th century was the founding of the Plunket Society. Truby King founded Plunket in 1907 in order to improve the fitness of Caucasian New Zealand babies. Dr King was a member of Dunedin's Eugenics Society, assisted in the management of Seacliff Asylum, and went on to become New Zealand's Inspector General of Health. He wrote, in 1912, “*The destiny of the race is in the hands of its mothers*” and advocated strongly for scheduled feeding, exposure to sunlight, and cleaning. Truby King claimed that asylum admittance was a result of poor feeding and claimed that “*Education in parenthood offers, I submit, the main hope for the reduction of insanity.*”

Western psychology has been, and continues to be, influenced by eugenics-based beliefs. Gould (1996) detailed the development of empirical practices in psychology to support eugenics and racism in his book, *The Mis-measure of Man*. Eugenics was fundamental to the establishment of empirical methods and behaviourism:

Determinations of what constitutes mental health and human fitness,

acceptance of normed assessment and testing practices, minimization of history, social context, or subjectivity, use of animal models of behavior, and focus on self-control and resilience may be among many eugenics-related values that remain dominant in Western psycho-therapy practices (Yakushko, 2019, p. 8)

The continued influence of eugenics in Western psychology is most visible in the biologising of human differences, the minimising of social contexts, and the division of individuals into groups according to their supposedly innate characteristics (e.g., intelligence and optimism) (Bergstrom, et al., 2024).

One empirical component linked with eugenics is the idea of “normal”. The concept of a “norm” entered the English language in the mid-1800 and means conforming to or regular (Davis, 2013). To understand disability, it is important to reflect on what constitutes normal and how and why we know this information. American Disability Studies writer and activist Eli Clare positions the use of normal as a tool of oppression, linking it to White Western cultural ideals that value worthiness and wholeness (2017). The concept of abnormality results in individuals being othered and labelled into defined positions, leading to incarceration, institutionalisation, and sterilisation (Clare, 2017). As Annette Malakoff, a disability studies trainee writes, “As one who identifies as disabled, ‘normal’ will probably always make me turn my head and wonder... but I write this in hope of a greater understanding of the potential for negative connotations – and the acknowledgment of my own biases against the word” (Malakoff, 2023). The concept of what is normal is inherently unstable and fluid given that society constantly changes and evolves, but is still holding sway in terms of the body, the medical, and the push to diagnose disabilities (Davis, 2013). Davis argues that we need to continually question the idea of normality and expand into areas such as neurodiversity, chronic illness, and invisible illnesses. This would move us from eugenics (segregation or elimination of difference) to intersectionality, multiple identities, and complexities.

Our task as practitioners of critical health psychology is to create alternatives to—and question the construction of—normalcy, not just to include disability as normal. We can also change our language. The term normal is used in everyday speech, but care needs to be taken to prevent using normal as a type of bias, to exclude others, or to pass judgement.

A combination of eugenics-based values and the dominant biomedical approach, alongside a poor understanding of mental health and limited knowledge of neurodivergence, resulted in legislation being passed in Aotearoa New Zealand that actively removed disabled persons from society. One such example is the Mental Defectives Act, which was passed in 1911. This Act gave the state power to imprison anyone classed as “defective” for as long as the state thought in necessary. At the time, *Kai Tiaki*, the *Journal of the Nurses of New Zealand* enthusiastically noted the passing of the bill: “By detention of many such, who out in the world would marry and perpetuate their kind, surely something will be done toward stemming the tide of race deterioration, which fills to overflowing our mental hospitals” (New Zealand Nurses Organisation, 1912, p. 20). A little later, the Education Act (1914) required parents, teachers and police to report “mentally defective” children to the Department of Education and created a School Medical Service to identify “defective” children so they could be subject to surveillance. These punitive approaches continued into the 1920s. A Committee of Inquiry into Mental Defectives and Sexual Offenders (1925) linked intellectual impairment with moral degeneracy and potential sexual offending. The creation of

health camps temporarily removed children from their families. The Mental Defectives Amendment Act (1928) created segregated facilities for those imprisoned as a way to “avoid contaminating the race”. These legislative acts and associated segregationist practices remained in place for many decades. The ideas continue to linger and impact on societal attitudes to disability in Aotearoa New Zealand today.

After World War I, the medical and general population of Aotearoa New Zealand became increasingly aware of mental illness and physical impairments due to the experiences of soldiers returning home after war. This shifted the approach from segregation to one of rehabilitation. There was a need for better services, including psychiatric treatment, physiotherapy and plastic surgery. War injuries resulted in the development of improved medical skills such as treatment for burns, plastic surgery and orthopaedics (Figure 3.4.1).



Figure 3.4.1 World War I returned servicemen embroidering (Hinge, Leslie, 1868-1942. Hinge, Leslie 1868-1942 :World War I returned servicemen embroidering. Original photographic prints and postcards from file print collection, Box 6. Ref: PAColl-5932-27. Alexander Turnbull Library, Wellington, New Zealand. records/23068112. Reproduced with kind permission.)

The horrors of World War II also resulted in a reduction in eugenics-based values. Nonetheless, the segregation and institutionalisation of disabled children and adults continued. In 1949, New Zealand parents of children with impairments began advocating for schools and community facilities for their children so they could keep them at home and out of residential institutions—a key recommendation from the World Health Organization. In London, a manifesto published in 1976 called for a change of attitude to disability and disability policy (The Union of the Physically Impaired Against Segregation & The disability Slliance,

1976). The authors challenged the medical model of disability that framed disability as an individual's problem, and as something wrong or broken that could be cured or contained.

Nonetheless, it took time for attitudes in Aotearoa New Zealand to shift. Disability advocates finally started to see progress in the first decade of the 21st century with the first Minister for Disability Issues, a dedicated office in the Ministry of Social Welfare, and a social-model-based New Zealand Disability Strategy (Stace & Sullivan, 2020). The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) was finalised in 2006 and ratified by the New Zealand government in 2008. This provided one mechanism for achieving disability rights. The New Zealand government implemented various pieces of rights-based legislation, including the promotion of New Zealand Sign Language as an official language. After a march on Parliament, the last residential institution, Kimberley in Levin, was closed in 2006 (Stace & Sullivan, 2020). The lasting impact of the abuse, cruelty, and harm suffered by those in Aotearoa New Zealand's residential institutions has been documented in the Royal Commission Inquiry into Abuse in Care. While not limited to disabled children and adults, many of those abused were disabled. The final reports on the abuse and neglect of children, young people and adults in the care of the state and faith-based institutions in Aotearoa New Zealand between 1950 and 1999 are available online and can be downloaded and read in full from the abuse in care website: www.abuseincare.org.nz

Models of disability

Moral

The moral model of disability is a historical framework that interprets disability as a moral failing, as a punishment, or as divine retribution for sins (Tran et al., 2024). This model leads to **stigma**, shame, and marginalisation for disabled persons and their families (Olkin, 2002). Subsequently, individuals and families may conceal disability (or even the disabled person) to avoid societal judgement and associated stigma. Disability-related stigma continues today and is influenced by a combination of cultural beliefs and the moral model of disability (Jost et al., 2022).

See list below for examples of attitudes and beliefs grounded in the moral model from Courtney Jost (2021):

- disability viewed as a punishment for personal or ancestral transgressions.
- media depicting disabled persons as objects of pity and/or as inspirational figures who have overcome adversity (these narratives reinforce the idea that disability is a personal tragedy, which is an idea grounded the moral model).
- religious attitudes that attribute disability to spiritual causes and associated practices aimed at “curing” the disability through faith-based interventions. These attitudes and beliefs perpetuate the idea that disability is a result of moral or spiritual shortcomings.
- individuals blamed for their disability and/or circumstances.
- segregationist policies and social exclusion. Also rooted in eugenics (see earlier section), with the idea that the moral failing (which led to the disability) must be isolated to prevent contagion.

Critical health psychology practitioners can assist with counteracting these moralistic beliefs and attitudes by:

- promoting the social model of disability (more on this below).
- shifting the focus to societal barriers that prevent or hinder full inclusion.
- facilitating participation in society and foster informed attitudes towards disability.
- advocating for rights-based frameworks, such as the UNCRPD (discussed earlier).
- raising awareness about the context and detrimental effects of the moral model.

Medical

The medical model of disability conceptualises disability in terms of the physical or mental impairment. Essentially, it views disability as a problem located within the individual (Berghs et al., 2016). This is the dominant approach to disability within Western cultures. The medical model characterises disability as deviance from an idealised construction of wholeness (Tran et al., 2024). The main emphasis is on diagnosis, treatment, and cure, with the aim of improving functionality to that considered “normal” (Olkin, 2002). When working within a medical model, health professionals are considered experts and the disabled person and their family are expected to adhere closely to their expert directives or advice. The language of the medical model is clinical and medical, for example, referring to paralysis on the left side of the body as left hemiplegia, or to a spinal injury as a partial lesion at the T4 level. Medical terminology is useful for medical specialists to communicate precisely. It is less useful for determining responses to an injury. Shifting to a medical approach, from a moral one, has led to scientific advancements in treatment. However, this has not necessarily resulted in disability liberation.

A focus on the biomedical approach to disability has resulted in psychological research undertaken from a deficit-oriented lens. Individualistic approaches to disability, excluding disabled perspectives from research, and a focus on overcoming impairment are all damaging to the psychological well being of disabled persons (Goodley et al., 2017). Psychology, within a medical model (a focus on individuals following professional advice, ideas of “curing” illness), has historically had a systematic disregard for disabled people in psychology (Quirk, 2022). The medical model continues to have significant impact on perceptions of disability, and the way in which disabled individuals are treated.

Examples of attitudes, beliefs, and practices grounded in the medical model of disability:

- focusing on the impairment only can lead to pathologising disability. This fosters stigma and discrimination and may result in people viewing disabled persons as “defective”.
- an over emphasis on finding a cure. Prioritising medical solutions can lead to unnecessary medical interventions that have limited success. It can also result in neglecting to address wider social and environmental barriers to inclusion.
- internalisation of medicalised views of deficiency, resulting in poorer mental health, feelings of inadequacy, and reduced social participation.

Critical health psychology practitioners can address the limitations of the medical model by:

- promoting the social model of disability (more below).
- advocating for holistic approaches to health and disability.
- addressing environmental issues and emotional well being.
- shifting societal attitudes.
- engaging in education of communities.
- advocating for the removal of barriers and the fostering of inclusive practices.

Social

The social model of disability was first theorised by Oliver (1982). This represented a significant shift in the theorisation of disability as the focus moved from the “deficient” individual to the role of society, as well as distinguishing between impairment and disability:

Disability is the disadvantage or restriction of activity caused by the political, economic and cultural norms of a society which takes little or no account of people who have impairments and thus excludes them from mainstream activity (Therefore disability, like racism or sexism, is discrimination and social oppression). Impairment is a characteristic of the mind, body or senses within an individual which is long-term and may, or may not, be the result of disease, genetics or injury (Oliver et al., 2012, p. 16)

The social model of disability theorises that it is society that creates disabled conditions through environmental barriers, attitudes, and discrimination. The focus for change shifts to society, which must now ensure accessible structures, work to decrease stigma, and legislate for inclusion (Tran et al., 2024). Disability is constructed as an aspect of a person’s identity, and it is the environment that creates barriers, not the disability (Olkin, 2002). From this perspective, the way to address disability is to change the environment and society (compared to changing the person). Table 3.4.1 highlights the comparisons between the medical and social models.

Table 3.4.1 Comparisons of the medical and social models

What is disability?	Medical Model	Social Model
Implication and impacts	The condition of being unable to perform a task due to impairment, which is an individual burden.	The restriction of activity caused by the design of environments that exclude disabled people from fully participating in society.
	The individual must adjust or become more “normal” to fit into society and the established environments.	Society must adapt the design of environments. Individual differences are normal and accepted.
	Eligibility process	Everyone is included
	Activities & environments are retrofitted	Inclusive design reduces retrofitting
	Segregated or parallel services & experiences	Inclusive strategies minimise segregation
	Minimal legal requirement	Best practices for inclusive design
	Disabled students, staff, faculty ask to be included	Disabled students, staff, faculty are included by design

The adoption of the social model has significantly reshaped contemporary perspectives on disability:

- **Policy and Legislation:** Many countries have integrated the social model into their disability policies, emphasising the removal of societal barriers and the promotion of equal opportunities.
- **Educational Reforms:** There is a growing emphasis on inclusive education, where learning environments are designed to accommodate diverse needs, reflecting the social model's principles.
- **Public Awareness:** Campaigns and media representations increasingly highlight societal contributions to disability, challenging stereotypes and promoting a more nuanced understanding.

While there is positive change, a lot of work remains to be done. Barriers to full inclusion in society persist. These include physical barriers (e.g., steps instead of a ramp, buildings without lifts, public transport that cannot take a motorised wheelchair, minimum standards legislation that does not require generous adjustments for a wide range of people) as well as negative stereotypes and discriminatory attitudes. Psychologists and practitioners of critical health psychology can play a pivotal role in advancing the social model of disability and addressing the work that still needs to be done. Critical health psychology's recognition of cultural identities and the need for humility, and the importance of research "with" not "on" people, are strengths of the discipline when working with people with disabilities.

A socio-ecological model of social inclusion (Riemer et al., 2020) demonstrates the importance of critical health psychology in exploring the psychosocial and psycho-emotional aspects of disability. Research methods that support the social model are methods that centre disabled people, affirm their aspirations, and support self-determination across the research process (Forshaw, 2007). There remains a need for research that considers the psychosocial nature of disabling and enabling cultures and is mindful of the epistemological positions at play (Goodley & Lawthom, 2005). A critical health psychology approach to disability is one that emphasises the importance of integrating and incorporating disabled people and families across all areas of research and practice.

Critical health psychology practitioners can advance disability related interests by:

- **promoting awareness** of the social model among healthcare professionals and the public.
- **undertaking research** with disabled people that utilises social models of disability and moves beyond identifying barriers to start to address barriers and change discourses around disability.
- **developing policies** that are by and for disabled people and families.
- **engaging in therapy and practice** that incorporates the social model into therapeutic settings and recognising the external factors affecting clients' well being.
- recognise ableism and developing **cultural humility** (Atkins et al., 2023) as a way of recognising intersecting dimensions of disability, inequity, and privilege.

Critical disability studies

Critical disability studies (CDS) offers a theoretical and methodological basis for psychology practitioners.

CDS challenges the limitations of various models of disability. Instead, CDS proposes the use of a “critical lens” to understand the lived experiences of individuals with a disability (Flynn, 2024). Key scholars in CDS frame the field in the following ways:

- disability is understood from the disabled person’s perspective (Reaume, 2014).
- social justice work for people with stigmatised bodies and minds (Minich, 2016).
- challenges approaches that pathologise physical, mental and sensory difference as being in need of correction (Reaume, 2014).
- a means to explore issues of illness, health, and disease that often intersect with race and class (Minich, 2016).
- an intersectional framework that looks to political perspectives such as feminism, Black, queer, and trans (Goodley et al., 2021).

To work effectively in CDS requires challenging our assumptions and attitudes around disability (Flynn, 2024). It also requires breaking down the boundaries between identity positions (e.g., race, gender, disability) to address the divide between disabled and non-disabled people (Goodley & Lawthorn, 2005). As Shildrick (2012, p. 30) states, “Critical disability studies requires practitioners to consider the whole question of self and other.”

Two other models that emerged within critical disability studies are the affirmative non-tragedy model and Crip theory. The **affirmative non-tragedy model** is a theoretical framework within critical disability studies that challenges the traditional view of disability as a tragic condition (Flynn, 2024). Here are the main points:

- **Positive Identity:** The model emphasises that disability can have positive aspects and should be affirmed. It highlights the strengths and benefits of disabled lifestyles, promoting a positive social identity for disabled individuals.
- **Cultural and Social Identity:** It recognises the importance of disability culture and community, where disabled people can form their own social identities and communities.
- **Opposition to Tragedy Model:** The model stands in direct opposition to the dominant personal tragedy model of disability, which views disability as a negative and pitiable condition.
- **Extension of Social Model:** While it builds on the social model of disability, which separates disability from impairment and focuses on societal barriers, the affirmative model extends this by also affirming the positive aspects of disability.

Crip theory stems from queer theory and feminist disability studies. A central aspect of Crip theory is its critique of the binary structure of society according to which the able-bodied and the disabled are seen as opposites (Sandahl, 2003). Crip studies academics are staunch critics of the category of disability and say, “*the problem with disability is not definitional but structural ... Disability gets its power from specific cultural, geographical and historic contexts and these contexts pervade all ways of understanding disability*” (Smilges, 2023, p. 10). This occurs irrespective of the model used. As Karlsson and Ryndstrom (2023) state, “*Crip Theory provides a clear and powerful framework for undertaking a comprehensive critique of ableist inequalities in society and for developing activist strategies aiming to influence those who have the legislative power to address those inequalities*” (p. 406).

Critical health psychologists can draw from all of the above models and theories in their practice. It is useful to consider which approach might be the most beneficial for the disabled people and families we are working alongside. In order to start to use and integrate theory into practice, it is important to understand ableism, a key driver of discrimination (Watson & Vehmas 2020). When a society is ableist, we prioritise the needs of non-disabled people and assume that the “normal” way to live is as a non-disabled person.

Ableism

Ableism is widely accepted within society and occurs across a range of everyday places and spaces. Ableism is defined as follows:

The act of prejudice or discrimination against people with disabilities and/or the devaluation of disability (Kattari, 2015, p. 375)

Institutional ableism refers to those systemic practices and processes that disadvantage and marginalise disabled people. Academic ableism refers to the way in which academia treats able-bodiedness and able-mindedness as the “norm” (see above) within academia and makes assumptions regarding social and communicative hyperability (Dolmage, 2017, p. 7). There are two main types of ableism: **implicit** (automatic and unconscious) and **explicit** (conscious and intentional). These can be broken down further into **hostile** (openly aggressive and discriminatory), **benevolent** (expressing pity or praise, being patronising or infantilising) and **ambivalent** (combination of both). Examples of hostile ableism include medical rationing during the COVID-19 pandemic (see Brooks & Haller, 2024), workplace discrimination (e.g., pay inequity, lack of remote working options), or educational exclusion (e.g., lack of accommodations).

Friedman and Owen (2017) determined different types of ableism, discrimination, and prejudice, and how they intersect. They theorised two axes—**symbolic** and **aversive**. The logic behind both of these is that since there is human rights legislation, people’s disadvantages must be due to the person themselves, not discrimination. These terms can be summarised as follows and in Figure 3.4.2:

Symbolic ableism. This is high in explicit prejudice and high in implicit prejudice:

- expressed through symbols (e.g., opposition to affirmative action, ‘identity politics’). People rationalise and justify their prejudice.
- high in individualism and believes that people just need to try harder.
- regards people with disabilities as making excessive demands on the system and as demanding special favours.

Aversive ableism. This is low in explicit prejudice and high in implicit prejudice:

- being progressive and egalitarian is important to self-concepts. People believe that they are not prejudiced.
- act in prejudiced ways in ambiguous situations where it is harder to be “caught” or publicly shamed for being prejudiced.



Figure 3.4.2 Ableism spectrum ([Ableism Spectrum](#) by Carli Friedman, Copyright © 2016. Reproduced with kind permission)

Stereotypes, prejudice and discrimination are related but distinct concepts. Tran et al. (2024) define these concepts in relation to disability:

- **Stereotypes:** Common stereotypes for disability include perceiving an individual as personable and warm but also assuming they are incompetent or unhealthy.
- **Stigma:** Disability stigma—or the associations between disability as human difference and undesirable attributes—results in prejudice. Stigma for disability often is linked to whether the disability is visible or not.
- **Prejudice:** Among nondisabled people, prejudice may manifest as fear of contagion, pity for people with disabilities, or experiencing emotions of disgust when seeing someone with a visible difference.
- **Discrimination:** Discriminating against disabled people can include avoiding people with disabilities, deciding not to hire someone because of their disability status, or failing to provide reasonable accommodations.

Stereotypes, stigma, prejudice, and discrimination can show up as both macro-aggressions (systemic forms of discrimination and oppression that impact many disabled people) and micro-aggressions (intentional or unintentional, brief and often commonplace daily behavioural, verbal, and environmental indignities and interactions) (Jammaers & Fleischmann, 2025). For example, denial of disability experience, personal identity, privacy, or being patronised. Keller and Galgay's (2010) research on micro-aggressions towards disabled people observed that micro-aggressions resulted in negative mental health outcomes. The participants felt perceived as helpless, experienced infantilising and/or patronising language, and were treated as second-class citizens. They were also either desexualised or considered exotic and offered unasked-for spiritual intervention. Jammaers and Fleischmann (2025) locate microaggressions within structural oppression of ableist society, highlighting how intertwined emotions, behaviours, and negative outcomes are.

Examples

The study of ableism in population health: a critical review (Mannor & Needham, 2024). This paper critically examines how ableism functions as a social determinant of health, advocating for a shift from the traditional medical model to a social model that recognises societal barriers as primary contributors to health disparities among disabled people.

Online culture perpetuates harmful stereotypes and misconceptions about disabled individuals through the use of ableist memes. Bree Hadley (2016) identified four commonly circulating categories of meme—the inspiration, the charity case, the cheat, and the comedic punchline (examples are shown in Table 3.4.1 and in Figure 3.4.5). Creating and sharing such memes contributes to ableist representations of disabled people. Also, depending on the images used in the meme (White person and middle/upper class with expensive equipment), privilege can be inadvertently mediate and diminish some of the impacts of some impairments.

Table 3.4.2 Ableist examples of memes

Meme Type	Example	Why is it ableist?
The Inspiration	Images portraying individuals as overcoming their disability through working harder. Captions are meant to motivate able-bodied people by either shaming them for accomplishing less than disabled people, or by inspiring them with feats that the disabled subject performs (see Figure 3.4.3).	Objectifies disabled individuals for the benefit of non-disabled viewers; implies that disability is something to be overcome; ignores systemic and social barriers. Sets up exceptional examples as inspirational.
The Charity Case	Images portraying disabled individuals as objects of pity, often accompanied by captions soliciting sympathy or charity. Some images are “stolen” and repurposed or commodified for personal gain by non-disabled persons (Liddiard, 2014).	Reduces disabled people to their impairments; fosters a narrative that disabled people are helpless; upholds a medical view of disability as a sickness to be cured.
The Cheat	Images portraying people using disability equipment who are “not really disabled”. For example, a notebook for sale depicting a person in a wheelchair saying back in the day wheelchairs were for disabled people not fat people.	Promotes the misconception that individuals using mobility aids are exaggerating their disabilities or are simply lazy; undermines the legitimacy of invisible disabilities and personal experience.
The Comedic Punchline	Jokes that mock disabled individuals or use disability as a punchline. Memes that use offensive terms or depict disabled people in demeaning ways (Clark, 2003).	Perpetuate negative stereotypes; contributes to the marginalisation and dehumanisation of disabled people.



Figure 3.4.3 Meme illustrating Inspiration Porn for Disability. (Meme creator unknown. Photo reproduced with kind permission from [Andy Hooper](#), 2009)

Critical health psychology practitioners are in a unique position to challenge ableism by combining research, advocacy, and activism. All three can be used to address the systemic, social, and structural factors that create and maintain ableism through challenging stereotypes, stigma, prejudice, and discrimination. It is important to note that anti-ableist movements required on-going commitments to anti-racism and anti-capitalist agendas because “disability, race and class are categorically and phenomenologically entwined” (Smilges, 2023, p. 14). CDS offers a unique way of exploring health and illness experiences that considers the intersectional nature of a broad range of social drivers. Lived experience is also valued and appreciated.

Test your understanding of the core concepts so far with these five interactive questions.



An interactive H5P element has been excluded from this version of the text. You can view it online here:

<https://oercollective.caul.edu.au/critical-health-psychology/?p=986#h5p-9>

Intersectionality in research and practice

My Story by Amber Rose

“So much of chronic illness is unexplored and stigmatized. I find that often as a chronically ill human being, I spend much of my appointments experiencing medical gaslighting, explaining illness to practitioners, advocating for myself, and fighting for appropriate medication. In fact, I would not have my disabilities if not for the medical neglect I dealt with as a teenager.

As a teenager, I suffered from an extremely heavy and painful menstrual cycle. I would bleed for months at a time, often passing out, dealing with chronic nausea and dizzy spells. I knew something was wrong, but every doctor that I went to told me that it was normal. That every girl when adjusting to their period experienced these symptoms, and for a while I believed them. It was only after bleeding for sixteen consecutive months, I finally went to the after-hours clinic in my hometown. This is where I was called not only hysterical, but drug-seeking and ‘just anxious’.

It was there, I also disclosed to a practitioner that I was queer, something that the nurse on duty felt was morally abhorrent. After receiving the verbal dressing down of my life, receiving no medications, and being told I just needed to ‘handle being a woman’, my fear of medical professionals was born. This mistrust would lead me to avoid health care to my own detriment, often putting off receiving help for minor ailments until they became an even larger and unavoidable issue.

My fear of having another experience like that led to me ignoring my glandular fever, until I developed chronic fatigue syndrome when I was sixteen. When I was twenty, I developed extreme nausea and was unable to keep solid food in my body for three months. I swallowed my fear and again went to the emergency room. This time, I was told that I could stand to lose weight and that I was exaggerating my symptoms. After fighting for blood tests, they found that I was extremely dehydrated and malnourished. I needed six IV bags, and intestinal feeding tube before I was released with ‘non-specified’ gastrointestinal issues.

What happened to me was never diagnosed and never properly treated. I still have symptoms today. This was the triggering event for my POTS (Postural Orthostatic Tachycardic Syndrome), a dynamic disability that affects both my mental and physical abilities. The level to which they affect me varies from day to day. If I had had medical intervention sooner, there is every chance I would not have this illness.

Chronic illness and disability are largely misunderstood by not only the medical community, but by the general population. From invasive questioning to feeling entitlement to my personal information and having to justify my disability to strangers, these are still regular occurrences in my

life. At any given moment there is always someone willing to challenge me on my own abilities in life through their own narrowminded definition of disability. I have what is considered an invisible chronic illness, and as such I don't fit into the stereotypical idea of what someone disabled 'should' look like. This is such a widespread issue that we must use symbols such as the sunflower lanyard as some sort of visual indication people are expecting of disabled populations to try and get the accommodations we need with as little fight as possible.

Ultimately, this has emphasised to me the importance of listening to disabled voices—not correcting, speaking over, or making assumptions. We deserve agency and autonomy within the system that was not built for us.”

What to read more?

Ableism Is a major barrier to mental healthcare (Wang et al, 2024). This research highlights how ableism within mental health services creates significant barriers for disabled individuals, leading to unmet needs and exacerbated health disparities.

Implications of internalised ableism for the health and wellbeing of disabled people (Jóhannsdóttir, et al., 2022). This article explores how internalized ableism affects the health and well-being of disabled individuals, leading to complex psychological, social, and physical consequences.

The history of clinical psychology and its relationship to ableism: Using the past to inform future directions in disability-affirming care (Bergstrom et al., 2024). This article reviews clinical psychology's history and current relationship to ableism. The disability community reflects on current treatments and the impacts of disability stigma.

Critical health psychologist can challenge ableism by:

- engaging in a critique of overly medicalised approaches.
- centring disabled people and their lived experience.
- working alongside disability activists.
- addressing ableism in healthcare.
- applying an intersectional lens.
- advocating for supported decision making.
- and/or conducting critical policy analysis.

Contemporary approaches to disability in Aotearoa New Zealand

Aotearoa New Zealand's contemporary approach to disability is rooted in a human rights framework that emphasises self-determination and inclusion. Key government directives include the following:

The **New Zealand Disability Strategy**: This strategy operationalises Aotearoa New Zealand's commitment

to the UNCRPD. It acts as a guide to government agencies. The strategy emphasises the removal of societal barriers and the promotion of inclusive practices across various sectors.

The **Disability Action Plan**: This presents priority work programmes and actions to deliver the eight outcomes in the [Disability Strategy](#) (Ministry of Health, 2025).

The **Health of Disabled People Strategy**: This strategy sets the long-term priorities for the health system, towards achieving equity in disabled people's health, and wellbeing outcomes between 2023 and 2033. It provides a framework to guide health entities in improving health outcomes for disabled people and their whānau. Priorities include enhancing self-determination, ensuring accessible healthcare services, and integrating health systems to address broader determinants of health (Ministry of Health, 2025).

The New Zealand government established **Whaikaha – Ministry of Disabled People** in 2022. The current focus of Whaikaha is to lead and coordinate strategic disability policy across government ministries. Another key approach to disability is **Enabling Good Lives (EGL)**. This approach emphasises **self-determination, flexibility, and inclusion** for disabled people and their whānau (families). EGL represents a paradigm shift from the top-down, medical model of disability support to one that emphasises autonomy, inclusivity, and respect for disabled individuals as active participants in their communities. There are eight foundational principles (source: [Enabling Good Lives](#)) summarised in Figure 3.4.4 and outlined below.



Figure 3.4.4 Enabling Good Lives Principles. ([Enabling Good Lives Principles](#). Reproduced with kind permission from Enabling Good Lives, from the Firstport.co.nz disability information website.)

- **Self-determination:** Disabled people are in control of their lives.
- **Beginning early:** Invest early in families and whānau to support them; to be aspirational for their disabled child; to build community and natural supports; and to support disabled children to become independent, rather than waiting for a crisis before support is available.
- **Person-centred:** Disabled people have supports that are tailored to their individual needs and goals, and that take a whole life approach rather than being split across programmes.
- **Ordinary life outcomes:** Disabled people are supported to live an everyday life in everyday places; and are regarded as citizens with opportunities for learning, employment, having a home and family, and social participation – like others at similar stages of life.
- **Mainstream first:** Disabled people are supported to access mainstream services before specialist disability services.

- **Mana enhancing** – The abilities and contributions of disabled people and their families and whānau are recognised and respected.
- **Easy to use:** Disabled people have supports that are simple to use and flexible.
- **Relationship building:** Supports building and strengthening relationships between disabled people, their whānau and community.

Disability prevalence in Aotearoa New Zealand

The Washington Short Set of survey questions is a set of questions developed for use in censuses and sample-based national surveys that are not disability specific (WG Short Set on Functioning (WG-SS) (The Washington Group on Disability Statistics, n.d.). They were included in Aotearoa New Zealand for the first time in the General Social Survey (GSS) for the 2016/17 collection year and have been consistently adopted in a wide range of surveys across government, including the Census. This has improved availability of data.

The 2023 Household Disability Survey provides a picture of disability in the Aotearoa New Zealand population, including disability prevalence and the outcomes and experiences of disabled people. The prevalence of disability is estimated at 17% (or 1 in 6 people) (Statistics NZ, 2025). Some key findings are:

- female disability rate was 18% compared to the male rate of 15%.
- child disability rate was 10% and disability rates increased with age (17% between 45-64, and 35% for people 65+years).
- the Māori disability rate was 24 percent, the Pacific people rate was 21 percent, and the Asian rate was 13 percent.
- the age-adjusted disability rate for the LGBTIQ+ population was 31 percent, significantly higher than the non-LGBTIQ+ rate of 17 percent.
- regions with disability rates significantly higher than the national rate were Northland (23 percent), Manawatū-Whanganui (21 percent), and Taranaki (21 percent).
- for adults, difficulties with physical functioning were the most common disabilities. For children, difficulties with mental health and with accepting change to their routine were the most common disabilities.

More detailed findings from this survey can be located at [Statistics New Zealand](#).

Indigenous approaches to disability

As noted in [Chapter 3.1](#), Indigenous psychologies are epistemologically and ontologically different in orientation to positivist psychological approaches. As a discipline, Critical Health Psychology has work to do in terms of affirming and supporting Indigenous ideas and approaches in health and related services.

Aotearoa New Zealand: Māori

The influx of colonial settlers from Britain to Aotearoa New Zealand also brought associated attitudes towards disability and health. Their imported ideas regarding disability, morality, and physical health starkly contrasted with belief systems and attitudes grounded within **te ao Māori**. The imposition of settler-oriented health systems resulted in significant disadvantage to Māori (Hickey, 2020). This continues today, with core institutions in the Aotearoa New Zealand health system designed by and for settler-colonials and their descendants (Reid et al., 2019). Models of health in practice remain dominated by biomedical approaches, which are grounded in positivist worldviews and reflect Western values (Reid et al., 2017).

Most Māori disabled identify as Māori first and may or may not identify as disabled, despite having some form of impairment (Hickey & Wilson, 2017). The term **whaikaha** is translated as “people who are determined to do well”. It is used in a disability context with *tāngata* (people) to refer to disabled people. The words *tāngata whaikaha Māori* is a strengths-based phrasing for Māori disabled. The phrase *tāngata whaikaha Māori and whānau* includes family members as an all-inclusive term that acknowledges the complexities of disability, ethnicity, and familial relationships.

The dominance of settler-colonial ideas means that *tāngata whaikaha Māori* commonly experience discrimination and face multiple systemic and structural barriers in accessing disability related services (King, 2019). This, alongside chronic underfunding of Māori health services, compounds the exclusion and isolation experienced by *tāngata whaikaha Māori* (King, 2019). In addition, social and economic factors such as lower income, poverty, higher unemployment, and reduced access to education combine to compound the poorer life outcomes experienced by *tāngata whaikaha Māori* (Statistics New Zealand, 2015).

Subsequent changes by successive governments have not addressed persistent inequities embedded into the health system, nor the prioritisation of **Pākehā** health needs (King, 2019). Māori continue to experience low-quality health services, which leads to poorer health outcomes (Graham & Masters-Awatere, 2020; Wepa & Wilson, 2019). These experiences are exacerbated for *tāngata whaikaha Māori* (Ingham et al., 2022). Effectively, the health and disability related needs of Māori are rendered less important and are at times unseen. This is particularly relevant in disability, where Māori identities are routinely overlooked by specialists and professionals (Hickey, 2020).

Some of the key health-related issues that *tāngata whaikaha Māori* in Aotearoa New Zealand continue to experience are poor quality care, culturally inappropriate care, and insufficient access to publicly funded specialist services (Graham et al., 2023; Graham & Masters-Awatere, 2020). Non-Māori-led research by non-disabled medical specialists has been entirely inadequate in addressing these issues due to extractive research practices that strip Māori of their cultural contexts (Seed-Pihama, 2019). Worse, medical publications continue to perpetuate deficit views of Māori and paternalistic assumptions regarding disabled persons (Graham et al., 2023).

Health and psychological research and practice in this area needs to enable self-determination and democratic participation by both Māori and disabled. There is some emerging material on this topic (for example, Ingham et al., 2021). However, there remains room for future research that engages iteratively with *tāngata whaikaha Māori* in the health and disability space.

Australia: Aboriginal and Torres Strait Islanders

Scott Avery (2018), in his beautifully presented tome *Culture is Inclusion*, brings the voices of Aboriginal and Torres Strait Islander people with disability to research and policy. There is no word for disability in Aboriginal languages. Rather, difference was accepted as part of the fabric of society and people included in everyday life. Avery explains:

First Peoples expression of humanity and diversity are more than just observances of functional linguistics. They speak of a belief system that values a person's centeredness over biomedical and physical differences, and acceptance of difference as within the natural order of the world. It is a belief system that governs their behaviours, and comes with such a long-standing track record that it need not be consciously taught. Rather it is modelled through Indigenous people's attitudes towards other members of their community (Avery, 2018, p. 5)

The cultural and belief systems of Aboriginal and Torres Strait Islander people are radically different to Western constructions of disability as a deficit that needs to be fixed, rehabilitated, or prevented (Berghs et al., 2016). In Australia, this dichotomy in belief systems has created a barrier to accessing disability services and supports, exacerbating inequities in health care.

Health-related research and practice that centres the perspectives of service providers and clinicians cannot, by definition, detect or determine the influence of bias regarding care provided to Aboriginal and Torres Strait Islander people with disabilities (Avery, 2018). Instead, an ongoing intersectional approach that emphasises the perspectives of Indigenous groups and those with lived experience of disability must be taken. This may require considerations beyond the disability or impairment to include the wider context of people's lives.

As Avery (2018, p. 158) notes:

The interpretation of what I 'reasonable and necessary support' in Aboriginal and Torres Strait Islander communities requires a much deeper interrogation. If people are starving, then food is necessary. If people are homeless, then shelter is necessary. These observations relate to the essential foundations of survival.

A key challenge is the way in which disability related supports (such as the National Disability Insurance Scheme or NDIS) end up being implemented. The default ends up being a transactional process, whereby eligibility is determined via a highly bureaucratic assessment process that centres biomedical need. Whilst well-intentioned, the NDIS positioning of people as passive participants, that the NDIS happens "to", the narrow framings of need, and the unchanged nature of the power relationships wherein the assessor determines applicability of criteria falls short of the schemes intent to empower disabled people and provide choice and control. It is imperative to remain vigilant regarding implementation of programmes to avoid the slow return to default mechanisms and power structures.

Discussion questions

- What can be done to highlight power relationships in disability service provision?
- How can critical health psychology practitioners support disability service providers to improve their services and support Indigenous persons to access services?

Case studies and examples

The following section covers four case studies including a Māori community example, a policy case study, a case study of neurodiversity, and Rainbow health.

Case study: Kāpō Māori Aotearoa New Zealand

The community organisation: Kāpō Māori Aotearoa New Zealand Inc (KMA) is a national Indigenous organisation in Aotearoa. KMA was founded by blind, low vision, vision impaired and deafblind Māori and their whānau. Kāpō is the te reo Māori word for people who are blind, deafblind, or low vision. KMA is guided by Māori values, principles and practices to support tāngata Whaikaha (disabled people), and their whānau to attain whānau ora (well being) and to be strong self-advocates and leaders in their whānau and communities.

Pre-colonisation: Within the context of traditional Māori storytelling, or *pūrākau*, *kāpō* are depicted as strong and knowledgeable individuals. In these stories, blindness, disability, and even death are treated as ordinary parts of the rhythms of life. Disability and care are constructed as occurring within the context of wider familial and friendship connections, with an emphasis on the relationships that people have with each other. The stories of strong and knowledgeable ancestors who were blind (Tikao et al., 2009) provide a strengths-based alternative to the paternalism endemic to research on disabled persons.

The challenge today: *Tāngata kāpō Māori*, along with their *whānau*, have consistently reported facing challenges in accessing adequate and comprehensive health services. The existing provision of services is often characterised as patchy, difficult to access, and burdened by administrative complexities and bureaucratic barriers (Graham & Masters-Awatere, 2020). Moreover, the available data pertaining to the health service requirements of *whānau kāpō Māori* is deemed insufficient (Himona et al., 2019).

The research project: To address the above concerns, a research collaboration was developed. Professor Masters-Awatere, Dr Graham, and Ms Cowan worked to implement a research process that would identify key priorities for *tāngata kāpō Māori* and their *whānau*. Central to this collaboration was a clear commitment to self-determination for *tāngata kāpō Māori*, including intentionally centring *tāngata kāpō Māori* lifeworlds by documenting their experiences and those of their *whānau*. Self-determination over health data and related research (data sovereignty) means Māori determine (either alone or jointly) the type of data collected, the process of analyses, and the appropriate forms of reporting or dissemination (Cormack et al., 2019). The overarching objective was to advance the state of Māori and Indigenous peoples' eye health and overall wellbeing.

Information was collected from a series of *wānanga*. *Wānanga* are distinct from Western-style meetings. Masters-Awatere et al., (2024) explain:

-[wānanga] meeting protocols support an understanding of the tapu (sacredness) of learning [21]. Protocols that may be unfamiliar to non-Indigenous researchers, but are familiar to many Māori, include (while not being restricted to) opening speeches and karakia (ritual prayers), ensuring appropriate time to engage in whakawhanaungatanga (relationship building), answering questions of attendees, and the provision of manaakitanga (hospitality). Intertwined with these are ways of engaging that are specific to Māori, which are location- and context-specific, such as regular use of te reo Māori (Māori language), humour, care for others, and deference to kaumātua (older persons) [22] (Masters-Awatere et al., 2024, p. 343)

The research team engaged in *wānanga* with *tāngata kāpō Māori* and their *whānau* over three years. They also engaged with key end-user informants and subject matter experts, and undertook a comprehensive literature review (Graham et al., 2023). The review collated previously published research and re-evaluated it from a Kaupapa Māori perspective. Taken together, the information collated across each of these data sets provided a comprehensive record of the experiences and preferences of *tāngata kāpō Māori* and their *whānau*.

Key outcome: The Kāpō Māori Declaration on Engagement and Exchange. A significant outcome of this research collaboration was the development of a core document, the *Kāpō Māori Declaration on Engagement and Exchange*. The Declaration aims to create a respectful and equal engagement between KMA, its representatives, and others. It provides a framework that clearly identifies the ways in which individuals, groups, organisations, agencies, and governing bodies can approach and engage with KMA and its representatives in a way that upholds the **tino rangatiratanga** (self-determination, sovereignty), **kawanatanga** (government), and **oretitanga** (equity) of *tāngata kāpō*.



Figure 3.4.5 Tino Rangatiratanga, Kawanatanga, Ōritetanga. (Pounamu Wharekawa (Ngai te Rangi, they/themme). Permission given by Chrissie Cowan, CEO of Kāpō Māori Aotearoa (KMA). All Rights Reserved)

Policy case study: Whānau Ora

The **Whānau Ora** initiative, based on Māori cultural values, was driven by the Māori parliamentary party as part of its coalition agreement with the National Party following the 2008 general election. Whānau Ora represents an alternative model in which the power of central government decision making is devolved to foster a greater sense of local community and individual responsibility. Embedded into parliament legislation and with funding secured, this initiative ensured that Māori centred values and practices were central to funding initiatives for Māori well being. It shifted thinking away from the narrowly defined biomedical practices of health into holistic alternatives.

The Whānau Ora Outcomes Framework built on the work of the Taskforce on Whānau Centred Initiatives, which carried out extensive consultation in 2009. It operationalised the ideals of Whānau Ora and provided a practical framework for assessing the outcomes of proposed projects. Whānau Ora is achieved when whānau are self-managing, living healthy lifestyles, participating fully in society, confidently participating in te ao Māori, economically secure and successfully involved in wealth creation, cohesive, resilient and nurturing, and responsible stewards of their natural and living environments. The framework recognises the long-term and progressive change required for whānau to achieve these aspirational goals by including short, medium and long-term outcomes ([Whānau Ora](#)). Whānau Ora signals a way forward for tāngata whaikaha Māori and tagata Pasifika with disability, and whānau. The Whānau Ora approach and Enabling Good Lives (EGL) are aligned with a mutual emphasis on building whānau capacity, collective leadership, and whānau planning.

One example of this in action is Te Pūtahitanga o Te Waipounamu, a Whānau Ora commissioning agency. Responsible for commissioning pieces of work that develop and enhance Whānau Ora, the organisation has seven pou (pillars) as their foundation ([Te Pūtahitanga o Te Waipounamu](#)). These seven pou provide the basis for assessing funding applications; projects must demonstrate their alignment to the Whānau Ora pou and how their project or kaupapa will benefit whānau. The seven pou are:

- Pou Tahi (one) aspires for whānau to be self-managing—exercising **rangatiratanga** on a daily basis and making informed decisions about their lives.
- Pou Rua (two) encourages whānau to lead healthy lifestyles, maintaining a quality of life that meets their health needs across all aspects of **Te Whare Tapa Whā**.
- Pou Toru (three) is about empowering whānau to participate fully in society and giving them the opportunity to participate in education and employment to their fullest potential.
- Pou Whā (four) portrays whānau as confidently participating in te ao Māori, secure in and proud of their cultural identity.
- Pou Rima (five) focuses on making sure that whānau are economically secure and successfully involved in wealth creation, building security for themselves and future generations.
- Pou Ono (six) is the goal that whānau will be cohesive, resilient, and nurturing, and that whānau relationships are positive, functional, and uplifting of all members.
- Pou Whitu (seven) encourages whānau to be responsible stewards of their living and natural environments, recognising our inherent and enduring connection (te ao tūroa) to the land and the benefits that come from strengthening that.

Taken together, the seven pou comprise a roadmap for Whānau Ora. When these seven pou stand tall and strong, they work together to uphold the wellbeing of individuals, families and communities.



Figure 3.4.6. Seven pou (pillars) of Whānau Ora. ([Whānau Ora Outcomes](#) by Te Puni Kōkiri, 2017. [CC BY-NC 4.0](#))

Case study: neurodiversity, education and health

Neurodiversity is a biological reality and refers to the variation all humans have in neurocognitive functioning (Walker, 2025). We all think, learn, perceive the world, and process sensory information differently. This impacts how we engage in the world and how we interact with others. In this way we are all neurodiverse as no-one brain works the same. Education and health systems are typically set up for the majority, the normal, or neurotypical (their minds conform to constructions of normal in their society) (Hamilton & Petty, 2023).

Neurodiversity is different to being **neurodivergent**. An individual is considered *neurodivergent* if their mind functions differently from the dominant societal standards of normal. A group of people is *neurodiverse* if it includes more than one *neurotype*. As the concept of diversity applies to groups of people, an individual cannot be neurodiverse or have neurodiversity. Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD) and dyslexia are examples of neurodivergence (but there are others included in this umbrella) (Walker, 2025).

The neurodiversity paradigm is a specific perspective on neurodiversity and the **Neurodiversity Movement** is a social justice movement that seeks civil rights, equality, respect, and full societal inclusion for the

neurodivergent (Walker, 2025). From the neurodiversity paradigm, neurocognitive difference is viewed as natural rather than defective, and is described in terms of neurotypes rather than disorders. Through acknowledging the role of socially constructed norms, we intentionally draw attention to the power dynamics involved. This includes aspects such as majority privilege that have contributed to framing of minority neurotypes as abnormal or deficient. While not all neurodivergent people subscribe to the neurodiversity paradigm, it is a useful tool for language and framing that avoids deficit narratives.

The illusion of inclusion – “The story it tells is nothing short of devastating.”

The Education Hub in 2024 gathered the stories from 2,400 neurodivergent young people, parents, whānau, teachers, educators, and support workers about their school experiences. The report highlights some of the wonderful work undertaken by individual educators and school communities. However, it also highlights systemic failure and broken systems. Ongoing systemic issues include inadequate funding, poorly set funding settings, a dearth of trained supports, unavailable and/or low-quality provision of services, unrealistically high teacher ratios in school classrooms, alienating school environments, and a desperate need for training and practice development across teaching staff. The report also highlighted how strong leadership, thoughtful policies, and cultures of inclusion all make a positive impact for neurodivergent learners.

For more information [see the full report](#).

The story for tertiary settings is not much better. While all tertiary providers must now have a disability action plan, an increasing amount of research indicates that significant barriers for students and staff remain. Stigma, traumatising school experiences, and lack of universal design in tertiary environments mean that outcomes for neurodivergent and disabled learners remain poor (Hamilton & Petty, 2023).

What to read more?

Why critical psychology and the neurodiversity movement need each other (Thomas, 2024). This article challenges ableist trends within critical psychology and emphasises the importance of integrating neurodiversity perspectives to combat systemic marginalisation of neurodivergent individuals.

Lived experience voices

Personal stories and perspectives on how race, gender, class, and other identities intersect with disability can reveal the multiplicity of factors that disabled people experience. Critical health psychology has a long history of qualitative research that includes lived experiences. However, much of the time these stories remain in research spaces with minimal translation into practice that makes meaningful change, for the communities whose voices are highlighted. There are increasing movements in health and psychology more broadly that enable change as seen in the policy case study and Kāpō Māori Aotearoa New Zealand Inc (KMA) example in this chapter.

Mental distress is currently the leading cause of disability worldwide: the World Health Organization's Comprehensive Action Plan 2013-2030 states a vision of a world where mental health is valued, promoted, and protected, where people experiencing mental distress can exercise the full range of human rights and access to quality care to promote recovery, and where lives are free from stigmatisation and discrimination (World Health Organization, 2021). The World Health Organization European Region's (2024) Mosaic Toolkit is one recent response to that call and prioritises "collaboration led or co-led by people with lived experience, within and across health and other sectors" (p. v).

This same call can be seen from all marginalised communities "nothing about us without us". It is essential that we involve people with lived/and or living experience. Disability affirming practice at the minimum includes representation of people with lived experience, creating communities to advocate and support each other, better training, and research that is done with and for the disabled community (Bergstrom et al., 2024). The case study below reveals the challenges but also highlights small changes that can be made.

Case study: Rainbow communities

Contributed by Amber Rose

Being disabled has plenty of challenges on its own, but when faced with the intersectionality of other minority groups people often get stuck in repeating cycles of disadvantage and injustice (Ker et al., 2022). Results from the 2023 Household Disability Survey note the significantly higher rate of disability in the LGBTIQ+ community: 31%, whereas the non-LGBTIQ+ rate is 17%. The question is why? Why should this statistical difference be so great, when Western centric culture insists it treats its patients and societies the same? The simple answer is equity instead of equality. A **Rainbow** person faces discrimination in many ways along the course of their life. This is both due to conscious and unconscious biases from the medical community, general community, and inner circles. The example of Jane illustrates intersectionality and the impact of social determinants of health.

Jane is applying for a job. However, the second her prospective workplace becomes aware that she is a part of the Rainbow community, she becomes less likely to be hired. Not only that, but if she had gotten the job, she was likely to be earning up to 10% less than her cisgendered, heteronormative counterparts. Due to these discriminatory practices, one in four Rainbow people are unemployed.

Unemployment almost always leads to poverty. Jane, after searching for months has run out of savings: she hasn't been able to find a job and is now living in poverty. The odd, temporary jobs she has been able to find are barely covering rent, meals and utility, let alone covering any extra costs that come up, medical or otherwise. Poverty leads to decreased quality of life, both physically and mentally. It also decreases access to adequate housing, food and water, with costs being the primary barrier. As a result, people living in poverty, like Jane, are more likely to fall ill.

Not only is Jane more susceptible to illness as a result of her socioeconomic status, but poverty itself is a major discriminating component within healthcare. No expendable income means long waitlists, and often, an inability to pay even prescription and appointment costs within the public system. This economic lack of access to safe, equitable healthcare means minor health problems are pushed back, time and time again. Over time, these issues can turn into major health problems, and, without adequate care, full blown disabilities, often chronic illnesses or

physical disabilities. Jane is now stuck in a repeating cycle that is entirely not of her own making. A cycle that thousands of Rainbow peoples fall victim to everyday.

The issues are not confined to the scenario outlined above. There are plenty of other Rainbow specific barriers, including but not limited to practitioner education, bedside manner and social acceptance. For example, members of the community often have to spend significant portions of, if not all of their appointment time educating practitioners on Rainbow-based healthcare. This involves explaining to their own doctors and psychologists the ins and outs of hormone replacement therapy, same gender sexual protection, and the practical information behind polyamorous relationships. In contrast, cisgendered and heteronormative counterparts can just go into an appointment with their identity in context, safely and with ease.

Additionally, a transgender person may experience other types of discrimination within a healthcare context. Misnaming and misgendering, accidental or not, being evangelised to, and other forms of emotionally and mentally taxing behaviours from practitioners all take their toll. A general lack of social acceptance can also cause anxiety and danger heading to and from appointments. The health system is already discriminatory towards Rainbow people and with the addition of systematic issues, these challenges will continue to worsen.

These Rainbow specific issues and disability specific issues are so much more than they appear on the surface; issues run deep. They have been around for a long time and may not be as glaring as other systemic issues have been. Rainbow spaces and communities have often been overlooked, and it is up to us and our new practitioners to have a more holistic, compassionate, and change-making view on healthcare and practice. Intersectionality in our healthcare spaces is becoming more and more of a necessity, and many times the education required from this must be self-directed. We must be committed to learning, compassion, and putting people at the centre of psychological practice.

Examples

There are many examples and reading you can do to expand your learning in this area. This is just a small sample from Aotearoa, New Zealand.

- Fraser, G., Brady, A., & Wilson, M. S. (2022). Mental health support experiences of Rainbow rangatahi youth in Aotearoa New Zealand: Results from a co-designed online survey. *Journal of the Royal Society of New Zealand*, 52(4), 472-489.
- Parker, G., Ker, A., Baddock, S., Kerekere, E., Veale, J., & Miller, S. (2023). "It's total erasure": Trans and nonbinary peoples' experiences of cisnormativity within perinatal care services in Aotearoa New Zealand. *Women's Reproductive Health*, 10(4), 591-607.

Counting Ourselves is an anonymous health survey designed by and for trans and non-binary people living in Aotearoa New Zealand (for more information <https://countingourselves.nz/>)

PRIDE stands for Program for Research on Identity, Development, & Emotional wellbeing (PRIDE)

and is a psychology research lab based at Massey University
[tps://www.pridelabnz.com](https://www.pridelabnz.com)

Critical health psychology practitioners can:

There are plenty of small, easy steps that can be taken towards helping the Rainbow community feel safe and accepted.

- adding preferred names to intake forms.
- staff wear name and pronoun pins regardless of being cisgendered or not.
- visible support in the form of pride information such as a Rainbow tick or information leaflet.

Small changes can mean the difference between a helpful, positive appointment, and an anxiety inducing, negative appointment. But these small, easy steps must be backed up with knowledge and seeking information about the community. Critical health psychology is a major part of that. By breaking down barriers using a significantly more diverse and accepting health model we can address patient issues holistically and without bias.

Areas of opportunity for critical health psychology

Greater understanding of disability can enable critical health psychology practitioners to respond to the groups with whom they work and the social problems they seek to ameliorate (McDonald et al., 2007). One way to do this is to develop shared narratives as a pathway through which marginalised individuals can contest and alter the frameworks of meanings that have underpinned and perpetuated their oppression (Madyaningrum, 2017).

Cross-fertilisation between disability studies and psychology gives each discipline insight, pools resources to support disabled people and empower action, and improves robustness and applicability of findings. The ability to learn from disability studies and disabled people can be achieved through respecting people's individuality, being an inclusive practitioner, working harder to listen, and working harder for people to be heard (Richards, 2022). Holding a critical attitude to research is important, as is considering a diverse range of research methods (Forshaw, 2007).

There remains room to improve recognition of the power imbalances between disabled people and psychologists (Nelson et al., 2001). Psychologists need to recognise their responsibility to address disability-related discrimination and ableism (Teizaria et al., 2009). Solutions include engaging in practice within a commitment to recognising and exposing the impact of oppression and discrimination (Teizaria et al., 2009). There are many opportunities for allyship when coming from positions of humility.

Critical health psychology practitioners can offer reflection, partnership, and a critical examination of the processes and outcomes of the partnerships. Critical health psychology also offers practical ways to address power imbalances (through participatory research methods), alongside arguments that psychological well-being requires social and political transformation. Critical health psychology, with its orientation to systemic

change, has the potential to advance with disability studies in partnership, endorsing disabled voices and striving for disability justice.

Research topics that require further exploration include:

- issues that the disability community is advocating for.
- disability diversity, intersectionality and social class.
- indigenous elements of disability.
- cultural narratives related to disability and class.
- awareness of personal responsibilities, biases, power and positionality.
- research and frameworks aligned with disability studies.
- collaboration between critical health psychology and critical disability studies.
- further development of the social model of disability.

Conclusion

We close this chapter coming back to question we posed at the start—**“How can critical health psychology practitioners use disability theories and models in practice?”**

“Making a start requires us to reflect on the history of disability in Aotearoa, New Zealand and more globally, including the difficult parts, such as the shameful embracing of eugenics. This chapter has introduced a broad-brush history of eugenics and disability, before discussing models of disability. These are an important base for understanding the context of psychology and disability. The section focusing on ableism frames how prejudice, stereotypes and discrimination work in the disability space, and how critical health psychology practitioners can actively address and reduce these in their practice.

Contemporary approaches to disability in Aotearoa New Zealand have been outlined, included current government strategies. Nonetheless, good policies and a United Nations convention signing does not necessary lead to positive outcomes. We have provided specific examples that we consider “good practice” grounded in the idea “nothing about us without us”.

Throughout our chapter we have provided specific challenges ranging from small personal goals to wider social change that you can take into your personal and professional lives. These ideas will be useful for all people working in psychology, health psychology, mental health and critical health psychology. To answer, **“How can critical health psychologists use disability theories and models in practice”**, we suggest **“how can you not”**?

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Glossary

Ableism

The act of prejudice or discrimination against people with disabilities and/or the devaluation of disability (Kattari, 2015, p. 375). Reference: Kattari, S. K. (2015). Examining ableism in higher education through social dominance theory and social learning theory. *Innovative Higher Education*, 40(5), 375–386.

Adherence

This is a paternalistic view in medicine, similar to compliance, which assumes that the informed (but still passive) patient will stick to taking their recommended treatment, barring errors. For a more detailed discussion, see Chapter 1.5.

Affective atmospheres

This term describes the feelings that are generated in a particular moment in an interaction between humans and their material environment. For example, tracking apps can have an “optimistic affective atmosphere”, in terms of their promises of a hoped-for expectation of a better life, while home can produce a sense of safety.

Affirmative non-tragedy model

A model that views disability as a positive aspect of human diversity, not a tragedy.

Affordances of social media

A term to describe the way technical features, in interaction with the way that users perceive and use them, enable or constrain, users’ actions. For example, “liking” a post, affords the possibilities of giving positive feedback and connecting with others who like the same post.

Agential realism

An epistemological position that there is a reality out there, but we cannot completely observe it because, (1) observations are snapshots of a dynamic world, and (2) the act of observing profoundly changes what is being observed. See Chapter 1.3 for more details, including Barad (2011) in the references.

Āhua

Personalised indicators in the *Meihana Model*; appearance, nature.

Anti-psychiatry movement

A movement that challenges traditional psychiatry. It argues that psychiatric diagnoses and treatments often cause harm, ignore social and political causes of distress, and give too much power to medical professionals. It calls for more humane and socially aware approaches to mental health.

Aotearoa New Zealand

A term used to acknowledge and respect Māori language and identity, and is thus a more inclusive term for the country.

Assemblage

A “concept for a number of components of any kind whatsoever that interact with one another... [in

a] dynamic, open-ended, complex configuration that is unfolding in often abrupt and unexpected directions" (Alverson and Sköldberg, 2017, p. 54). The idea was advanced by Deleuze and Guattari (1987) and has since been substantially developed. See Chapter 1.2 for references.

Ate

Seat of emotions, liver.

Atua

Referring to Māori gods, deities, supernatural beings, or ancestors with continuing influence.

Autocracy

A system or state where one person has absolute power, such as a monarchy or a dictatorship.

Aversive ableism

A term used to describe people who are progressive and well-meaning yet still participate in biased actions or thought. Aversive ableists believe they are not prejudiced—in fact, egalitarian values are important to their self-image—yet feel discomfort around people with disabilities and often act in prejudiced ways in scenarios where their prejudice is less overtly evident. Because of their egalitarian values, aversive ableists have low explicit prejudice. Reference: Friedman, C., & Owen, A. L. (2017). Defining disability: Understandings of and attitudes towards ableism and disability. *Disability Studies Quarterly*, 37(1). <https://dsq-sds.org/index.php/dsq/article/view/5061/4545>

Awa

A Māori word for river.

Becoming

When used in Deleuzian-informed poststructuralist work, including more-than-human theory, it describes an ongoing, dynamic process that can be contrasted with the word "being", which implies something finished or static.

Behaviourism

An approach to psychology based on the study of objective, observable facts and explaining behaviour through learning principles (<https://dictionary.apa.org/behaviorism>).

Biomedicine

A dominant Western approach to healthcare focused on the biological aspects of disease and illness, emphasising diagnosis and treatment through scientific methods, and often excluding social or psychological factors.

Biopsychosocial approach

Originally developed by George Engel (1977) as a critique of the reductionist biomedical model, the biopsychosocial approach considers the interplay between biological, psychological, and social factors. Critics argue the approach fails to adequately interrogate power, inequality, and social determinants of health. See Chapter 1.2 for Engel (1977) reference.

Body mass index (BMI)

A metric calculated by dividing a person's weight by their height squared, often used as a proxy for health. For critique, see Chapter 1.4; also the "Weight" chapter in Riley, S., Evans, A., & Robson, M. (2019).

Broker (in healthcare)

A healthcare professional who actively navigates systems, negotiates options, and advocates on behalf of patients to facilitate access to appropriate care.

Causal mechanisms

A term used in critical realistic epistemology that describes (often unobservable) mechanisms that produce specific observable outcomes.

Chronic health condition

A term used to describe an ongoing health issue that a person needs to manage on a daily basis. This term also allows inclusion of people who are managing a health condition without a diagnosis because their symptoms do not map against recognised medical criteria.

Cisheteronormativity

The prioritisation and normalisation of cisgender (the assumption that everyone identifies with the gender they were assigned at birth) and heterosexual identities, treating heterosexuality and the gender binary as the default and marginalising LGBTQI+ individuals.

Compliance

A term used in medicine to describe how well a patient follows a doctor's instructions, such as taking medication or making lifestyle changes. This paternalistic view assumes the doctor knows best and that the patient should follow their advice.

Concordance

A model of shared decision making in healthcare where the patient and provider reach agreement on treatment, acknowledging patient values and preferences.

Conscientisation

A concept developed by Paulo Freire that refers to the process of becoming critically aware of social, political, and economic injustices, and recognising one's capacity to challenge and change them. Through dialogue and reflection, people develop a deeper understanding of how power and oppression shape their lives—moving from passive acceptance to active transformation of their world. Conscientisation is central to critical pedagogy and liberation psychology. Reference: Freire, P. (2000). *Pedagogy of the oppressed* (30th Anniversary edition). Bloomsbury.

Contested illness

A condition whose legitimacy is questioned due to uncertain causes, diagnosis, or treatment, making it difficult for sufferers to gain recognition and support.

Cosmogony

Beliefs, theories, or branch of science focused on how the universe or the cosmos began.

Cosmology

Beliefs, theories, or branch of science concerned with the nature of the universe, including its origin

and development. While cosmogony is primarily concerned with the birth or creation of the universe, cosmology studies the nature of the universe from its origins to its end.

Credibility work

The efforts individuals make to convince others that their symptoms are genuine and deserving of medical attention or social support.

Crip theory

Centres and affirms the lived experiences of disability and understandings that emerge from such experiences. It is an approach that combines queer theory and disability theory through social justice frameworks.

Critical phenomenology

An epistemology that centres lived experience but also considers how social structures and systems of oppression (e.g., patriarchy) shape that lived experience.

Cruel optimism

A term coined by Lauren Berlant that describes how things we desire may actually be an obstacle to our flourishing, either because they are unattainable or because they are toxic. For example, neoliberal health culture encourages individuals, especially women, to strive for self-improvement (e.g., through wellness regimes and dieting practices). The promise is wellness, thinness, and happiness, but ultimately, people are often striving for an unattainable ideal and can be harmed in the process. For example, they may develop an eating disorder in the process. See Chapter 1.4 for further discussion and references.

Cultural safety

A healthcare approach that focuses on recognising, respecting, and responding to the cultural identity of patients, and addressing power imbalances in the healthcare encounter.

Delegitimation

The denial of a person's claim to illness, undermining their right to be seen as sick and thus barring access to support or understanding.

Deregulating industry

A term is to describe the removal or reduction of government regulations and controls over businesses, a core principle in neoliberal economics.

Determinism

The view that events, behaviours, or outcomes are caused by specific, identifiable factors, often reducing human experiences to biological or environmental causes.

Disability

Oliver et al., (2012, p. 16) define disability as “the disadvantage or restriction of activity caused by the political, economic and cultural norms of a society which takes little or no account of people who have impairments and thus excludes them from mainstream activity (therefore disability, like racism or sexism, is discrimination and social oppression). Impairment is a characteristic of the mind, body or senses within an individual which is long-term and may, or may not, be the result of disease, genetics

or injury.” Reference: Oliver, M., Sapey, B., & Thomas, P. (2012). *Social work with disabled people*. Palgrave Macmillan.

Discourse

Foucault (1977, p. 49) stated that discourses are “practices that systematically form the objects of which they speak.” Discourse refers not just to language or conversation, but to systems of knowledge, practices, and institutions that define what is true, normal, or possible within a given historical and cultural context. Discourses shape how we think, talk about, and experience the world, including bodies, illness, and health. Discourse is also deeply connected to *power*, as it governs what can be said, who can speak, and what counts as legitimate knowledge. In health psychology, discourses about mental illness, obesity, or risk, for instance, are not neutral; they carry moral, political, and social implications. Reference: Foucault, M. (1977). *Discipline and punish: The birth of the prison*. Vintage Books.

Disease

A pathological condition characterised by symptomatology and diagnosed by medical experts. Diagnosis often involves identifying and assessing problems in the body's structure or function, detected through tests and assessments, and based on medical categorical criteria (e.g., IBS, hypertension, depressive disorders etc.).

Disease mongering

A practice of widening the boundaries of treatable illness to expand markets for those who sell and deliver treatments. For further discussion, see, for example, Moynihan, R., Heath, I., & Henry, D. (2002). Selling sickness: The pharmaceutical industry and disease mongering. *British Medical Journal (Clinical research ed.)*, 324(7342), 886–891. <https://doi.org/10.1136/bmj.324.7342.886>.

Dual methodology

A research approach in which two parallel analyses are undertaken, using incompatible epistemological methods, to better understand an issue from multiple perspectives.

Ecological level

An ecological level refers to the layer or scale at which health and wellbeing are influenced or addressed. In health psychology, these levels are often grouped into:

Micro level – the individual or intrapersonal level (e.g., thoughts, behaviours, physical health)

Meso level – the interpersonal or relational level (e.g., family, peers, workplaces)

Macro level – the societal or structural level (e.g., laws, culture, economic systems)

Ecological thinking helps health psychologists understand how different levels interact, and why effective interventions often need to work across more than one level to create lasting change.

An example you may be familiar with from developmental psychology is Bronfenbrenner's ecological model, which depicts how human development is influenced by interconnected environmental systems.

Image: [Wikimedia Commons](#)

Embodiment

The idea that bodily experiences, including illness, are shaped by social, cultural, and historical contexts, making the body both a biological and social entity. Within phenomenological traditions, “embodiment” includes how a person's interpretations of their world, including their thoughts and feelings, are produced through their body, so that all knowledge is embodied.

Empiricism

The theoretical position that all knowledge can only come from direct sensory experience and observations.

Epigenetics

The study of the interaction between genetics and the social context. The focus is on changes in gene expression influenced by environmental factors, behaviours, or life experiences (not alterations to the DNA sequence itself). These can affect how genes are turned on or off and may be passed on to future generations, affecting health and emotional wellbeing.

Epistemic injustice

Fricker (2007, p. 1) defined epistemic injustice as when “someone is wronged specifically in their capacity as a knower”, either by having their credibility unfairly undermined due to prejudices about the speaker or by underrepresentation of marginalised groups in collective knowledge making. Reference: Fricker, M. (2007). *Epistemic injustice: Power and the ethics of knowing*. Oxford.

Epistemology

The branch of philosophy concerned with the nature, scope, and limits of knowledge. That is, how we know what we know. In critical health psychology, epistemology is intertwined with considerations of power, positionality, and the politics of knowledge. Critical health psychologists are often open to multiple ways of knowing, aligning with plural, situated, and reflexive epistemologies, as a deliberate move away from the hegemony of positivist epistemologies that dominate mainstream health psychology.

Eugenics

Eugenics is a philosophy and value system that advocates controlling reproduction to produce better offspring. Reference: Tolerton, J. (2011). *Contraception and sterilisation – information about our contraceptives*. Te Ara – the Encyclopedia of New Zealand. <http://www.TeAra.govt.nz/en/document/26996/eugenic>

Feeling rules

Socially shared expectations for how feelings and emotions may be felt or expressed. A concept coined by sociologist Arlie Russell Hochschild. Reference: Hochschild, A.R. (1983). *The managed heart: Commercialization of human feeling*. The University of California Press.

Food deserts

Areas where access to affordable, nutritious food is limited or unavailable, disproportionately affecting low-income communities. Food deserts are caused by a lack of nearby grocery shops selling fresh produce, sometimes accompanied by a high concentration of cheaper fast-food restaurants in the area.

Fugue

A dissociative condition involving sudden, unexpected travel away from one's usual environment, accompanied by amnesia and confusion about identity. Historically considered a psychological response to stress or trauma.

Gatekeeping (in healthcare)

The role of primary care providers in controlling access to specialist services, diagnostic tests, or treatments, often to manage costs or streamline care.

Global North

Global South and Global North are terms used to describe shared characteristics of a range of countries. Global South countries are mostly in the southern hemisphere and have socioeconomic and political characteristics that produce multiple health inequities, including those arising from colonisation. Global North countries tend to be in the northern hemisphere and are characterised as post-industrial nations with significant influence in the global economy. These terms highlight geographical divisions in power and inequity. There are many critiques of this terminology but it can still be useful.

Global South

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Good life discourses

Discourses that construct what it means to live a good life and be understood by oneself and others as doing so. Often these relate to normative accounts of what it means to be a “good” person or live a “good” life.

Governmentality

Is a way of enacting power through people’s psychology, so that people choose to manage themselves accordingly, rather than being explicitly told to do so. Foucault described governmentality as “conduire des conduites” (translated, as guiding the possibility of conduct; 1994, p.237). Governmentality refers to the ways in which populations are governed not just through laws or coercion, but by shaping how people think, act, and conduct themselves. In health contexts, governmentality describes how individuals come to monitor and regulate their own behaviour in line with societal norms, without needing external enforcement. References: Foucault, M. (1994). *Dits et écrits IV*. Gallimard; Madsen, O. J. (2014). Governmentality. In T. Teo (Ed.), *Encyclopedia of critical psychology*. Springer.

Green prescriptions

A prescription for a support service or activity (e.g., an exercise class), in contrast to a pharmaceutical prescription.

Hā a koro mā, a kui mā

Breath of life from ancestors.

Hapū

A kinship group or subtribe, comprised of a number of whānau (family) and sharing a common ancestor; section of an iwi (tribe) and the primary political unit in traditional Māori society.

Hauora

A Māori word that refers to the breath of life and spirit; a physical sense of wellbeing for an individual, and integrated with, and dependent upon, collective qualities. References: Henare, M. (1988). Ngā tikanga me ngā ritenga o te ao Māori: Standards and foundations of Māori society. In *The April report: Report of the Royal Commission on Social Policy. Volume 3, Part 1: Future directions, associated papers*. The Royal Commission on Social Policy. <https://ndhadeliver.natlib.govt.nz/delivery/>

[DeliveryManagerServlet?dps_pid=IE17401282](#); Pihama, L., & Smith, L. T. (2023). *Ora: Healing ourselves: Indigenous knowledge, healing and wellbeing*. Huia.

He Whakaputanga o te Rangatiranga o Nu Tirenī (He Whakaputanga)

The Declaration of Independence, signed in 1835, declaring the independence of *rangatira* and asserting Aotearoa New Zealand as an independent state.

Healthism

A worldview/belief system, rooted in neoliberal ideology, that emphasises individual choice and responsibility for health over broader social, environmental, and structural factors, making health a personal responsibility. A term coined by Crawford (1980). Reference: Crawford, R. (1980). Healthism and the medicalization of everyday life. *International Journal of Health Services*, 10(3), 365–388. <https://doi.org/10.2190/3H2H-3XJN-3KAY-G9NY>

Hegemonic masculinity

A term coined by Raewyn Connell to describe a dominant and culturally valued form of masculinity, contrasted and defined against femininity, and in hierarchical relationships with other forms of masculinity. For a discussion of this concept that has developed over the years, see Messerschmidt, J. W., & Bridges, T. (2024). Legitimation as linchpin: On Raewyn Connell's changing conceptualization of 'hegemonic masculinity'. *International Review of Sociology*, 34(2), 211–239. <https://doi.org/10.1080/03906701.2024.2388616>

Hermeneutics of empathy

Hermeneutics is a branch of philosophy related to the theory and practice of interpretation. Hermeneutics of empathy is an approach to interpretation that focuses on people's worldviews. It seeks to deeply understand, capture, and reflect back how people experience an issue, and make sense of those experiences.

Hermeneutics of suspicion

Hermeneutics is a branch of philosophy related to the theory and practice of interpretation. Hermeneutics of suspicion is an approach to interpretation that interrogates the claims presented in the data, seeking to uncover more than the surface meaning. The researcher may use a theoretical framework to do this, for example, poststructuralism or psychoanalysis.

Heteronormativity

The assumption that heterosexuality is the norm or default, which can marginalise LGBTQ+ individuals in healthcare settings and research.

Hine-ahu-one

Atua, god, first woman.

Hine-nui-te-pō

Atua, god, whom *Hine-tītama* recreates herself as.

Hine-tītama

Atua, god, first daughter of *Hine-ahu-one* and *Tāne*.

Hinengaro

Mind, thought, psychological; see also *Te taha hinengaro*.

Hōhā

To be bored/boring, annoying/annoyed, to be fed up with.

Hysteria

A now-discredited medical diagnosis, historically applied primarily to women, that attributed a wide range of physical and emotional symptoms to dysfunctions of the uterus or nervous system. Often used to pathologise women's distress and resistance.

Iatrogenesis

Harm caused unintentionally by healthcare interventions, including side effects, psychological damage, or reinforcing stigma.

Idiographic

An approach that prioritises understanding the unique individual, such as their characteristics, behaviour, personality, or lived experience, and interpretation of those experiences. Can be contrasted with the nomothetic approach, which seeks to produce generalisable or universal patterns or principles of human behaviour.

Illness narratives

Stories people tell about their, or other people's, illness that can provide a resource for making sense of that illness.

Imperialism

When a powerful country extends its control over other countries or territories, often through force, colonisation, or political and economic dominance. It involves exploiting land, resources, and people for the benefit of the imperial power, and usually imposes its own values, systems, and authority on those it dominates.

Induction

The medical process of artificially starting labour by using medications or other methods to initiate contractions, rather than waiting for labour to begin naturally.

Injury

The physical harm or damage to the body resulting from an external force, such as accidents or violence. Injuries can range from minor to severe and can have immediate and/or long-term effects on an individual's health and functioning, sometimes creating disability or vulnerability to subsequent disease.

Interpellate (also interpellating, interpellated)

Refers to the process of being hailed by an identity. It includes the process of giving someone or something an identity (e.g., when a magazine addresses the reader in a particular way), but also that person's identification with, or acceptance of, this identity. The philosopher Louis Althusser connected interpellation to ideology, using the analogy of a policeman shouting "hey you" as people walk down a street. The person who turns towards the policeman has recognised that the "hailing" was for them. In

this analogy, the policeman is an ideology (e.g., healthism), and responding to the call is the process of internalising and accepting that ideology (e.g., identifying with, and enacting, digital health citizenship).

Intersectional profiling

The use of intersecting identity markers (like race, age, gender, class) by healthcare providers—often unconsciously—to make assumptions about patients' risk or credibility.

Intersectionality theory

A theoretical framework for conceptualising how multiple social positions, including racialised, gendered, classed, and those related to sexuality, disability, and immigration status, intersect together to create complex forms of inequality, discrimination, or disadvantage. Intersectionality was a term coined by legal scholar Kimberlé Crenshaw in 1989, to highlight how Black women, in particular, experience overlapping and intensified forms of oppression. When using intersectional theory, it is important to recognise that race is essential to the theory, and studies using intersectional theory that do not consider race (e.g., those exploring the intersections of class and gender only) belie the foundations of the theory, and risk whitewashing it.

Interventionism

A focus on actively intervening in the body to address illness, often through medical procedures, pharmaceuticals, or technologies, emphasising treatment over prevention or social determinants of health.

Intra-action

A term often used by Karen Barad (2007) to describe how elements are not separate, pre-existing entities that subsequently interact, but are co-constituted, or produced through emerging relational entanglements. It can be contrasted with the term “interaction”, in which two already existing elements interact. Reference: Barad, K. (2007). *Meeting the universe halfway: Quantum physics and the entanglement of matter and meaning*. Duke University Press.

Intrauterine device (IUD)

A form of contraception placed inside a uterus to prevent pregnancy.

Iwi

Extended Māori kinship group, tribe, nation; a large group of people descended from a common ancestor and associated with a distinct territory, usually comprised of a number of hapū (subtribes).

Kaitiakitanga

Guardianship, stewardship.

Kapa haka

Māori performing arts group.

Karakia

Prayer, incantation, chant.

Kaupapa

Topic, policy, matter for discussion, plan, purpose, scheme, proposal, agenda, subject, programme, theme, issue, initiative.

Kaupapa Māori

A Māori approach embedded in Māori knowledges and worldviews.

Kaupapa Māori theory

Research theory and practice that emphasises Māori cultural ways and knowledges, with a focus on transformative outcomes for Māori (Smith, 2017). Reference: Smith, G. H. (2017). Kaupapa Māori theory: Indigenous transforming of education. In T. K. Hoskins & A. Jones (Eds.), *Critical conversations in Kaupapa Māori* (pp. 70–81). Huia.

Kāwanatanga

Referring to governance, as a *provision* of Article 1 of *Te Tiriti o Waitangi*.

Kōrero

Discussion, dialogue, narrative, story, speech.

Kura Kaupapa Māori

Māori immersion primary schools.

Kurawaka

The place in Māori creation narratives where the first woman, Hineahuone, was created.

Lay knowledge

Everyday understandings of health and illness held by people outside the medical profession, often rooted in lived experience and cultural context.

Liminal hotspot

A certain kind of liminal space where there is risk of getting "stuck" between two mutually exclusive alternatives due to a lack of ability to move toward one or the other.

Liminal occasion (also liminal state)

The period of time or event in which liminality is a defining characteristic.

Liminality

A period of transition, where someone or something moves from one form or process into a different, but recognisable kind of state or process (e.g., moving between careers or from the situation of being healthy to acquiring a chronic condition).

Mainstream psychology

An individualist, often socio-cognitive psychology that dominates English-language psychology.

Mamae

Pain, suffering, wound, trauma.

Mana

Spiritual authority or power.

Mana ake

Unique identity.

Marae

A gathering place for Māori made up of a communal complex of buildings and grounds belonging to a particular hapū (sub-tribe). The marae includes the courtyard, wharenui (meeting house), wharekai (dining hall), and sometimes other grounds and buildings.

Matariki

A star constellation (Pleiades) signalling the Māori new year.

Mātauranga

A body or continuum of Māori knowledges; refers to something unique and valuable about the Māori world (Royal, 2012); encompassing of all branches of Māori knowledges, including past, present, and still developing (Mead, 2016). References: Mead, H. (2016). *Tikanga Māori: Living by Māori values*. Huia; Royal, T. A. C. (2012). Politics and knowledge: Kaupapa Māori and Mātauranga Māori. *New Zealand Journal of Educational Studies Te Hautaki Mātai Mātauranga o Aotearoa*, 47(2), 30–37.

Materiality

In more-than-human theory, this refers to the elements of the physical world in an assemblage. It includes bodies, buildings, technology, and any other physical elements, both human and non-human made. Within these theories, these material elements are conceptualised as agentic, in the sense that they create affective relations that increase or decrease the capacities of an assemblage. For example, in Chapter 1.2 we discussed how a cardioverter-defibrillator (a device implanted in people with heart arrhythmias or other conditions) is part of a dynamic network of interacting human and non-human elements that produce a heartbeat.

Maunga

Mountain.

Mauri

Life essence; see also *Mauri ora*.

Mauri ora

Refers to the life-giving essence, the spark and vitality of life that binds the spiritual and physical (Barlow, 1991; Mead, 2016). References: Barlow, C. (1991). *Tikanga whakaaro: Key concepts in Māori culture*. Oxford University Press; Mead, H. (2016). *Tikanga Māori: Living by Māori values*. Huia.

Mechanistic view

A perspective in biomedicine that treats the body as a machine, with health problems understood as malfunctions of individual parts that can be fixed or replaced.

Medical authority

The socially and legally sanctioned power of medical professionals to diagnose, treat, and make decisions about health and illness.

Medical gaslighting

A situation where a healthcare professional dismisses or minimises a patient's symptoms, concerns, or experiences, leading the patient to doubt their own perceptions and delaying proper diagnosis or treatment. Also see, epistemic injustice.

Medicalisation

The expanding remit of medicine, where aspects of life that were once not seen as medical come to be understood as medical, and therefore needing medical treatment. For example, addiction, often previously considered a personality or moral issue, is now often considered a medical one. Other examples, include personality traits like shyness or “natural” processes like aging or menopause.

Meihana Model

A Māori model of health to guide assessment and treatment that is represented as a *waka hourua* traversing the ocean. *Whānau* are placed at the centre, alongside the individual, and the model includes the four dimensions of *Te Whare Tapa Whā*. The historical and social context of Aotearoa New Zealand is represented as *ngā hau e whā*, the four winds. It also includes components from *te ao Māori* that influence wellbeing, depicted as *ngā roma moana*, ocean currents (Pitama, et al., 2007, 2017). Discussed in detail in Chapter 1.1.

Mind-body dualism

A philosophical concept that separates the mind and body as distinct entities, with the mind associated with thoughts and emotions, and the body viewed as a physical machine. This perspective has influenced biomedicine by prioritising physical health over psychological or emotional factors.

Minority stress

The chronic stress experienced by marginalised groups due to stigma and discrimination.

Moana

Ocean.

Moral responsibility (in health)

The expectation that individuals are accountable for their health status or choices, often shaped by neoliberal and healthism discourses.

Mōteatea

Lament, traditional chant, sung poetry.

Mythical norm

A term coined by Black feminist scholar, Audre Lorde, to describe the standards that society upholds as the norm, marginalising those who do not fit into this narrow framework: “there is what I call a *mythical norm*, which each one of us within our hearts knows ‘that is not me’. In America, this norm is usually defined as white, thin, male, young, heterosexual, Christian, and financially secure. It is with this mythical norm that the trappings of power reside within this society” (Lorde, 1984, p. 116). Reference: Lorde, A. (1984). *Sister outsider: Essays and speeches*. Crossing Press.

Natural science paradigm

Underpins the belief that health phenomena are rooted in physical or biological processes, and can be objectively measured, quantified, and explained through the scientific experimental method and

cause-and-effect relationships. In critical health psychology, the natural science paradigm is critiqued for its narrow focus on biological determinants of health.

Neoliberal citizenship

A way of conceptualising citizenship that gives value and status to people who are economically active, “appropriately” consuming so that they can participate in consumer culture, and able to manage economic risks to meet the needs of a fluctuating market economy and avoid being a cost to the state (e.g., through welfare or health service use). Examples include spending money on consumer goods, especially in a recession, producing one’s sense of self and identity through consumption (e.g., buying a house, paying for gym membership), understanding economic risks and responding accordingly, such as retraining into a new industry that has more economic opportunities. To enact this citizenship, neoliberal subjects are self-disciplined, reflexive, risk-managing, and autonomous, managing themselves as a project to remain a valued citizen within neoliberal economies, primarily through economic and consumer participation. Neoliberal health citizenship applies this logic to health, where the citizen is viewed as a rational actor who must actively manage their own health through personal choice, discipline, and market participation. For more information see, for example, Mavelli, L. (2022). *Neoliberal citizenship: Sacred markets, sacrificial lives*. Oxford Academic.

Neoliberalism

An economic and political approach that promotes free markets, individual responsibility, and limited government. In health, it often means shifting responsibility for wellbeing onto individuals instead of addressing wider social issues like poverty, racism, or inequality.

Neurasthenia

A 19th- and early 20th-century diagnosis describing fatigue, anxiety, and weakness, thought to result from the stresses of modern life. It was often linked to middle-class men but later pathologised women as well.

Neurodivergent

Sometimes abbreviated as ND, neurodivergent means having a mind that functions in ways that diverge significantly from the dominant societal standards of “normal” (Walker, 2025, <https://neuroqueer.com/neurodiversity-terms-and-definitions/>).

Neurodiversity

The diversity of human minds, the infinite variation in neurocognitive functioning within our species (Walker, 2025). Reference: Walker, N. (2025). *Neurodiversity: Some basic terms & definitions*. <https://neuroqueer.com/neurodiversity-terms-and-definitions/>

Neurodiversity movement

Is a social justice movement that seeks civil rights, equality, respect, and full societal inclusion for the neurodivergent (Walker, 2025). Reference: Walker, N. (2025). *Neurodiversity: Some basic terms & definitions*. <https://neuroqueer.com/neurodiversity-terms-and-definitions/>

Neurotypical

Often abbreviated as NT, neurotypical means having a style of neurocognitive functioning that falls within the dominant societal standards of “normal” (Walker, 2025). Reference: Walker, N. (2025). *Neurodiversity: Some basic terms & definitions*. <https://neuroqueer.com/neurodiversity-terms-and-definitions/>

New materialism, also feminist new materialism

An umbrella term for several theoretical “posthuman” approaches that share the idea that materiality plays an active role in shaping the issue under study. It incorporates critical theory, such as poststructuralism and feminist theory, and explores the dynamic, co-constituting relations between the human and the nonhuman by giving agency to non-human actors; it also decentres the human, in contrast to, for example, humanism.

Ngā hau e whā

The four winds.

Ngā manukura

Leadership, leaders.

Ngā roma moana

The ocean currents.

Ngā tikanga katoa rite tahi

Referring to all of the rights as a *provision* of Article 3 of *Te Tiriti o Waitangi*.

Ngākau

Heart, seat of emotions.

Noa

Ordinary state, to be free from the restrictions of *tapu*.

Nomothetic

An approach that seeks to produce generalisable/universal patterns or principles of human behaviour by identifying patterns across large groups of people. It can be contrasted with the idiographic approach which focuses on studying unique elements of individuals.

Obesogenic environment

A setting or set of conditions that promote excessive calorie intake and sedentary behaviour contributing to weight gain. This can include factors like the availability of unhealthy food options, lack of (safe/adequate) spaces for physical activity, and social or cultural norms around eating and exercise.

Ontology

A branch of philosophy concerned with the nature of being, existence, or reality. Ontology considers the assumptions that we make about what kinds of things exist (e.g., health, illness), and how they come into being.

Open science

A movement to open up all stages of the research process, including publicly registering research questions, hypotheses, and analysis plans before data collection begins, as well as making data sets publicly available.

Pākehā

A New Zealander of European descent, often a form of positive identification in relation to te ao Māori.

Papa

Earth, ground, also an abbreviation of Papatūānuku.

Papatūānuku

Earth, Earth Mother.

Pathologisation

The process of treating difference as something abnormal or in need of medical treatment. It reflects the workings of institutional authority, particularly psychiatry, psychology, and medicine, in defining what counts as “normal”, “healthy”, or “sane”. For example, until 1973, homosexuality was historically pathologised as mental disorder when listed in the Diagnostic and Statistical Manual of Mental Disorders.

Patient-centred care

An approach to healthcare that centres the patient’s needs, values, and preferences, and encourages shared decision making and holistic support.

Pattern shift

A positive transformation resulting from a liminal occasion. See Chapter 3.2 for further discussion.

Pedagogy of disgust

A strategy used in some health promotion campaigns that aims to change behaviour by deliberately evoking feelings of shame, fear, or revulsion. It often relies on stigmatising images or messages to discourage behaviours seen as unhealthy (e.g., smoking, drug use, or “obesity”). While intended to motivate change, this approach can reinforce stereotypes, blame individuals for their health, and cause psychological harm—especially for people from already marginalised groups (Lupton, 2015). Reference: Lupton, D. (2015). The pedagogy of disgust: The ethical, moral and political implications of using disgust in public health campaigns. *Critical Public Health*, 25(1), 4–14. <https://doi.org/10.1080/09581596.2014.885115>

Phenomenological psychology

Phenomenology is the “study of human experience and the way in which things are perceived as they appear to consciousness” (Langdridge, 2007, p.10). Psychological research informed by phenomenology focuses on conscious individual experience, including interpretation of that experience. The person is conceptualised as an interpreter who is constantly making sense of their conscious experiences. Phenomenological psychological research considers how a phenomenon is subjectively perceived, experienced, and interpreted by a person. Reference: Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method*. Pearson Education.

Positionality (also social positionalities and social positions)

Refers to how social and cultural categories, such as those related to a person’s gender, sexuality, ethnicity, race, class, able bodiedness, and so forth, locate them in the world, providing them with certain vantage points, as well as frameworks from which they might be understood by others.

Post qualitative

An approach within qualitative research that challenges traditional approaches within qualitative psychology that have the individual as the primary unit of analysis. Instead, it undertakes research that decentres the human, explores the interconnectedness of human and nonhuman, and is often critical

of pre-defined methods or methods that reproduce the values of quantitative research. It informed by critical theories including, posthuman and more-than-human theories, poststructuralism, feminist and queer theories, and Indigenous scholarship and philosophies.

Post-truth

A term used to describe an element of our current political era where objective facts and truth claims have less value in public and political discourse than personal beliefs, opinions, emotional appeals, or explicit use of untruths or unsubstantiated claims that are presented as truths.

Postfeminism

A term with multiple meanings. Here, we use it in reference to Rosalind Gill's (2007) concept of a "postfeminist sensibility" in which notions of choice, individualism, and empowerment are connected with expectations to work on and transform the body and mind, often through consumerism. Postfeminist sensibility is usually considered in relation to disciplinary power [see Chapter 1.4]. Reference: Gill, R. (2007). Postfeminist media culture: Elements of a sensibility. *European Journal of Cultural Studies*, 10(2), 147–166. <https://doi.org/10.1177/1367549407075898>.

Postfeminist healthism

A framework for understanding how healthism is gendered, which for girls, women, and other people interpellated by femininity, connects healthism (health as a personal responsibility) to a postfeminist sensibility, where work on the body and mind to meet normative constructs of healthy femininity is constructed as empowering, but which often functions as a social prescription and form of disciplinary power. References: See Chapter 1.4 of this volume. Also see Riley, S., Evans, A. & Robson, M. (2019). *Postfeminism and health*. Routledge.

Posthuman

An umbrella term to describe a range of approaches that challenge humanist ideas that centre humans and conceptualise them as bounded and self-contained actors in the world, instead, emphasising dynamic, co-constituting relations between the human and nonhuman.

Poststructuralism

At its broadest level, poststructuralism can be defined as an approach that seeks to push the focus of inquiry beyond knowable structures in the study of social behaviour. It brings to the fore the importance of knowledge systems and their power in limiting the breadth of human thought and action. Rather than drawing causal links between structures (be they economic, social, linguistic, or otherwise) and human behaviour, poststructuralism seeks to interrogate the forms of knowledge, the logics, and the assumptions that underlie our actions and—for the purposes of critical psychology—our interventions on the social. Reference: Macleod, T., & Palmer, M. (2014). Post-structuralism. In T. Teo (Ed.), *Encyclopedia of critical psychology*. Springer.

Pou

Carved wooden poles or posts that can serve as boundary markers and support structures integral to the building of Marae, a gathering place for Māori made up of a communal complex of buildings and grounds belonging to a particular hapū (sub-tribe). The pou support the Marae meeting house, and for that reason this term is sometimes adopted by institutions to refer to the central values supporting the work that is done within them.

Pou of critical health psychology

To introduce the foundations of critical health psychology, we described five pou (pillars or central

values), namely, (1) valuing theoretical/conceptual thinking, (2) challenging taken-for-granted understandings, (3) paying attention to issues of power and equity, (4) moving beyond individualist psychology, and (5) considering knowledge as produced in context.

Power asymmetry

Unequal distribution of power in healthcare interactions, often seen in the authority held by providers over patients' bodies, choices, and narratives.

Practice

Critical health psychologists tend to use the word “practices” rather than “behaviour” when talking about things that people do. This is because the word practices recognises the performative, social, and relational elements of what we do. Rather than locating behaviour as an outcome of individual decision, the word “practices” recognises that people’s behaviours are shaped by a range of social and relational elements, such as social norms, expectations, power relations, and the contexts in which they live and interact with others. While “behaviour” implies something inherent or individual, “practice” highlights that actions are embedded in these contexts.

Praxis

From a critical theory perspective, this entails a cycle of engaging with theory, taking action, and reflecting and critiquing the action to then inform the theory, and so on.

Principles

The current day consideration of the terms of agreement of *Te Tiriti o Waitangi* and *The Treaty of Waitangi*.

Processual philosophy

Emphasises the continual unfolding of an emerging world, directing attention to those forces that shape the emerging world, rather than its separated-out components.

Productive power

A Foucauldian term, productive power operates when some ideas about the world, and the people in it, accrue greater cultural acceptance than others. We can think of this as power that *produces* particular understandings, in contrast to coercive power, which is enacted when a person explicitly, and forcibly, wields power over another. See Chapter 1.4 for further explanation.

Pronatalism

A belief system or cultural norm that values and promotes childbirth and parenting, often positioning those who are childfree (by choice or circumstance) as deviant or deficient.

Provisions

The specific terms of agreement within the text of *Te Tiriti o Waitangi* and *The Treaty of Waitangi*.

Psy-complex

The wide system of ideas and practices that make up psychology. This includes fields like psychiatry, social psychology, social work, and education, which use psychological approaches to address social issues.

Psychoneuroimmunology (PNI)

An interdisciplinary field studying the interactions between psychological processes, the nervous system, and the immune system, exploring how mental states such as stress and emotions can influence immune function and overall physical health.

Puku

Seat of emotions, stomach.

Pūrākau

Māori narratives or stories.

Rainbow

In this context, an umbrella term that covers all sexual and gender minorities, and people with variations of sex characteristics, and which avoids the acronym LGBTQIA+. This can be used to identify communities as well as an individual. Reference: <https://www.publicservice.govt.nz/guidance/glossary/diversity-and-inclusion>

Rangatira

Chief, leader.

Rangatiratanga

Independence, authority, sovereignty.

Rangi

Abbreviation of Ranginui; Sky, Sky Father.

Ranginui

Sky, Sky Father.

Realist ontology (also known as realism)

A realist ontology is philosophical understanding that a real world, or “singular reality”, exists independently of people perceiving that world, and which has enough constancy that stable patterns of reality exist to be discovered.

Reductionism

The approach of simplifying complex phenomena by breaking them down into their smallest components, often overlooking broader social, cultural, or systemic influences.

Reflexivity

The process of critically examining one's own role and assumptions. This means exploring how your values and social positions shape your knowledge production, from project conceptualisation through to analysis. Reflexivity can occur at multiple levels, including your values; positions of privilege and marginality; methodological, theoretical, philosophical, political, or disciplinary assumptions or commitments; and your hopes, expectations, anxieties and fears for your work.

Reifies

The process of making something abstract more concrete or real.

Relational healthism

A term coined by Robson et al. (2023) to describe how healthism materialises in intimate relationships, so that expectations to work on one's health as part of an understanding of health as a personal responsibility extend into romantic relationships, producing health as a joint endeavour. Reference: Robson, M., Riley, S., Gagen, E., & McKeogh, D. (2022). Love and lifestyle: How 'relational healthism' structures couples' talk of engagement with lifestyle advice associated with a new diagnosis of coronary heart disease. *Psychology & Health*, 38(12), 1606–1622. <https://doi.org/10.1080/08870446.2022.2033240>

Relativist epistemology (also known as relativism)

A relativist epistemology is philosophical understanding that we cannot access the real world directly, because our experience of it is always mediated, though, for example, our biology, personal histories, and available social constructs. The knowledge we have of the world, and our methods for making that knowledge, are therefore always partial, shaped by who we are, and cannot include the full "reality".

Reo

Language; see *Te reo Māori*.

Reproductive justice

A framework that links reproductive rights to broader social justice, emphasising the right to have children, not have children, and parent in safe, supportive environments, especially for marginalised groups.

Responsibilising

Refers to the processes by which individuals are made to feel personally responsible for managing their health and wellbeing, often in ways that align with neoliberal rationality and values of self-discipline, appropriate risk management, and autonomy.

Role (in healthcare interaction)

The function or identity a healthcare professional takes on—such as expert, educator, advocate, or gatekeeper—that shapes how they relate to and interact with patients.

Rongoā

Traditional healing practices and medicines.

Scripts

Are defined as “prevailing sociocultural understandings (sets of meanings, metaphors, representations, images, stories, statements, and so forth) present in society's language practices and in the particular context in which [talk] is situated” (Morison & Macleod, 2015, p. 9). Reference: Morison, T., & Macleod, C. (2015). *Men's pathways to parenthood: Silence and heterosexual gendered norms*. HSRC Press.

Shared decision making

A collaborative process in which healthcare providers and patients make treatment decisions together, based on clinical evidence and the patient's values.

Sick role, The

A temporary social position granted to people who are perceived as legitimately ill, allowing them exemption from normal responsibilities and granting them support.

Sign

An observable, measurable indication of a health condition, such as a rash or fever, recognised as objective evidence of disease.

Social cognitive models

Psychological frameworks that explain health behaviours by focusing on how people think, feel, and make decisions, often considering factors like beliefs, attitudes, self-efficacy, and social influences.

Social constructionism

A range of approaches that share the ideas that knowledge is historical and culturally specific, produced through language and other forms of representation, and that knowledge and social processes go together, since how we understand the world is produced in interaction and shapes what is possible for people to think, feel, say, or do. Although there is variety in the way social constructionist approaches engage with power, social construction has an inherently critical agenda “since it seeks to question taken-for-granted knowledge about the social world and how we categorise it, which proclaims itself (sometimes subtly and sometimes not so subtly) to be self-evident truth” (Cooper & Thorogood, 2013, p. 21). References: Burr, V. (2025). *Social constructionism* (4th ed.). Routledge; Cooper, S. & Thorogood, N. (2013). Social construction of health and health promotion. In L. Cragg, M. Davies, & W. Macdowall (Eds.), *Health promotion theory* (pp. 20–34). McGrawHill.

Social gradient in health

The social gradient in health refers to the consistent finding that people with lower socioeconomic status tend to have worse health outcomes than those with higher status, with health improving at each step up the social ladder.

Social justice

The pursuit of a fair and equitable society in which all people have equal access to rights, resources, and opportunities, regardless of their raced, gendered, classed positions, ability, sexuality, and so forth. Social justice moves beyond a focus on rights, by challenging power imbalances, and questioning the systemic barriers to health and structural causes of health inequities.

Social prescriptions

Social prescribing (SP) is where a patient is referred to a “link worker”, who considers their needs and then “prescribes” or connects them to appropriate community-based resources and services to improve patient health and wellbeing. Friedli, L., & Watson, S. (2004). *Social prescribing for mental health: A guide to commissioning and delivery*. Care Services Improvement Partnership—provides examples of social prescribing initiatives in the UK, including those that address housing and other social issues.

Social reception

How a particular illness is received by others; how they respond to people with different conditions.

Social sanctioning

The process by which others recognise or deny a person's claim to be ill, influencing whether that person receives sympathy, care, or assistance.

Socio-ecological model

A framework to understand human development including the interactions between individuals and their social environments. Developed by Urie Bronfenbrenner.

Spatiality

Refers to the lived experience of space, emphasising how our bodies and spatial positioning shape our understanding of the world, rather than viewing space as an abstract entity.

Stigma

The negative attitude attached to a characteristic of an individual that may be regarded as a mental, physical, or social deficiency; an “attribute that is deeply discrediting” (Goffman (1963, p. 3). Stigma implies social disapproval and can lead unfairly to discrimination against, and exclusion of, the individual. References: <https://dictionary.apa.org/stigma>; Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Simon & Schuster.

Stigmatisation

The negative labelling and social devaluation of individuals because of their illness, often leading to exclusion and discrimination.

Stoicism

A philosophical tradition associated with thinkers like Epictetus, Seneca, and Marcus Aurelius. Stoicism values self-control, rationality, and acceptance of things beyond one's control. In health contexts, it can shape the expectation to endure suffering without complaint.

Subject position

A term used to describe how discourses produce types of persons or roles that have associated ways of speaking and acting (Davies & Harré, 1990). When people occupy a subject position, they have a particular vantage point to understand themselves or be understood by others. Reference: Davies, B., & Harré, R. (1990). Positioning: The social construction of selves. *Journal for the Theory of Social Behaviour*, 20(1). <https://doi.org/10.1111/j.1468-5914.1990.tb00174.x>

Subjective experience (of illness)

The personal, emotional, and embodied experience of being unwell, often differing from biomedical interpretations of disease.

Subjectivity

How we make sense of ourselves; a person's understanding and sense of themselves. Social constructionist and critical theorists prefer the term subjectivity to identity, because identity implies a fixed characteristic located within the individual, whereas subjectivity implies a more ongoing sense of self, produced within social context.

Sunflower

A flower and symbol for invisible disability.

Survivorship discourse

Cultural narratives that position people with serious illness (like cancer) as heroic survivors, often placing pressure on individuals to “fight” or “overcome” disease.

Symbolic ableism

A subtle form of prejudice against disabled people. It is often expressed through seemingly harmless or even positive statements that perpetuate negative stereotypes and reinforce systemic discrimination. Symbolic ableists score high in terms of individualism, including the idea that if people with disabilities

try hard enough, they can succeed (Friedman & Owen, 2017). Reference: Friedman, C., & Owen, A. L. (2017). Defining disability: Understandings of and attitudes towards ableism and disability. *Disability Studies Quarterly*, 37(1). <https://dsq-sds.org/index.php/dsq/article/view/5061/4545>

Symptom interpretation

The process of understanding bodily changes as signs of illness; influenced by personal, social, and cultural factors.

Symptoms

Subjective, personal experiences of a bodily sensation that may indicate illness, such as pain or fatigue.

Taha

Referring to domains and dimensions in Māori models of health.

Taken-for-granted understandings

Ideas that people do not notice because they feel normal and natural.

taken-for-granted understandings

Tāne

An atua or god in a Māori worldview; offspring to Papatūānuku and Ranginui.

Tangata whai ora

Person seeking wellness (plural: tāngata whai ora).

Tāngata whaikaha

Disabled people.

Tangata whenua

People of the land, local people, Indigenous people.

Tapu

A state of restrictedness, sacredness.

Tauira

A student/pupil.

Tauiwi

A Māori term for non-Māori people living in Aotearoa New Zealand.

Te ao Māori

The Māori world, Māori worldviews.

Te ao mārama

Refers to the third phase in time in the origins of the universe from a Māori worldview, within which humans exist; meaning the world of light.

Te Kōhanga Reo

Translates in English to language nest, referring to Māori early childhood education. Focuses on total immersion in Māori language and values for preschool children.

Te kore

Refers to the most distant phase in time, the beginning of the universe from a Māori worldview; meaning the source of all life, the nothingness, and the void.

Te mana whakahaere

Autonomy, authority.

Te Moana Nui a Kiwa

Pacific Ocean.

Te oranga

Livelihood.

Te Pae Mahutonga

A Māori health model within health promotion represented as the Southern Cross star constellation, with four central stars and two pointer stars that symbolise the key tasks of health promotion (Durie, 1999). Reference: Durie, M. (1999). Te Pae Māhutonga: A model for Māori health promotion. *Health Promotion Forum of New Zealand Newsletter*. <https://www.cph.co.nz/wp-content/uploads/TePaeMahutonga.pdf> [PDF]

Te pō

Refers to the second phase in time in the origins of the universe from a Māori worldview within which only atua (gods) existed; meaning darkness, and the night.

Te reo Māori (te reo)

The Māori language.

Te ritenga Māori

Referring to Māori spiritual practices, as a *provision* of Article 4 of *Te Tiriti o Waitangi*.

Te taha hinengaro

Dimension of mental and emotional wellbeing.

Te taha tinana

Dimension of physical wellbeing.

Te taha wairua

Dimension of spiritual wellbeing.

Te taha whānau

Dimension of family and social wellbeing.

Te taiao

Natural environment.

Te Tiriti o Waitangi (Te Tiriti)

Te reo Māori text of the treaty signed in 1840 between the British Crown and Māori, referred to as the founding document of Aotearoa New Zealand as a nation. Discussed in detail in Chapter 1.1.

Te Whare Tapa Whā

A Māori health model that frames wellbeing across four domains: *te taha tinana*, physical wellbeing, *te taha hinengaro*, mental and emotional wellbeing, *te taha whānau*, family and social wellbeing, and *te taha wairua*, spiritual wellbeing (Durie, 1985, 2001). Discussed in detail in Chapter 1.1. Reference: Durie, M. (1985). A Māori perspective of health. *Social Science & Medicine*, 20(5), 483–486. [https://doi.org/10.1016/0277-9536\(85\)90363-6](https://doi.org/10.1016/0277-9536(85)90363-6)

Te Wheke

A Māori model of health that affirms individual wellbeing as inseparable from *whānau* wellbeing. Represented as an octopus, the head symbolises *whānau* and the eyes represent *waiora*, the overall wellbeing of *whānau*. Each of the eight tentacles represent a dimension of wellbeing, including those encompassed in *Te Whare Tapa Whā*: *wairuatanga*, *hinengaro*, *tinana*, and *whanaungatanga*, as well as a further four dimensions: *mauri*, life essence, *mana ake*, unique identity, *hā a koro mā*, a *kui mā*, breath of life from ancestors, and *whatumanawa*, healthy expression of emotions (Pere, 1997). Reference: Pere, R. (1997). *Te wheke: A celebration of infinite wisdom*. Ao Ako Global Learning New Zealand.

Technologies of the self

The work people do on themselves to produce themselves into a desired subject position; “technologies of the self which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality” (Foucault, 1988, p.18). Reference: Foucault, M. (1988). Technologies of the self. In L. H. Martin, H. Gutman, & P. H. Hutton (Eds.), *Technologies of the self: A seminar with Michel Foucault* (pp. 16–49). The University of Massachusetts Press.

Temporality

Refers to the human perception of time, including the social organisation of time and the state of existing within or having some relationship with time. People and objects are always spatially and temporally located.

The Treaty of Waitangi (The Treaty)

The English text of the treaty signed in 1840 between the British Crown and Māori, referred to as the founding document of Aotearoa New Zealand as a nation. Discussed in detail in Chapter 1.1.

Tikanga

Māori customs and correct processes.

Tinana

Body, physical; see also *Te taha tinana*.

Tino rangatiratanga

Independence, self-determination, sovereignty; referring to independence, as a *provision* of Article 2 of *Te Tiriti o Waitangi*.

Tīpuna/tūpuna

Ancestors.

Tohu

Sign or symbol.

Tohunga

Expert, skilled person, healer.

Toiora

Total vitality spiritually and physically.

Transformation imperative

Expectations that produce social norms and cultural imperatives to be continuously working on the mind and/or body in order to improve it; often linked to neoliberalism and postfeminism.

Tuakana

Elder sibling (of the same gender); mentor.

Tūrangawaewae

A place to stand or belong, a place where one has rights of residence and belonging through kinship and whakapapa.

Ūkaipō

Origin or homelands; source of sustenance.

Urupā

Cemetery, burial grounds.

Vā

A concept in some Pacific cultures that describes the interconnectedness between people, and people and the environment; it foregrounds the importance of building meaningful relationships, and describes the context in which relationships unfold and the importance of maintaining harmony and balance within these relationships. For further information see <https://ncea.education.govt.nz/pacific-values-framework>, which describes a Pacific values framework in education that connects vā (relationships, reciprocity), with kuleana (responsibility), alofa (love dignity respect), vaka (collectivism), and fonua (belonging and connectedness).

Values

Deeply held beliefs about what is important, right, or desirable. Values shape people's attitudes and behaviours, and reflect broader worldviews about how society should function and what kinds of outcomes are worth striving for.

Wahine/wāhine

Māori woman/women.

Waiata

Song.

Waiora

Refers to total wellbeing and strength of spirit, denoting flowing and life-sustaining waters (Pere, 1997). Reference: Pere, R. (1997). *Te wheke: A celebration of infinite wisdom*. Ao Ako Global Learning New Zealand.

Wairua

Describes the spiritual and unseen; central to a Māori worldview about reality and human life; the ultimate reality of existence for Māori (Marsden, 1992). Reference: Marsden, M. (1992). God, man and universe: A Māori view. In M. King (Ed.), *Te ao hurihuri aspects of Māoritanga* (pp. 117–137). Reed Publishing.

Wairuatanga

Spirit, spirituality; see *Wairua*.

Waka hourua

Large double-hulled canoe vessel (waka).

Whaikaha

People who are determined to do well.

Whakamā

Embarrassment, shame.

Whakapapa

Refers to genealogy and layers of genealogy. The Māori worldview describes human life as descending from gods, and as related to the natural environment; the structure by which all things are connected (Barlow, 1991). Reference: Barlow, C. (1991). *Tikanga whakaaro: Key concepts in Māori culture*. Oxford University Press.

Whakatauāki

A significant Māori saying or proverb attributed to a known person.

Whakatauī

A significant Māori saying or proverb with unknown origins.

Whakawhanaungatanga

The process of establishing relationships.

Whānau

Family, extended family.

Whānau Māori

Māori family or families.

Whānau ora

Describes family and collective wellbeing; a term promoted in contemporary Māori health policy.

Whanaungatanga

Relationships, sense of connectedness; refers to relationship and kinship; it highlights connections between the natural world, gods or deities, ancestors, and humankind and encompasses a collective interdependence (Henry & Pene, 2001). Reference: Henry, E., & Pene, H. (2001). Kaupapa Māori research: Locating indigenous ontology, epistemology and methodology in the academy. *Organization*, 8(2), 234–242. <https://doi.org/10.1177/1350508401082009>

Whare

House.

Wharekai

Dining hall.

Wharenui

Meeting house.

Whatumanawa

Healthy expression of emotions; seat of emotions.

Whenua

Land, earth; also refers to placenta.

References

There is a list of references at the end of each chapter.

The editors have also created a public Zotero library. Please see below for instructions on how to join and view it.

The Critical Health Psychology Zotero library

This shared Zotero group library is a companion to this open textbook: *Critical Health Psychology: Foundations, Approaches and Applications*. It brings together references and resources that speak to the themes in the book. Whether you are a student, teacher, researcher, or curious reader, the library is free to access, and anyone can join. Instructions for joining and using the library follow.

How to join the library

Step 1: Create a Zotero account (if you don't have one already)

- Go to www.zotero.org
- Click “Log In” in the top right corner, then “Register for a free account”
- Fill out the form and confirm your email

Step 2: Find the group

- Once you are logged in, go to the *Groups* tab on your profile
- Search for “Critical health psychology”; or follow this link: https://www.zotero.org/groups/5764436/critical_health_psychology_textbook

Step 3: Click “Join Group”

- The group is public, you will join immediately

Step 4: Access the library

- You can now browse and use the library directly via the Zotero website
- To sync with your own Zotero desktop app, install the app (if you haven't already) and make sure you are logged in with the same Zotero account.

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Gloria Fraser is a lecturer in health psychology at Te Herenga Waka – Victoria University of Wellington. Gloria is interested in mental health, identity and culture, and how academic teaching and research can make change in the real world. She has previously conducted community-based research about Rainbow peoples' experiences of accessing mental health support and gender-affirming healthcare. Currently, Gloria's work focusses on eating disorders and body image, particularly among Māori, and increasing the cultural responsiveness of clinical frameworks. Gloria spends a lot of time thinking about the transformative potential of friendship, and how she can disrupt productivity and optimisation culture through slow scholarship. When not at mahi, you will find her reading a book in the company of her extremely beautiful cat, or running on Wellington's south coast.

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Ally Gibson is a senior lecturer in health psychology and Programme Director of Health Psychology at Victoria University of Wellington. Ally specialises in qualitative research at the intersections of health psychology, sociology, and public health. Her research spans diverse topics, including sexual and reproductive health, gender and identity, and the experiences of marginalisation in health contexts. Ally currently leads three projects: mobile dating during COVID-19, psychosocial support for cancer patients, and the application of artificial intelligence in qualitative research. Committed to critical approaches in health psychology, Ally brings expertise in discursive methods and values collaboration with public sector organisations and NGOs. She is passionate about promoting equity and meaningful inclusion in health research and practice.

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Rebekah Graham is a registered community psychologist and is employed as the National Executive Officer for Parents of Vision Impaired NZ (PVI). PVI is a national charitable organisation that provides support and advocacy for parents and whānau of a person with a vision impairment. In her role Rebekah advocates strongly and consistently for inclusion, accessibility, and support for all, with a focus on parents/whānau of a vision impaired child. She is the current chair of the Parent/Family/Whānau Network and is particularly interested in creating healthy communities that facilitate human flourishing. Being part of the Waikato Enabling Good Lives demonstration has shown her what is possible when you get the disability support that your family needs to live an ordinary life.

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Siobhán Healy-Cullen is a postdoctoral researcher at Massey University, New Zealand, working in the field of critical health and social psychology. Broadly speaking, her research explores gender, sexualities, and sexual socialisation using a range of critical, qualitative research methods. More specifically, she uses a social justice lens to understand psychological issues as located in socio-political, historical contexts, particularly within the current cultural climate, which places a high value on neoliberal economics and individualism. She is particularly invested in questioning taken-for-granted ideas about what “good” “healthy” sex/uality is, especially for young people. Siobhán has published on topics that relate to intersections of gender, power, and sexuality, such as pornography, “porn literacy”, sexual consent, sexual violence, “chemsex”, and sexual scripting theory. Her work on pornography joins a growing body of international scholarship that challenges the dominant protectionist, patronising, and disciplinary lens on young people and their sexualities.

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Aorangi Kora is currently a Māori doctoral student within the School of Psychology, Massey University. She is affiliated to the Centre for Indigenous Psychologies, School of Psychology, Massey University, Manawatū, with experience in various teaching and research capacities within the Centre. Her research expertise is on Kaupapa Māori and decolonising research methodologies, with a particular focus on hauora Māori (Māori wellbeing), critical health psychology, te taiao (the natural environment), and Māori experiences of digital technologies.

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Melinda Lewthwaite is a PhD candidate at Massey University, New Zealand. Her PhD research explores experiences of day-to-day dietary practices enacted in response to irritable bowel syndrome (IBS) symptom management. More specifically her research focuses on understandings of healthy eating within the IBS context and dietary practices, which whilst considered to be adaptive, functional and “normal” within IBS populations, have the potential to assemble with wider life contexts and temporalities in ways that can be both helpful and harmful. Melinda’s research interests include understandings of healthy eating, dietary practices associated with self-management of diet related chronic health conditions, orthorexia, and disordered eating/eating disorders. Melinda is interested in qualitative research and the use of assemblage theory and other new materialist theoretical perspectives to explore understandings of food/body practices.

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Kathryn McGuigan is a senior lecturer in Health and Social Psychology at Massey University, Auckland campus, New Zealand. Her research interests are broadly in the area of critical health psychology using qualitative methodologies. More specifically Kathryn is interested in exploring the intersections of health and wellbeing within disability, neurodivergence, eating and food practices, and gender. Kathryn is a passionate ally for social justice for disability and neurodiversity, with recent research focusing on neurodivergent tertiary students' experiences. Kathryn is also passionate about innovative qualitative methods, including arts-based research.

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Tracy Morison trained as a research psychologist and began her research career at South Africa's Human Sciences Research Council, where she conducted research addressing societal challenges. Her scholarship focuses on sexual and reproductive health, exploring how social contexts shape decisions and practices. She uses feminist and critical theories with qualitative methods to investigate topics like contraception, abortion, sexual violence prevention, and healthcare access for marginalised groups. Tracy's research aims to highlight structural barriers to reproductive choices and advocate for equitable health policies. She is committed to making academic knowledge accessible and applicable to real-world issues, including in teaching. Tracy is an associate professor at Massey University's School of Psychology and the director of the Health Psychology programme. She holds adjunct positions at her alma mater Rhodes University as an honorary research associate, Critical Studies in Sexualities and Reproduction programme and as editor-in-chief of *Feminism & Psychology* journal.

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Clifford van Ommen is an associate professor in the School of Psychology at Massey University, Auckland. He is interested in the socio-politics of rental housing, particularly in Aotearoa-New Zealand, and the consequences of this for the wellbeing of renters. He has a background in critical psychology, with previous research focussing on, amongst others, the history of psychology, neuroscience and subjectivity, racism, and precarity. He is a registered clinical and neuropsychologist.

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Sarah Riley is a Professor in Critical Health Psychology, at Massey University, Aotearoa New Zealand. Her award-winning, transdisciplinary research has explored multiple topics through the lens of subjectivity and power. She has worked in multiple successful collaborations with leaders in the field. Her co-authored books include *Technologies of Sexiness* (2014), *Postfeminism and Health* (2019), *Postfeminism and Body Image* (2022), and *Digital Feeling* (2023). Her co-edited books include *Critical Bodies* (2008), *Doing Your Qualitative Psychology Project* (2024), and *Doing Qualitative Research in Psychology* (2025). Her current projects explore relationships between gender and digital technologies, funded by the New Zealand Royal Society Te Apārangi. She is a senior fellow of the HEA, winner of the Massey University teaching award 2024, and past chair of both the International Society for Critical Health Psychology, and the British Psychology Society's Qualitative Research in Psychology Section.

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Amber Rose, Ngai Tahu

Amber Rose has many years lived experience, and now operates within the political health scape. She works with the United Nations and Te Whatu Ora to advocate for and provide expertise within queer spaces, ensuring everyone in life gets a fair chance and proper treatment.



Jessica Tappin, BA(Hons)

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Jessica Tappin is a senior tutor in the School of Psychology at Massey University (Aotearoa New Zealand). Her research interests lie in the overlapping and broad areas of critical health psychology, gender, sexuality, feminism, and critical media studies. Her PhD research used a feminist poststructural perspective to examine the discursive landscape of women's sexual desire within media and psychological literature. This focus includes how these prevalent discourses define and delimit women's opportunity for sexual subjectivity and agency. She teaches various Health Psychology courses at Massey University and is the co-editor of the blog and website for the International Society of Critical Health Psychology (ISCHP) and editorial assistant for *Feminism & Psychology*. Outside of work, she enjoys exploring the outdoors, working on pottery and knitting projects, and spending time relaxing in the garden with her partner, friends, and fluffy cat.

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Gareth Terry is broadly interested in the intersections of gender, bodies, and health. His research has explored men's sexual and reproductive health and decision-making, and men's embodiment and experiences of illness, injury, and body modification. He has also contributed to research exploring the decision to be "childfree" (for men and women), sexual consent practices (and implications of these for sexual violence), reproductive health in mid-life, and most recently, work in rehabilitation, disability and access (informed by critical rehabilitation studies). Gareth teaches about qualitative methods (especially reflexive TA) in university courses and through workshops (online and in person). He has written many chapters related to qualitative methods, with various combinations of Virginia Braun, Victoria Clarke, and Nikki Hayfield. He is co-author, with Nikki, of [*Essentials of Thematic Analysis*](#), part of *The Essentials of Qualitative Methods* series from the American Psychological Association.

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Alex Walker is a PhD student at Te Herenga Waka – Victoria University of Wellington. He has worked in Aotearoa's mental health sector since 2016, in crisis phonenumber roles and peer support. His research explores the role of experiential knowledge within mental health services, and strategies for honouring the unique epistemic contributions that peer supporters bring to the workforce. Alex is a passionate educator and has served as tutor and teaching assistant for postgraduate Health Psychology courses as well as undergrad Health Policy—in fact, his happy place is in the classroom! His favourite dinosaur is the triceratops, and he is a big fan of elephants.

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Peer review statement

Critical Health Psychology: Foundations, Approaches and Applications has been written by people who actively research and teach in this subfield of psychology. We recognise the importance of critical, and considered, expert review in producing textbooks, and accordingly, invited feedback for this work at every stage of development. Significant points of evaluation and development included:

- (1) Our large editorial team collectively supported the chapter authors and/or section editors in planning content for each chapter.
- (2) Once written, each chapter was reviewed internally by two people on the editorial team who were not authors of that chapter. They were encouraged to give substantial feedback, and each chapter was amended accordingly.
- (3) The whole book was then externally reviewed by two international experts in the field, Wendy Stainton Rogers (Professor Emerita in Health Psychology, Open University, UK), and Martine Robson (Lecturer in Psychology, Aberystwyth University). They were invited to comment on their overall opinion of the book, structure and organisation, coverage of the subject, content of each specific chapter, and any inaccuracies or inconsistencies. Chapter content was amended accordingly.
- (4) Recognising students are experts of their own learning and our primary target readership, where possible, draft chapters were shared with students on relevant courses. They were invited to give anonymised feedback, which was acted upon.
- (5) All the chapters were also reviewed Dr Eleanor Brittain for their engagement with Kaupapa Māori scholarship and representations of te ao Māori.
- (6) Because of the different content, the Hauora chapter followed a separate pattern of review, which included the expert review and consideration of Tā Mason Durie, as well as an earlier internal review by a member of the editorial team who was not an author.

Reviewer comments:

This book is outstandingly good, in very many ways. It is erudite and impressively scholarly, covers an amazingly broad knowledge-base, and offers students a massive bounty of resources they can access to help them gain real insight and in-depth understanding of contemporary critical health psychology. Its treatment of and respect for Māori scholarship in relation to healthcare policy and practice is very impressive, making it an ideal resource for teaching health psychology in A/NZ. The text weaves a compelling narrative around the different approaches to health psychology, including mainstream, phenomenological and social constructionist approaches, as well as theorization from a 'more than human' perspective. The book can be very much recognized as 'cutting edge' – really up to date and informed by recent scholarship in the field, making it also relevant for an international readership. *Wendy Stainton Rogers, Professor Emerita in Health Psychology, Open University, UK.*

I found this textbook engaging to read, thought-provoking, and generative. It meets the goal of centring the Aotearoa and Māori context while offering important and innovative theoretical perspectives that have a global applications where medicine and discourses of neoliberal healthism are decontextualized and disconnected from collectivist values and goals, and subjugated minoritized and Indigenous knowledges. It offers an affirmative as well as in-depth perspective – the examples of alternative practice are valuable and generative, inspiring optimism and empowerment in relation to systemic and community level change. The end-of-chapter activities, directions for future reading and thinking, and reflections offer clear opportunities

for deeper engagement. The focus on inclusive, culturally-informed and ethical critical health approach and practice has wide applicability as a framework for understanding complex contexts of health behaviours and outcomes, planning for change, and implementing effective interventions. *Martine Robson, Lecturer in Psychology, Aberystwyth University, UK.*

I really enjoyed this textbook, as not only was it simple to follow and easy to read, but it felt relatable and real. What I mean by this, is that often in textbooks they discuss elaborate topics or theories that discuss how we know the world works the way it does, or theories that are purely theoretical and lack application. In this textbook, a lot of the theories had real world examples and used real people and cultures to elaborate on this, and made me think of my own life and the people in it... I also enjoyed reading the historical context of Māori, the colonisation they have faced, and how it is still seen in today's structural systems. *Anonymous student on 175.743 Health the Social Context, Massey University.*

Versioning history

This page provides a record of changes made to this textbook. Each set of edits is acknowledged with a 0.1 increase in the version number. The exported files for this book reflect the most recent version.

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Version	Date	Change	Details
1.0	July 2025	Book published	
1.1	February 2026	DOI assigned	
