INTERVIEW

The psychological transformer

Critical health psychologist **Kerry Chamberlain** (Massey University, New Zealand) talks to Lance Workman about the academic evolution of his career

You began your career as a cognitive psychologist, developed an interest in social psychology and then moved into health psychology. Did one area lead to another?

It definitely was an evolution over time. When I was a student I was really attracted to experimental psychology. I actually kept away from social psychology because I saw it as a soft option – it wasn't really scientific, I thought then. When I started teaching and research, through my interests in memory and cognition, I developed an interest in visual imagery and visual memory processes. I then became interested in how we measure psychological concepts. This started me thinking about the nature of how we live and more generally about social processes. This led to an interest in doing more broad-based survey research work, and I spent a sabbatical year at the Survey Research Centre at the Australian National University. During the course of that I met an American academic, Lester Milbrath, who was also there on sabbatical. He was interested in social indicators and that got me interested in subjective social indicators in society, and ultimately in psychological well-being. This was related to the research being done by Angus Campbell, Frank Andrews and Stephen Withey. One day around that time I recall someone asked me what sort of psychologist I was, and I had to say to my surprise 'I think I have become a social psychologist!'

In terms of my move from there into heath psychology, when I was due for another sabbatical, I decided that I wanted to go to Paris, and work at UNESCO, for whom I had done some work on social indicators. But at that time UNESCO was short of money and closing down its social indicators programme, so I contacted people at the World Health Organization. They were supportive of a visit and suggested I work on physical health issues. So I ended up in Geneva for six months. I went there knowing very little about physical health but I very quickly discovered this whole literature on well-being-related work – the 'quality of life' literature – which was quite disconnected from the psychological social indicators work. One of my roles there was to do some of the very early developmental work on the WHOQUAL (World Health Organization Quality of Life) Scale, to develop a quality of life measure that would be applicable to everybody in the world, across cultures and across diseases.

When I went back to my day job I started reading much more about health and quality of life in health, and started talking with a colleague who was also interested in illness. We developed a postgraduate course in health psychology in the university: the first one offered in New Zealand, and it eventually grew into our present health psychology master's programme. So, in effect I became a health psychologist because I couldn't get to go to Paris!

That's quite a journey! You are interested in everyday illness – do you think this has been underresearched?

Yes I do. I think what's happened is we have spent a lot of time looking at major illness – cancer, diabetes, rheumatism and things like that. These severely impact on people's lives – so it is understandable that people haven't focused on mundane or everyday illness that much. But my interest here has been driven more by the move that I have taken into qualitative research and trying to think more about the contexts in which people live. My early thinking on everyday illness was driven by some work with people who had Type 1 diabetes. Although Type 1 diabetes can lead to some very serious consequences, when I worked with sufferers, I found that the things they talked about weren't the major problems with diabetes but the more mundane aspects. They were telling me things like they could walk into a food store and often know right away they had to walk straight out again because there was nothing they could eat. So sometimes it can be very difficult just finding somewhere to buy lunch without making your everyday management worse. This sort of problem intrigued me – how people lived day by day and hour by hour. People were talking to me about actually living in two- to three-hour blocks – that's how they thought of their lives. But if you start thinking about everyday illnesses, everybody has a sore knee or an ankle that gives them a bit of a twitch or the fact that their throat is always the first thing to play up when they're tired. People have these minor bodily dysfunctions but they manage them. I'm interested in this. One of the current projects we are doing is with homeless people – we are interested in how they cope and survive. Their everyday lives, and the notion of the flow of everyday life, what makes us who we are, and what we can and can't do – that intrigues me.

You recently co-authored *Health Psychology: A Critical Introduction*. Does the 'critical' in the title suggest that you and your ilk have problems with health psychology?

Well, you have to be critical about the term 'critical'. In our book 'critical' has more than one meaning. The first is the lay one – being thoughtful and critical, in both negative and positive ways, about our activities. Another involves being critically reflexive about what we do – about ourselves, our values, our approach to research and interventions, etc. And another again is the critical psychology use – who will benefit from our work, or more importantly, who is privileged and who is excluded by what we do? That's the large question – often someone will benefit from what we do, but somebody else will be disadvantaged by it.

So the core of critical psychology is thinking about these notions of disadvantage. This is closely lined up with our standards of status, orientation, ideology, and the way things are done. So the book was an attempt to write a general health psychology text with a strongly critical thread. The chapter on death and dying, for example, talks

quite a lot about how people often fall out of social life before they fall out of biological life. There's a lot of work around the notion of what makes a good death. Is a good death one where everything is tidy? Is it one where everything is good for the relatives? These are the sort of things that the book is grappling with – trying to show the complexity of health issues and a variety of ways we might approach them.

Talking about death, I read in your book that Australians have a longer life expectancy than New Zealanders. Are there psychological factors that play a role here?

We were trying to make the point that in societies that are really quite similar, Australia and New Zealand, you wouldn't really expect differences in mortality rates. So what is going on here? We don't know for certain, but we can see there are small, subtle things that go on that can impact on life expectancy. One explanation is that this is connected to differential levels of disadvantage – the difference between the best-off and worst-off – that have developed between the two countries after New Zealand took a much stronger stance on economic reform in the late '80s. Another relates to the different levels of migration to the two countries, with New Zealand taking in more people from Northern Europe and the near Pacific, whereas Australia has taken many more from Southern Europe and South-east Asia. So, the point is that the differences in mortality are more likely a result of socio-structural factors than psychological factors directly, even though these are bound up together.

Am I right in thinking that you would like to extend the remit of health psychology to cover areas such as the media and poverty?

Yes, that really arises out of the critical part of my interest. The structural social features of life, where people are positioned in certain ways such that some are disadvantaged, is fundamental and critical in relation to health. Media stories around health affect our understandings of how health is sustained and constrained, and helps to determine how we might be. In a paper on this we wanted to move the discussion about physical illness onto socio-structural issues like poverty and crime as key features. So we argued for extending the remit of health psychology. In relation to other work on media representations, our objective was to try and understand how health stories got told – and to suggest that journalists might consider broadening their agenda. We've been quite successful in that some journalists have asked us for material and we've been able to provide them with information and extend their stories in these ways. So we also argue that health psychologists need to collaborate with the media more and influence how stories get told, especially the overlooked stories of health disadvantage.

I get the impression that you think to date health psychology has been too medicalised?

Yes I think health psychology has largely operated in the service of medicine and taken up medicalised agendas. Here, I tend to make the distinction between mainstream health psychologists and critical health psychologists. The former tend to ask what's going on in health, what do you need us to do so that we can solve the psychological issues in relation to the treatments of illness, coping with illness, preparing for treatment. And that's all fine. But to my mind it actually positions health psychology as an adjunct to medicine, as a servant of medicine, and to doing whatever medicine wants. But health psychology ought to have a broader remit than that. Critical health psychologists tend to take on a larger agenda, and try to consider such things as how the work in health psychology is ideologically driven, how it functions to limit or constrain certain health practices, and the consequences of that more broadly for health and illness.

You were one of the academics that set up the International Society of Critical Health Psychology. Did you feel that health psychology was a bit complacent when you set that up?

I wouldn't say complacent. But I would say it was going down a mainstream path and a small group of us were concerned that we should introduce more critical thinking and more qualitative research into health psychology. I think we had spent many years going to conferences, like the European Health Psychology Society conference, and running critical symposia. But we never really made much of an impact on mainstream health psychology. We decided to set up our own organisation so that we could develop and extend our work rather than try to convert people that didn't understand why their approaches had limitations. The first meeting we had was called 'critical and qualitative approaches to health' in 1999. People wanted to continue, and it's now over 10 years old, holds a strong conference every two years and has more than 400 members.

Partly as a result of that, health psychology has developed a lot over the last 10 years. Where do you see it going in the next decade?

I suspect, due to inertia, it is likely to be roughly similar in 10 years' time to what it is today for most health psychologists. But at the same time there's been a lot of change in some areas. For example, in 1999 when Michael Murray and I produced an edited book, *Qualitative Health Psychology*, we found it very difficult to find heath psychologists that were doing qualitative work – nearly everyone was quantitatively oriented. Today, we would have trouble deciding who to choose. I think this move towards qualitative methods is one way in which it has changed substantially, and will continue to develop. I think that pressure for change should also drive the critical element of health psychology. But it does depend on where you are located to some degree – critical health psychology is quite strong in the UK but there is very little of it in apparent the USA.

And where do you see yourself going over the next decade?

I'm supposed to be getting close to retirement, but we don't have compulsory retirement in New Zealand, so I'm not thinking about that. So, I've just started a major project on the social and domestic life of medications, where our primary focus is on medications within households – where they are in the house, how they flow through the house, who controls and uses them, and how they structure everyday life, are involved in caring, and create identities. I've always enjoyed being an academic in the sense that you can transform yourself to another type of academic – as I have done. In most jobs you just can't do that. In a way, I think I'm perhaps in process of becoming more of a sociologist than a psychologist – that's what I read most of these days. So in 10 years time I may consider myself to be more a sociologist – because ultimately I'm most interested in social processes and societal processes – yet another transformation!