Health Psychology in Autobiography: Three Canadian Critical Narratives

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Running head: Health psychology in autobiography

Abstract

Three Canadian colleagues in health psychology recount their careers in a field of research and practice whose birth they witnessed and whose developments they have critiqued. By placing the development of health psychology in Canada in a context that is both institutional and personal, Stam, Murray and Lubek raise a series of questions about health psychology and its propagation. While uniquely Canadian on the one hand, their professional careers were affected by international colleagues as well as others – patients and community members – whose views shaped their perspectives. This article is a plea for the continuing development of critical voices in health psychology.

Key Words: History; Health psychology; Autobiography; Canada

It may be a sign of hubris to believe that one's personal journey in an academic discipline has any relevance for the field as a whole. At the same time, when such journeys are unconventional they illuminate something of the deviations of a field from the expectations of its early practitioners as well as the problems a field might have articulating its aims. Autobiography has a long history in psychology as seen, for example, in the series *A History of Psychology in Autobiography* that began publication in 1930. However, these texts were – to put it mildly – celebratory of the careers and achievements of the "pioneers" and acclaimed psychologists that came to make up "the mainstream" of the discipline. The reflections in this paper are more reminiscent of the version of the *History of Psychology in Autobiography* edited by Leendert Mos in 2009 which included the autobiographies of psychologists who were definitely *not* in what is euphemistically called "the mainstream" but who had each contributed to a critical or alternative form of psychology. And we are aware, as Roy Porter (1987) noted in his study of the mad, that autobiography is a genre of both pathos and unintentional self-parody. Although we have no illusion that our autobiographical accounts are in the least exemplary of "what to do" or illustrative of a single critical approach, we do try to understand, through the form of a personal narrative, the degree to which we have both been influenced by and have tried to influence health psychology, even if without much success. In the process we have thought, if not taught and finally worked on alternative versions of that recently developed sub-discipline of psychology.

The aim of this paper is neither to proselytize nor a call to arms. Health psychology will do what it will, subject to multiple competing pressures and challenges. Instead we have chosen this format to indicate that (a) health psychology is neither a single, coherent discipline, (b) those who enter it do so under various contexts and local conditions, (c) to be successful often requires adherence to norms and standards of research and practice that are counter-productive to the stated aim of producing knowledge that matters, and (d) the forms of resistance are many and individual, but marked by certain refusals along the way. We do not anticipate that our accounts are any way to a new and different form of health psychology, we merely wish to indicate that not all roads lead to randomized controlled trials and the search for ever larger grants. To begin, however, we try to place health psychology in a socio-historical context.

The origins

Health Psychology as a specialty developed gradually but consistently in the 1970s. Shortly after its arrival as an institutional reality, some of its most stalwart promoters were already proclaiming its "history" as long and steady, going back to the early 20th century or to psychosomatic medicine (e.g., Stone, 1979). This fit well within the narrative of a new field: proclaim that which is new as the outcome of forces long at work, ideas that were germinated over time and inevitably developed into a sub-discipline whose time had come. What the new versions of the history of health psychology managed to portray in the 1970s and 1980s, at the moment of its formation, was the arrival of a new sub-discipline that was somehow long anticipated. However, a more sustained historical examination clarifies something more fundamental about the appearance of health psychology: It emerged at a time of the unprecedented expansion of biomedicine into a vast industry in the industrialized world supported by government and foundation funding. In addition, it also came at a time when the expansion of postwar universities slowly crawled to a halt forcing psychologists to consider alternative careers. These would be largely professional careers outside large mental-health facilities as psychiatry was de-institutionalizing and closing large psychiatric hospitals. These large-scale social changes had an immediate impact on psychology and the unfolding personal narratives recounted here reflect these changes.

That expansion of biomedicine and the changes in health care has been well documented; particularly in the US since it was here that the largest expansions began (see for example, Rosenthal, 2017 for a recent overview and critique). This includes the vast expansion of hospitals into large medical systems, the demise of the family physician and the rise of large insurance companies, and the expansion of technical developments in health care itself. It was accompanied by the creation and propagation of medical research as a government sponsored enterprise. The National Institutes of Health were founded in 1948 and in the 25 years after WWII, the US federal government increased funding for biomedical research from 27 million to 1.7 billion dollars (Keating & Cambrosio, 2003). By 1980 the number of academic clinicians had increased from 1,000 (1950) to 12,000 ensuring that medical schools became increasingly research oriented (Keating & Cambrosio, 2003). The National Health Service in the Britain in 1948 gave the health ministry the ability to fund and conduct research leading to the establishment of clinical research units in universities and hospitals. Keating and Cambrosio (2003) note that this has led to the collapse of the distinction between biology and medicine. The health care industry currently employs one in nine working people in the US and for every physician there are 16 other health care workers (Terhune, 2017). The growth of the pharmaceutical industry is a related subject, which we cannot begin to address here (see, e.g., Cooter & Pickstone, 2000).

Canada and the US do health care quite differently. In Canada, socialized medicine is technically a "public contracting" model because it uses public funding to finance private providers (Deber, 2017). Furthermore, it is technically not "Canadian" (i.e., national) since the Canadian provinces are responsible for healthcare. The history of how this hybrid model was created and eventually came to be widely accepted is complex (see Making Medicare, 2017). Nonetheless, universal coverage for essential services remains the core of the system along with its principle of health care as a right (Kluge, 1999). Furthermore, the "Canadian model" as it is referred to, particularly in the US, offers health care to all its residents at a significantly lower cost than the US private system which does not insure all its citizens, even after the creation of the Affordable Care Act under President Obama. Despite these differences, Canada has also been deeply affected by the institutional changes that created modern biomedicine in all industrialized countries. The Canadian Institutes of Health Research is the primary source of funds for health- related research and it supports this research with approximately $CAN1 billion per year.

Another well-known feature that accompanies these structural changes in all industrialized nations is the shift of focus over the course of the 20th century from acute and infectious diseases to chronic disease. Chronic diseases are long-term, incurable but consist of acute episodes possibly interspersed with remission. They have come to define the focus of treatment for contemporary medicine (Omran, 1971). Although sometimes viewed as merely another expansion of biomedicine (Armstrong, 2014), this has nonetheless been taken up as a standard account of the necessity of the expansion of medicine and the importance of behavioural aspects of prevention and treatment. Despite a resurgence of infectious diseases (e.g., Ebola, HIV/AIDS), the general consensus is still that these changes are more or less permanent. In addition, the "demographic stretch" (Pablos-Mendez, Radloff, Kahjavi & Dunst, 2015) has had a major impact on the lives of populations around the world. This phenomenon refers to the transition from high to low levels of mortality and from high to low levels of fertility in the industrial and post-industrial worlds. One consequence of this "stretch" is that it moves the burden of chronic diseases and disability to older ages. That is, the reductions in fertility associated with increased levels of wealth and the increased greying of populations in industrialized countries has produced an aging cohort that will be the focus of health care.

As baby boomers who came of academic age in psychology during the 1960s and 1970s, the co-authors are self-consciously aware that these narratives are written by three white men, educated at a time when psychology was still strongly male-dominated and patriarchal in its practices. Missing are the views, voices and interpretations of not only women, but of Canada's many indigenous peoples, its diverse immigrant

communities (although both Murray and Stam are immigrants to Canada), its LGBTQ communities, and other age cohorts. We hope a more extensive critical history of health psychology will still be written. The three Canadian colleagues followed separate roads to "doing" health psychology and none have made major contributions to the mainstream. Their pathways have, however, overlapped in Critical Health Psychology as theoreticians, practitioners, and/or researchers.

The remainder of this paper focuses on the personal narratives of three colleagues who found themselves entering (and in one case, leaving) health psychology over the course of four decades. Each has become critical of aspects of the health psychology enterprise, but for different reasons. This is an attempt to bring these issues together through a set of personal accounts. It is neither a complete statement nor a final account of what health psychology is, or was, or should be, nor does it replace a thorough institutional history of health psychology, which has yet to be written. Rather it is a trio of personal witnesses to the issues that have driven health psychology in Canada since the 1970s and how it might be brought to bear on other issues if health psychology were not beholden to the overwhelming pull of biomedicine.

Three tales

All three authors were aware of the evolving critical literature(s) in psychology which had begun in the 1960s, grew in the 1970s and soon each would contribute in their own right to the development of critiques and suggested alternative formulations, e.g., Lubek (1976; 1983), Murray & Jarrett (1985) and Stam (1987). Many of the critiques had come from social psychology, and as Lubek et al (2017) point out, some social psychologists "converted" into health psychologists in the 1980s and applied their methods, theories and knowledge to (well-funded, government-prioritized) health issues such as smoking, obesity, alcoholism, etc., while clinical psychologists, especially those using behaviour modification techniques, became "behavioural medicine practitioners".

Given that each of the colleagues was familiar with the 1970s "crisis" in social psychology, it would only be a matter of time before they turned their critical eye onto health issues. In graduate school, each had a mentor who was not always considered to be mainstream. Stam studied with Nicholas Spanos, who wrote a number of important papers critiquing psychiatry's understanding of witchcraft and multiple personality, and undermined the standard view of hypnosis and altered states of consciousness (e.g., Spanos, 1996). In addition, Spanos's unusual take on psychology was due, in part, to the fact that he actually had a PhD in sociology, having studied under the ethnomethodologist George Psathas at Boston University. Murray, who was at that time in Scotland,

studied under Ivana Markova who developed a critique of mainstream psychology from a Hegelian perspective (e.g., Markova, 1982) although as a refugee from Czechoslovakia she was wary of radical political ideas. Lubek's thesis supervisor in the US was the radical social psychologist/activist Dana Bramel who, with Ron Friend, would form the first Marxist social psychology PhD program in the US in the early 1970s, along with the PsychAgitator Newsletter/collective.

Below, each recounts their trajectory towards (critical) health psychology, starting in a time before there was a formal institutional recognition of the sub-discipline and there were not clearly defined programs of study and career pathways and paradigmatic support as found today in academic programs, professional associations, and job availabilities. Each of the colleagues has taught psychology in Canada, including health psychology-related courses - Stam at the University of Calgary (1982 – present), Murray at Memorial University (1991-2006), and Lubek at University of Guelph (1971-2011). Each colleague eventually came to a critical health psychology position through the idiosyncratic pathways described below. These accounts are deliberately written in the third person in an attempt to achieve a degree of otherness and to locate the authors within the social and cultural context within which they found themselves.

Henderikus Stam – *the flâneur*

Stam trained as a social psychologist at Carleton University, where two major conferences were held concerned with the crisis in social psychology and the possibility of a renewal (Strickland et al, 1976; Strickland, 1979) during the 1970s. There a coterie of critical and feminist psychologists was formed in his graduate student cohort who were encouraged by young, critical and/or feminist faculty - Fran Cherry and Warren Thorngate. He left Carleton in 1982 with his PhD in experimental social psychology, moved straight out of graduate school into a Postdoctoral Fellowship at the University of Calgary and subsequently into health-related research (and retrained as a clinical psychologist) at the Tom Baker Cancer Centre. Prior to graduation he had spent six months at the University of Western Ontario in the psychology department and the dental school conducting research on temporomandibular joint pain (e.g., Stam, McGrath & Brooke, 1984). Having conducted research on hypnosis and pain, the move into health psychology was relatively straightforward. Stam had already immersed himself in the medical and health related literatures surrounding pain and its therapeutics. Working in the Cancer Centre, not only as a researcher but now as a clinician-in-training, he soon became uncertain of the relationship between clinical settings, psychology, medicine and health while conducting research in psychosocial oncology. He helped organize the first meeting of the Canadian Association of Psychosocial Oncology (CAPO) in Calgary in 1985 and gave an invited address at the third meeting of that organization in

Saskatoon in 1987. As a member of various societies devoted to health psychology, he had committed to a career in health psychology. His first publications in psychosocial oncology focussed on enumerating the kinds of problems with which cancer patients struggled (e.g., Stam, Bultz & Pittman, 1986) or debunking a number of myths around the psychological "causes" of cancer (e.g., Stam & Steggles, 1987; Challis & Stam, 1992). But very soon he moved to conducting a number of qualitative research studies with his students trying to capture the experiential and moral questions that emerge from an experience of cancer (e.g., Mathieson & Stam, 1995; Yaskowich & Stam, 2003). This was driven by the vast gulf that existed between the experience of working with actual cancer patients, whose lives were radically disrupted, and the strictures of the scientific literature. Spending time with the dying drove home that there were questions neither asked nor addressed by health psychologists, not even in the thanatology literature. Witnessing the brilliance but also the occasional arrogance of medical professionals simply reinforced these questions.

Over a period of a decade Stam left health psychology behind and concentrated on history and theory in psychology. In an attempt to understand the process by which a field could be so unresponsive to the needs of those it studies, he began to immerse himself in historical and theoretical studies of psychology, including the critical work of such authors as Edward Sampson, Dan Robinson, Valerie Walkerdine, Sigmund Koch, and Kenneth Gergen and such classic authors as John Dewey. This process began early when, while still working at the cancer centre, he organized a symposium at the University of Calgary in 1984 on theory that brought him into contact with Kenneth Gergen among others (Stam, Rogers & Gergen, 1987). Shortly thereafter he met members of the, then still functioning, Centre for Advanced Study in Theoretical Psychology at the University of Alberta in Edmonton. After returning to academia full-time in 1987, he went on to critically examine theories in psychology as a founding member of the International Society for Theoretical Psychology and as the founding editor of *Theory and Psychology,* which began publication in 1991. But moving through history and theory also opens one up to the problems in related disciplines, particularly anthropology and sociology. Ultimately Stam concluded that psychology is a moral, not just a social or strictly empirical science. By this he understood that psychology is deeply engaged in pursuing claims of human nature as it *ought to be,* while denying this in practice.[1]

As a consequence of trying to place health psychology in a broader historical and theoretical framework, he came to view health psychology not as a sub-discipline whose "time had come" (Weiss, 1982) but rather as a

[1] There is no room to elaborate on this here, I point the interested reader to the authors listed above and many contemporary authors who make similar claims (e.g., Brinkmann, 2011).

field of studies largely driven by incentives outside of psychology. As the biomedical disciplines became a growth industry and funding started to flow into health-related fields in the 1970s and 1980s, psychologists shifted their work on various topics to make them eligible for the large research grants then made available in the US and Canada. The research agenda was largely atheoretical, concerned with testing theories on new populations whose outcomes were not particularly relevant to the lives of those who suffered from the various problems under investigation, as discussed elsewhere (Stam, 2000). In short, the kinds of theoretical questions that psychologists formulated served their own interests in furthering their research agendas (and by extension their careers and reputations). They rarely however affected the lives of those being investigated.

This was most obvious to Stam in the case of psychosocial oncology. Having spent four years working in a cancer center and having conducted research in psychosocial oncology, he found the discrepancies startling. The new health psychology organizations purportedly devoted to research and education for the purposes of advancing health through psychological research were simultaneously involved in unvarnished careerism: creating a category of specialist within psychology and psychiatry whose primary purpose was to vie with other specialists in the vast field devoted to treating and caring for cancer patients.[2] This was not malevolent or always conscious; no intent is required for these professional forces to operate. There was an obvious sense in which competition between specialties inside and outside of psychology created the need for building fences, boundaries and specialized knowledge claims. For example, family medicine, nursing, physiotherapy, occupational therapy, social work, and others were all vying for the same clientele and scientific territory.

Pain and Mindfullness

What follows are several brief examples. Pain research in psychology has blossomed over the past three decades. Despite its growth, it is the pharmaceutical industry that has created a new arsenal of medications. The education of physicians is crucial in ensuring the appropriate dosing and prescribing of those medications. Psychologists have conducted a large amount of research on pain but have made little by way of substantial contributions to the actual treatment of pain in clinical settings. Likewise, cancer comes with a vast array of sequela that affect family, relationships, work, life-style and so on. Easing the psychological burden of the cancer patient can be done

[2] In addition to internal competition, disciplines also compete with patient groups and for those who have cancer there are many possible groups that are available to new patients. The groups allow for multiple kinds of "therapeutic" work and are largely driven by volunteers themselves (see Yaskowich & Stam, 2003). Although nominally not in competition, in practice self-help groups may come to have various negative views of non-patient mental health experts who have not lived through the experience of having cancer, while professionals often look with skeptical eyes to the practices of self-help groups.

with appropriate resources. In the case of psychosocial oncology, the research made possible a specialization that could, as with all professions, draw from an appropriate body of technical knowledge for its practices. However, its specialized knowledge was not devoted to easing the suffering of patients so much as advancing the careers of professionals. Because we already know a great deal of what it takes to make the lives of patients easier and more bearable–this is not science but sound clinical practice–the clear majority of the research in psychosocial oncology is of no particular use to the clinical psychologist or the clinical social worker on the front lines, not to mention actual patients. For example, clinical trials of mindfulness therapy will have little impact on the lives of patients, but speak to the power of the professional, of the reputation of science, of the importance of demarcating professions from one another, and of the large sums of money that governments, agencies and cancer control foundations are willing to spend for this kind of research that it is carried out in the first instance. There is not much by way of research that is going to provide the clinical psychologist with information that we do not already have.

Stam did not become anti-research; rather he noted that the kind of psychological research was conducted, was often largely for the benefit of professional reputation. Instead, through careful qualitative research we may come to know about the lives of patients in ways that will allow us to shape the response to the disease. And indeed, there are many studies that have been conducted and that are being conducted today that do help us understand the kinds of lives that cancer patients live, the kinds of problems that confront them when faced with menacing treatments, and the issues that face the terminally ill. Patients need to successfully reclaim their lives from colonizing medical narratives in much the way that colonial experiences are over-turned by post-colonial narratives (Frank, 1995). Psychological treatments often hold patients in a cycle of medical and psycho-medical narratives. Large scale randomized trials on such new-found "treatments" as mindfulness training are not going to enhance the lives of patients in any special way, beyond what is already known about mindfulness. Indeed, Stam wonders why clinical psychologists are not embarrassed by the fact that after decades of research and the expenditure of millions of dollars in research funds, the most innovative tool that clinical psychologists have been able to create in the past two decades is one that is a meditative technique appropriated and simplified from a religious tradition - Buddhism! So much for science.

In recent years, some measure of humility has crept into health psychology. The new editor of *Health Psychology*, the APA Division of Health Psychology journal, recently said about health psychology that "across the countless galaxies that fill the health care universe, few of the other inhabitants know or care about the minutiae of our small branch of applied science" (Freedland, 2017, p. 1). Unfortunately, Freedland's solution to health

psychologists' lack of visibility is to embrace "large-scale team science to answer the most challenging and important questions in behavioral medicine" (p. 2). Large, multicenter, randomized controlled trials to further mimic and integrate psychological research with biomedicine are simply more of the same. Most of the questions facing health psychologists are not medical but moral and normative. Perhaps this occasional moment of humility may spread.

Michael Murray – *the 'come-from-away'*

Fifteen years is a long time. When Murray moved from the UK to Canada it was a professional and a cultural as well as a personal jolt. In the 1970s, he had trained in social psychology with Ivana Markova at the University of Stirling in Scotland. Markova was a refugee from Czechoslovakia who had rejected Marxism but was schooled in Hegelian philosophy and the Prague school of linguistics. It was through Markova that he met Rob Farr who provoked his interest in social representation theory (Farr and Moscovici, 1984) and the work of Herzlich (1973) as well as his interest in history (Farr, 1996). But there was more to his becoming a critical social scientist. The 1970s was a period of radical political activity and, also, ferment and questioning within the social sciences. Murray avidly read the emerging literature. This included the beginnings of critique in social psychology in the works of Tajfel (1974), Armistead (1974), Shotter (1975) and the various writings by Peter Sedgewick (see Sedgewick, 1982) as well as the work of Kuhn (1960), Friedson (1970), Foucault (1973) and many others.

He moved to London (UK) in 1978 to work in a large public health research unit. There he was initially involved in extensive survey work on young people's smoking practices (e.g., Murray et al, 1982). However, he became disenchanted with this epidemiological work and gained funding for more qualitative work using semi-structured interviews to better understand the meanings of smoking to young people (e.g., Murray et al, 1988). He used Harré and Secord's (1972) ethogenic approach as his interpretive frame supplemented with ideas drawn from social psychology and critical sociology including Goffman (1970), Tajfel (1973) and Dorn (1983). But he was also reading more widely in radical politics in which he was active and developed what he grandly described as a materialist approach to health promotion (e.g., Murray & Jarrett, 1985; Murray, Jarrett, Swan & Rumun, 1988).

Eager to explore new opportunities, Murray moved to Canada in 1991 to a post at Memorial University, Newfoundland where he taught social inequalities in health to medical students and qualitative research methods to community health graduate students. There was a health psychology section in the Canadian Psychological Association which had been formed in the 1980s but which had become inactive. Over the

following seven years Murray worked with others to revitalise this section through organising conference symposia on such topics as qualitative methods and child health psychology and launching T*he Canadian Health Psychologist/Le Psychologue canadien de la santé*[3]. Murray's ongoing interest in the arts encouraged him to delve into narrative theory, particularly the writings of Paul Ricoeur (e.g., Ricoeur, 1981) and Mark Freeman (e.g., Freeman, 1993). He also came across the work by Hank Stam and Stam's first PhD student, Cynthia Mathieson, on narrative accounts of cancer (Mathieson & Stam, 1995).

Murray maintained links with the UK and Europe and at the 1994 EHPS meeting in Spain, where he was presenting some of his work on cancer stories, he met Kerry Chamberlain. Since they were two of the few at the meeting interested in qualitative work they soon struck up a friendship and Chamberlain invited Murray to Aotearoa/New Zealand where he was delighted to meet Chamberlain's PhD students Antonia Lyons and Chris Stephens and to participate in a meeting of the New Zealand Health Psychology Society (see Chamberlain, Lyons & Stephens, 2017). His work in New Zealand led to a monograph on narrative health psychology (Murray, 1997) and alerted him to the growing interest in various critical approaches.

Murray returned to Newfoundland enthused about the prospects of a revitalised health psychology. If there was a group of critical thinkers in New Zealand surely there were others. He gave a keynote presentation on narrative and health psychology at the European Health Psychology Annual Conference in Bergen, Norway in 1995 and convened a symposium on social and critical issues in health psychology at the XXVI International Congress of Psychology held in Montreal in 1996[4]. At a meeting on qualitative research in Vancouver Murray met Robert Kugelmann who expressed an interest in a forum for critical ideas (Kugelmann, 1997). Murray continued regular communication with Chamberlain and David Marks (UK)[5] and with them pursued a series of initiatives. With Chamberlain, he edited a special journal issue and book (Murray & Chamberlain, 1999) on qualitative research. With Marks he produced a textbook on health psychology (Marks, Murray, Evans and Willig, 1999). There was growing momentum to bring these critical scholars together.

[3] These are accessible at https://www.keele.ac.uk/psychology/people/michaelmurray/ and provide an insight into the state of health psychology in Canada in the 1990s. The poor French translations are by Murray.
[4] Other speakers in the symposium included Valach (Switzerland), Young (Vancouver), Berry (Kingston, Canada), Ager (Edinburgh) and Marks (UK) with a focus on language, culture and ethics. A version of Murray's paper was subsequently published as Murray (1996).
[5] Marks established the *Journal of Health Psychology* in 1996 with Murray as an Associate Editor.

With the support and encouragement of these international contacts Murray proceeded to plan a specialist meeting which took place in St. John's, Newfoundland in 1999. He recruited the keynotes – David Marks, Kerry Chamberlain, Hank Stam, Sue Wilkinson, Uwe Flick, Carla Willig, Wendy Stainton-Rogers, Alan Radley, Brinton Lykes, Mac MacLachlan and Bob Kugelmann – who were selected to reflect innovations in theory, method and practice. The fact that they all quickly accepted the invitation confirmed his sense that the time was ripe[6]. Initially the focus of the meeting was to be on qualitative research but in the planning Murray widened the remit and entitled the event 'Reconstructing Health Psychology: First International Conference on Critical and Qualitative Approaches to Health Psychology'[7]. The meeting was a success with over 120 participants from twenty countries. It was agreed that there would be a second in the UK to be organised by Stainton-Rogers. At this second meeting which took place in Birmingham, UK in 2001 the International Society of Critical Health Psychology (ISCHP) was formally established with Murray elected the first chairperson[8]. To mark that first meeting in St. John's, Murray compiled a special journal issue (Murray, 2000) and an edited collection (Murray, 2004).

Moving forward Murray was keen to push the agenda theoretically, methodologically and practically. He organised a special journal issue on social representations of health and illness and qualitative methods with Uwe Flick (Murray & Flick, 2002) confirming his continuing interest in that approach and of potential linkages with narrative psychology (Murray, 2002). Another participant at the conference was Catherine Campbell with whom Murray had previously struck up a correspondence. He was enthused by Campbell's work on activist approaches to health promotion in South Africa and she attended the meeting in St. John's. They subsequently penned a short rebuttal to what to them seemed to be a neglect of the material causes of health inequality in the growing debate about the role of language in shaping health and illness (Murray & Campbell, 2003). At the 1999 conference in St. John's Murray also met Geoff Nelson and afterwards they obtained funding from the Medical Research Council / Canadian Institutes for Health Research for a series of workshops to investigate the potential of developing a community health psychology. From this they published a report and a series of

[6] The offer to cover travel and accommodation may also have been an incentive although Murray originally had no funding for this event. When the invites were accepted he engaged in frantic fund-raising from university, government and health departments. Fortunately, Newfoundland generosity ensured the event went ahead but not without some amusing episodes.

[7] The word "First" was added later - an indication of Murray's growing confidence of the potential importance of the event.

[8] The ISCHP has continued to hold international meetings every two years in Birmingham, UK (2001), Auckland, NZ (2003), Sheffield, UK (2005), Boston, USA (2007), Lausanne, Switzerland (2009), Adelaide, Australia (2011), Bradford, UK (2013), Grahamstown, South Africa (2015) and Loughborough, UK (2017). Subsequent chairpersons included Kerry Chamberlain, Wendy Stainton-Rogers, Christine Stephens and Gareth Treharne. Further details are available at www.ischp.info .

papers (e.g., Murray et al, 2004). In addition, Murray worked with Campbell to edit a special journal issue on this topic (Murray & Campbell, 2004).

It is important to realise that the province of Newfoundland was heavily dependent on a declining fishing industry. Many of the residents lived in isolated fishing communities and had developed a distinct culture that had been threatened by the government's decision to limit fishing. Murray was fascinated by the rich culture of this province but also the many difficulties its people experienced and became involved in a series of local research projects. One was to explore both the causes and consequences of the high rate of accidents in the fisheries (e.g., Murray, 2007). Another was exploring the impact of the fishery crisis on the way of life in coastal communities. Around this time Murray met a local community activist, Neil Tilley, and together they spent lengthy periods visiting fishing communities getting to know the residents. It was through the conversations with Tilley that Murray learnt about the processes involved in community development. One approach that they worked on was to use arts-based activities including concerts and plays in small coastal communities to raise local awareness of issues such as the hazards of fishing (Murray & Tilley, 2006). Murray had also made contact through his cancer work with Ross Gray who had attended the St. John's meeting and was using arts-based methods as part of a cancer awareness programme (Gray & Sinding, 2002). After failing to get funding for a collaborative research initiative they decided to edit a special journal issue on health psychology and the arts (Murray & Gray, 2008), which was dedicated to Tilley who had sadly died in 2008.

His children having flown the nest, Murray left Canada to return to the UK in 2006. However, his fifteen years there were fundamental to shaping his ideas in many ways. Theoretically he expanded his interest in social representation theory to include narrative psychology (e.g., Murray, 2002). Practically, he developed skills and interest in community development and the role of the arts which he took forward in his work with older people in the UK (e.g., Murray & Crummett, 2010) while at the same time maintaining his awareness of the broader socio-political context (see Murray 2012). Organisationally, he worked with others to develop an international network of scholars interested in developing a more social and critical approach to health psychology. In many ways, he was responding to the circumstances in which he found himself on the rock of Newfoundland called by the novelist Wayne Johnston (1998) 'the colony of unrequited dreams.' It was the very physical location of the place as a bridge between Europe and North America which served as a rich melting pot for the development of new ideas coupled with a desire to do something which was of value to the local community. Murray's outsider status freed him from any inhibitions and enabled him to link theoretically ideas from Europe and North America as well as to promote and encourage greater collaboration among researchers

who had previously worked in isolation. Newfoundland is sometimes described as being on the edge (of the world). It is on the edges that new ideas can develop. The fact that the international collaboration initiated on the edge continues through the ISCHP and other activities confirms the continuing interest in critical ideas and actions among many psychologists engaged in researching health and illness internationally.

Ian Lubek – the 'Johnny come lately'

For Lubek, "critical community health psychology" (Lubek, Lee, Kros, Wong et al, 2014) cumulatively reflected field experiences that began in 1999, almost three decades after coming to the University of Guelph as a "social psychologist" in 1971. Before 1999, he had never taken, or taught, a health psychology course, read a relevant textbook or journal, or attended or presented papers at a health-related conference. While health psychology and behavioural medicine became institutionalized in the U.S. in 1978-1979, almost a decade after Lubek completed his PhD and had "returned to Canada", he had been affected by a "precursor" environment (Lubek et al., 2017) as a social psychology graduate student at the State University of New York, Stony Brook (SUNYSB), between 1967 and 1971. Here he took a variety of courses on physiological stress, personality, learning theory, and social psychology and participated in informal research brainstorming sessions on faculty and thesis research and pilot-testing, on such topics as urban noise and stress, environmental and dormitory crowding, pain reduction, and bureaucratic frustrations (e.g. Baum and Valins ,1974). These precursor studies would later be brought under the umbrella of health psychology. Even if one didn't attend the formal classes, there was much cross-sub-disciplinary knowledge acquired from both academic courses and informal exchanges.

At SUNYSB, protest and critique were constants. They influenced Lubek's experimental social psychology PhD thesis, which first discussed real-world police-student/citizen violence and ended with a laboratory experimental simulation.[9] But the results and discussion sections contained the beginnings of a critique of the methods used, and the possible lack of external validity or connectedness to the real-world phenomena, which purportedly had been simulated in a laboratory. However, returning to the laboratory after the major Washington protests of 1971 raised critical doubts about how social psychologists study social phenomena. No further experiments were ever conducted, nor were any papers based on the dissertation, published (despite

[9] Several fellow graduate students were badly beaten by Chicago police at the Democratic National Convention in Chicago in August 1968. During data-collection for a PhD preparatory study in May, 1970, appointments for "experimental subjects" were cancelled during a nation-wide university "strike", which followed the announcement of the bombing of Cambodia and the killing of protesting students at Kent State University. In May 1971, with Lubek's PhD study underway, many students and faculty participated in the country-wide "May Day" protests, as "we took off some time to go to Washington for some 'fieldwork'" in demonstrations against the war in Vietnam. There over 10,000 were arrested and held overnight in a football stadium, until bail could be arranged (Lubek et al, 2018).

pressures from 1970s tenure and promotion committees). Lubek left Stony Brook with both a healthy critical attitude and a respect for a broader version of social psychology, which encompassed psychological, social and biological levels. In the coming years, writings added historical, political, economic, and gender components. For Lubek, his 1971 "end of experimentation" occurred within the wide developing critique of social psychology which started in the 1960s.[10]

Lubek's own critiques ~~It would lea~~d involved a series of historical, theoretical and epistemological studies, moving away from experimental social psychology into critical social psychology, critical history of social psychology and then broader critiques of methodology, theory and epistemology (Lubek ,1976,- Lubek, 1979; Lubek 1995; Lubek & Stam, 1995; Stam, Lubek & Radtke, 1998; Stam, Radtke and Lubek, 2000). Additional critical perspective was due to frequent stays in Paris at the Laboratoire de Psychologie Sociale, directed by Robert Pagès, where social psychologists did not always accept mainstream American paradigms. Claudine Herzlich (2017) describes how she, Serge Moscovici, Erika Apfelbaum—who became a frequent co-author—developed as researchers there (see also Delefosse-Santiago and del Rio Carral, 2017; Apfelbaum, 2009). In addition to critical French thinking, a critical North American spirit was also nurtured, first by 1970s meetings of the Dialectical Psychology group[11] and later in the 1980s-1990s through the Toronto Interest Group for Epi-theoretical Research (TiGER). Lubek joined other existentially (and professionally) "marginalized" psychology scholars (~~K~~urt Danziger, Linda Wood, Rolf Kroger, Mac Westcott, Gerald Cupchick, David Rennie and Andrew Winston) for monthly evening sessions, sharing article and chapter drafts, offering mutual feedback and epicurean dinner adventures.

Fast forward to 1999, when Lubek travelled for four days to Siem Reap, Cambodia, as a tourist, to see the temples at Angkor Wat. Here, local Cambodians informed him of the deteriorating health situation in the community and asked him to help end the community HIV/AIDS epidemic. This would be a project in

[10] Lubek read the critiques of methodology, ethics, (ab)use of research "subjects", over-laboratorization, and lack of relevance that appeared in the U.S. (and Canadian) literature during the 1960s and 1970s, leading to what some called a "crisis in social psychology". Two conferences designed to provide new directions were held at Carleton University, one in 1974 (attended by Lubek) and one in 1976 (when Stam was an undergraduate there). These attempted to critically broaden the conceptualization of social psychology beyond its dominant North American paradigms, with contributions from Western and Eastern Europe (see Strickland, Aboud, Gergen, 1976; Strickland, 1979). In the 1970s, dialectical and other "radical" critiques occurred in other areas of psychology including developmental and clinical psychology. Feminist critiques of psychology began in the 1960s and 1970s, while Marxist critiques, long a part of European academic discussions, were now being developed. Even anarchistic critiques appeared, directed at psychology and social sciences (e.g., Rappoport, 1975). In the UK, where Murray was studying, additional critiques of various branches of psychology were being offered, e.g., Armistead (1974), Harré & Secord, 1972).

[11] Initially organized by Klaus Riegel, with Howard Gadlin, John Broughton, Leon Rapoport, Howard Gruber, Susan Buck-Morss, Edmund Sullivan, Wilbur Haas, and others (cf. Larsen, 1986)

community-initiated health psychology. In short order, Lubek wrapped up the programme of critical "armchair" historical and epistemological research (e.g., Lubek, 2000) and now became immersed in Cambodian health issues, tackled from the local community perspective. He found himself in Cambodia, replete with "critical" life-and-death health and safety challenges at the height of the HIV/AIDS epidemic.[12] By 2000, Cambodia's HIV risk-group rates were described as the highest in Southeast Asia: at the epicentre, the tourism centre of Siem Reap had a prevalence rate for brothel-based "direct sex workers" of 42 per cent sero-positive, and for women beer-sellers (Indirect Sex Workers), 20 per cent (Lubek et al, 2014, p. 111). In this context of a community health crisis, one interview produced an epiphany for a career-change.[13] From this conversation, Lubek learned how the community experienced the aftereffects of genocide, and now were experiencing directly the mortal effects of the epidemic. The conversation revealed that knowledge about disease prevention was not being behaviorally applied, and there was much risk-taking with alcohol overuse and multiple sex partners, including sex-workers and beer-sellers. All of this was compounded by the lack of medical resources and medications for HIV/AIDS and preventable/curable malaria, etc. This began an abrupt career switch from global tourist and historian/epistemologist to critical community health psychologist.

Lubek returned to Siem Reap to conduct a "needs assessment" to determine the social patterns of HIV transmission in various risk groups in the community. He conducted 23 3-hour open-ended private conversations in English or French, in which participants spoke of past events during the Pol Pot period, their current social life including risk-taking, and their ideas and concerns for the future. A summary of these interviews was then fed back to the community members at a dinner meeting , and a discussion was held about future actions. Their concerns in the interviews were clearly prioritized: 1) HIV/AIDS was devastating their friends and family; 2) gendered educational inequalities - noting that girls worked in the fields instead of going to school and then ended up in city jobs that were highly risky, as sex workers or beer-sellers; and 3) extreme poverty, about $1 per day, for almost everyone-- farmers, teachers, doctors, etc. At this feedback meeting,

[12] After the Khmer Rouge Genocide (1975-1979) and an 11-year occupation by Vietnam land-mine clearance was still in progress. The country had poor infrastructure, no income, a high rate of government corruption, with much of the population earning less that $1 per day, and with rates of Tuberculosis and Malaria over 60%. In addition, with 25% of the population murdered during the genocide period, all the survivors he met suffered their traumatic experiences in silence. No psychologists had survived at the Royal University of Phnom Penh; it wasn't until 2009 that a small program in clinical psychology was set up by UK psychologists.

[13] Here, one young Cambodian man told Lubek of his past and current life: "There's only me and my grandfather left now-- my parents and family all died during [the 70s] … I've never had a wife … Sometimes, I would go home, drink 20 or 30 beers a night, and on the weekends we drink and party with the [beer- promotion] girls. We know we should use condoms, but sometimes with all the beer, we just forget... Monday it's back to work. Each week now, we bury one of our friends, who has died of AIDS or of one of the complications. 'There's no medication here...you get sick, even malaria, you go home and you die in a week or two. " (Anonymous, Siem Reap, Personal communication, Feb., 1999).

SiRCHESI (Siem Reap Citizens for Health Educational and Social Issues) was formed as an independent local NGO (to avoid the endemic corruption of government agencies). The local community members agreed that they would become HIV/AIDS health educators for identified risk groups—including sex workers, beer-sellers, married women, men, and even young children (who as souvenir vendors were in contact with over 1 million tourists--now 3 million—annually). The "professor's" job would be to provide peer-educator training, health-promotion teaching materials, networking with NGOs and government agencies, fundraising and providing financial resources. [14]

Lubek now required a crash course in community health psychology, public health, and HIV/AIDS prevention. In Cambodia, Lubek visited other NGOs doing similar work, e.g., Doctors without Borders. He re-contacted social psychologist Sue Kippax at the interdisciplinary National Centre in HIV Social Research (NCHSR) in Sydney, Australia where he would become a Visiting Fellow. Here there was a cross-disciplinary group of committed, progressive, innovative and critical HIV/AIDS researchers. Starting from scratch in a new health-related discipline, not knowing the basic concepts, theories, researchers, journals, nor granting agencies, Lubek was a health research newcomer, starting in a new paradigm. He began contacting other international health researchers, went to conferences, and received suggestions about 'tried-and-true' 'best practices' to use in the fight against HIV/AIDS. One most fruitful collaboration began, serendipitously, when Lubek visited the National University of Singapore, to work on final page proofs for an article for a special journal issue on History of Social Psychology (Lubek, 2000). There Lubek met health psychologist George Bishop, who had collaborated with medical doctor Mee Lian Wong at the National University of Singapore (NUS) (Bishop & Wong, 2001). Lubek and Wong then spent a whole day planning how to adapt to Cambodia, her community medicine, 'action research' approach and her materials used with brothel workers in Singapore and villagers in Malaysia (Wong, 1990; Wong et al., 1998). Wong then brought these materials to Siem Reap for focus group testing in 2001. Peer-educator training workshops were run in 2002, and Wong was instrumental in designing surveys and questionnaires to evaluate the efficacy of health-promotion workshops and training. (Lubek and Wong, 2002; Wong et al, 2003).

[14] The Cambodia research/ intervention project, has now lasted 19 years with over 100 research colleagues, assistants and interns involved. As a full professor and completing a major editing project (Lubek, 2000), Lubek was able to immediately commit to the project, and managed to find a decade of funding from AIDS-related funders—Elton John AIDS Foundation and MAC Cosmetics AIDS Fund. In addition, some local co-funding came from the Cambodian Hotel Industry, and the NGO SiRCHESI staff helped create paid supervised internships. Additional fundraising activities were supplemented by donations of colleagues and friends and speaker's fees. As a "comfortable" professor, Lubek had the ability to commit his own funds to the project as needed.

The local NGO SiRCHESI grew to have a staff of six part-time staff and 23 peer-outreach workers, for health education to villagers and entertainment workers about HIV/AIDS prevention. Over 100 research collaborators, thesis students and interns helped the NGO's health promotion work against HIV/AIDS, alcohol abuse and related problems. For such interventions, local health workers/educators already on the ground, and engaged with the community, are needed. Which health problems to tackle are completely "community-defined", rather than generated by "theory" or directed and/or "parachuted in", top-down, by a granting or governmental agency (Campbell, 2003). Between 1999 and 2017, Lubek spent up to three months annually in Cambodia with students, colleagues, interns and the local NGO (and many interspersed visits to NCHSR in Sydney). SiRCHESI's Annual General Meetings (AGMs) and conferences gave all stakeholders a chance to review the year's accomplishments and to prioritize activities for the coming year. (The AGM minutes are posted at www.angkorwatngo.com). By 2005, the NGO's HIV/AIDS-related projects tackled inter-connected health issues, foremost among them alcohol abuse and workplace violence.[15] SiRCHESI also created a school (2006-2008) to combat economic insecurity and gendered illiteracy, two of the three SiRCHESI original priorities, after health. The trafficking of children also prompted a health/safety promotion program. These evidence-based health interventions are detailed elsewhere (Lee et al, 2010; Lubek et al, 2013; Lubek et al., 2014).

Community members lead the health research/promotion activities.. Beginning in 2002, the team collected data about the toxic workplaces of beer sellers, the overuse of alcohol, and customer violence and harassment—and directly sent these to the brewers and brand owners in Europe—e.g., AB-INBEV, Heineken and Carlsberg. Such direct communication, it was felt, would cause their executives to take needed steps to improve health and safety of their workers (Lubek, 2005). It did not, even after 4 in-person presentations to board members in their European headquarters in 2006. However, by sending data to unions representing the workers in Cambodia, and to "ethical shareholders" who had votes at the Annual General Meeting of Heineken, the data indirectly circulated to the press in Europe and Cambodia. Trade unions picked up the statistics, as did the opposition political party. A local chapter of the CFSWF union for beer sellers was formed in 2010 and in 3 years, had 400 members. SiRCHESI's cumulative data was made available in publications, press releases, and on various websites, to support requests for improvements in health, safety and remuneration. In 2011, Angkor Beer, owned by Carlsberg, went on strike for two weeks, and by connecting the journalists in Denmark and Cambodia

[15] One of the major transmission routes for HIV/AIDS involved the underpaid beer-sellers and hostesses in local restaurants who were forced to drink excessively with the male customers, who then might proposition them for sex; condoms were often forgotten. A program of in-restaurant interviews and breathalyser testing was begun, and interviewees were invited to health workshops. By 2017, over 3100 interviews had been conducted.

covering the story with the SiRCHESI data and each other, their detailed front-page stories of "the two-dollar strike" prodded Carlsberg to settle and pay each worker $320, a half year's salary (Lubek et al, 2013).

When Lubek visited Siem Reap in 1999, little did he realize that he would soon be involved with a grass-roots, PAR, evidence-driven health-promotion NGO that would continue for over 19 years. During that time, the transmission of HIV/AIDS was reduced significantly in several risk groups, including beer-sellers. SiRCHESI had set up a school for literacy and career training as a "primary prevention" that kept women out of work environments with high health risks. In this project, the relation between job and economic security, and health outcomes, was brought home. In addition, the NGO worked to reduce the risk of trafficking and sexual victimization of children. The health outreach peer-educators in 2015 met over 15,000 persons in the community. Interviews with entertainment workers indicated that women were dramatically underpaid by half by multi-national brewers. They in fact, needed a living wage of about US$160 monthly by 2013. SiRCHESI's figures were circulated in the press, through the unions, and the opposition party. By Dec. 2013, there were large demonstrations of workers and voters – up to 400,000 in Phnom Penh—carrying signs about workers' rights, their "stolen votes in the election", and a living wage of 160! Lubek's critical community-based health psychology was honed in the field in Cambodia, a resource-challenged environment with a high morbidity and mortality from usually preventable endemic diseases and epidemics. Canadian universities provided health-oriented students and interns willing to move beyond the security of a protective government health-care system to explore, with SiRCHESI and Lubek, the complex inter-twinings among culture, gender, illiteracy, poverty, health and institutional corruption[17].

Conclusion

Each of the Canadian colleagues came to health psychology, in Canadian universities, as auto-didacts. Their graduate work was completed in Social Psychology, in the 1970s, before there were any institutionalized training programs of health psychology. Each was a product of a particular moment in the history of psychology, driven by circumstances to work in locales and communities that were in the process of becoming places where the new health psychology was or would be practiced. Each had taken up a different stance on the questions that a health psychology would ask. None has made major contributions to Health Psychology but

[17] In the lead-up to the national elections, "critical" media were closed, some NGOs with international connections were banned, and SiRCHESI interviewers were denied entrance to restaurants where research data was annually collected. The opposition party, with over 44% of the votes cast in 2013, was" disbanded" in September, 2017 and its leaders arrested or driven into exile.

instead found in health psychology a reason for critical work. And each would contribute in some way to a critical literature on health psychology.

Comparing (and contrasting) the trajectories of Stam, Murray and Lubek, reveals three "Canadian voices", none of whom followed the dominant US/UK model. They were not trained in health psychology *per se*, but have done research, community programmes, and taught, mentored, and written about health psychology and related areas. Each idiosyncratically moved through the past five decades reforming their work in the face of a changing sub-discipline. As well it is a tale of performing, absorbing, mentoring, ignoring, restoring, and deploring; of criticizing, textbook-izing, and organizing; and teaching, researching. All the while, there is a critical outlook, resisting the mainstream framework as seen not just over the border in the US, but adopted whole-sale in most universities and health care institutions in Canada.

There is no general lesson here and we don't claim one, but there is a specific one. We hope for the continued functioning of a critical wing of health psychology but have no illusions about the future of the mainstream. Much of the research will continue, hand in hand with biomedicine and in search of the same rich research funding. It is unlikely to shift anytime soon. Nevertheless, if there is one thing these accounts illustrate, it is that the everyday lives of those who we purport to serve are sometimes better off with alternative visions. We should not be afraid to ask of health psychology: Whose health? Whose benefit? Whose questions? Whose knowledge?

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