

**Report to Canadian Institutes of Health Research**

**TRAINING  
IN  
COMMUNITY  
HEALTH  
PSYCHOLOGY**

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## Forward

### a. Health Research Personnel Development

In 1999 as part of the transition to the establishment of the CIHR, the Medical Research Council of Canada launched a series of funding initiatives. One of these was termed the Opportunity Program and was intended “to encourage the health research community to develop research agendas, collaborative networks and other novel initiatives so that it can compete effectively for the funding opportunities which will become available through CIHR.” There were several possible outcomes of this program, viz.

1. A research agenda
2. A proposal for a health research consortium
3. **A proposal for an initiative to address research personnel development in specific fields of health research where there is perceived to be a lack of adequate numbers of suitably trained and qualified research personnel. These could include training and re-training programs, career support programs, recognition and reward opportunities, or incentives to attract Canadians currently working elsewhere to return**
4. A proposal for initiatives which will facilitate clinical, health services, and translational research in CIHR
5. A proposal that addresses key areas of science.

In response to this opportunity, this project was developed to investigate the opportunities for training in community health psychology.

### b. Potential Role of Psychology

It is accepted that psychology has a central role to play in understanding the dynamics of health and illness. However, traditionally, psychology’s interest in health has been confined to mental health. This is apparent in the growth of clinical psychology. More recently, the growth of the sub-discipline of health psychology has seen a substantial widening of interest to include physical health. However, the orientation of researchers within health psychology is still toward the clinical/ individual issues that are typical of clinical psychology.

The increasing awareness of the social dimensions of health and illness requires a reassessment of the individual orientation of health psychology. There is a need to widen the training of health psychologists to include the theories and methods of community psychology/social ecology and an awareness of contemporary issues in community health. The aim of such a community health psychology would be both to deepen our understanding of the etiology of health and illness in society and to develop strategies which will contribute to a reduction in human suffering and an improvement in quality of life.



**The overarching aim of this initiative is to establish the parameters of a training program in community health psychology that would be interdisciplinary and change oriented. The initiative was designed to bring together national and international experts to review the current needs and strengths, to identify the opportunities and resources for different forms of research training, and to begin to develop materials that could be the basis of such a training program.**

### **c. Organization of Project**

The project adopted several approaches:

- a) review of the current role of psychology in researching health;
- b) review of the potential role of an expanded community health psychology;
- c) consideration of the research base of a community health psychology
- d) review of training opportunities;
- e) consideration of the training needs;
- f) consultation with potential stakeholders;
- g) preparation of report;
- h) preparation of training application.

The purpose of this report is to summarize our deliberations and the steps we propose should be taken to develop a training program in community health psychology. We would welcome any comments on its content. Please send these to Michael Murray (murraym@mun.ca).

## Chapter 1

### CHALLENGING HEALTH PSYCHOLOGY

#### 1.1 Current Character of Health Psychology

Over the past 50 years psychology has developed an important role in applied health research. In particular, through the sub-discipline of clinical psychology it now plays a central role in mental health research. The sub-discipline of health psychology is a more recent development. The Division of Health Psychology (Division 38) of the American Psychological Association was founded in 1978. In 1982, the division launched its own journal, *Health Psychology*. In Canada, the Section of Health Psychology of the Canadian Psychological Association was created in 1988 although its standing orders were not formally approved until 1994.

One of the founders of health psychology, Joseph Matarazzo (1982) defined health psychology as:

*the aggregate of the special educational, scientific, and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, the identification of etiologic and diagnostic correlates of health, illness, and related dysfunction, and to the analysis and improvement of the health care systems and health policy formulation (p. 4).*

While textbooks in health psychology make reference to the social context of health and disease, the preponderance of research and action in health psychology focuses on individual and microsocial factors. In particular, a variety of cognitive-behavioural approaches have been developed to understand and treat a variety of physical health problems, including smoking, substance abuse, obesity, heart disease, HIV/AIDS, headaches, pain, arthritis, cancer, and health problems experienced by the elderly and children.

For the most part, health psychology has focussed neither on the subjective experience and meaning of illness, nor on the larger macrosocial determinants of health and illness. Little mention is made of social class, power, and economic inequality, when in fact there is abundant research that demonstrates the importance of these factors for health and illness (Marmot & Wilkinson, 1999; Wilkinson, 1996). Health psychology interventions can be conceptualized as falling into two broad categories: clinical interventions in medical settings (Bennett, 2000) and health promotion programs in the community, which emphasize lifestyle change (Bennett & Murphy, 1997). Community development and social change are seldom mentioned as health promotion strategies.

Within health psychology and other disciplines, however, there is a growing base of scholarship

and action that takes a critical perspective on health issues, adopts critical and constructivist epistemologies, and utilizes alternative methodologies such as qualitative research (e.g., Murray, 2000; Murray & Chamberlain, 1999; Stainton-Rogers, 1996). However, these contributions have still not led to the development of a coherent research strategy that integrates health psychology with the recent developments in the other social sciences. Our aim with this initiative is to reframe health psychology by developing epistemological, conceptual, and empirical frameworks and strategies that address the social determinants of health and illness.

### 1.2 Understanding Health and Illness

Different societies have developed different explanations of health and illness upon which they have developed different ways of treating illness and promoting health. From their analysis of different cultures Shweder et al. (1997) identified seven “ontologies of suffering which are summarized in Table 1. In the Western world the dominant approach has been the biomedical approach. More recently this has been expanded to include social and psychological processes - the biopsychosocial model.

<b>Causal Ontologies</b>	<b>Explanatory References</b>	<b>Therapy</b>
Biomedical	Western: genetic defects, hormone imbalances, organ pathologies, physiological impairments	Direct or indirect ingestion of special substances, herbs and roots, vitamins, chemical compounds
	Non-western: humors, bodily fluids, juices	Direct or indirect mechanical repair (e.g. surgery, massage, emetics) of damaged fibres or organs
Interpersonal	Western: harassment, abuse, exploitation	Avoidance or repair of negative interpersonal relations
	Non-western: sorcery, evil, eye, black magic	Talismans, magic
Sociopolitical	Oppression, political domination, adverse economic or family conditions	Social reform
Psychological	Unfulfilled desires and frustrated intentions, forms of fear	Intrapsychic and psychosocial interventions, e.g. meditation, therapy
Astrophysical	Arrangement of planets, moon or stars	Wait with optimism for change
Ecological	Stress, environmental risks	Reduction of stress and environmental hazards
Moral	Transgressions of obligation or duty, ethical failure	Unloading one=s sins, confession, reparation

Source: Marks, Murray, Evans & Willig (2000)

Although health psychology has formally accepted the biopsychosocial model of health and illness, in practice it has limited its research to exploring the dimensions of various models of social cognition and their relationships with different health-related behaviours. As such, it reduces psychological issues to something that can be measured on a limited number of scales and concern with social issues to something to be controlled for in statistical analyses (Spicer & Chamberlain, 1996). To integrate concern for social processes into health psychology requires a substantial reworking of the sub-discipline.

### 1.3 Social Inequalities in Health

Internationally, perhaps the largest current debate in public health concerns understanding the extensive social inequalities in health that are now well documented. Evidence from many countries has confirmed that health is related to social position such that the higher the social position the better one's health. There is also evidence that this relationship is more pronounced in more hierarchical societies (Wilkinson, 1996). Health psychology has still contributed relatively little to this research effort besides describing the psychological correlates of certain health-related behaviours.

In 1994, the federal government established a National Forum on Health "to involve and inform Canadians and to advise the federal government on innovative ways to improve our health system and the health of Canadians." After extensive consultation the National Forum produced two substantial reports in 1999. Their Working Group on Determinants of Health concluded:

*There has been a great deal of discussion about the importance of personal health practices for the health of individuals and populations. While we have known for some time that poor health practices (such as smoking, poor eating habits or substance abuse) are determinants of ill health, we know that such practices are very much influenced by the social and economic environments in which people live and work. They involve less an individual choice than was once thought.*

Instead the Working Group emphasized that such issues as socioeconomic equity, employment, community dynamics and childhood relationships should be central to any attempt to understand health. As yet health psychology has fully to realise its potential in contributing to this research on social inequalities in health. This report argues that there is a need to substantially "socialize" the sub-discipline if it is to play a full role in both understanding health and contributing to the efforts to improve the health of society.

## 1.4 Culture and Health

The close intertwining of ethnicity with socio-economic status has sometimes concealed the particular importance of culture in exploring the nature of health and illness. Corin (1995) has defined culture as:

*above all a system of meanings and symbols. This system shapes every area of life, defines a world view that gives meaning to personal and collective experience, and frames the way people locate themselves in the world, perceive the world, and believe in it. Every aspect of reality is seen as embedded within the webs of meaning that define a certain world view and that cannot be studied or understood apart from this collective frame (p. 273).*

Psychology in general has had a long-standing interest in culture as evidenced in the extent of research in cross-cultural psychology. However, this research has often been limited to exploring psychological differences between various ethnic groups and less upon the cultural constitution of identity and psychological processes. Recently, there has been a move to develop a more intensive cultural psychology (e.g., Much, 1995) which is an interdisciplinary project that attempts to develop a more sophisticated understanding of local cultural worlds particularly using a range of innovative ethnographic research methods.

An understanding of health and illness requires an understanding of these cultural worlds. However, health psychologists have still not recognized the importance of integrating the study of culture into their research practice (Hope & Landrine, 2000). The growing ethno-cultural composition of Canadian society has brought this requirement clearly to the fore.

Besides the need to explore the cultural constitution of health and illness two related issues concern work with Canada's indigenous peoples and the participation of psychologists in work in developing countries. It is well established that Canadian natives have poorer health status and lower life expectancy than other Canadians. While some psychologists have become involved in exploring mental health issues among this population there is still limited involvement in exploring broader health issues.

Finally, Canada has traditionally been involved in a wide variety of health-related projects in developing countries. Perhaps the largest health issue facing developing countries today is the rapid growth of the AIDS epidemic. Psychologists have been to the fore in offering a variety of prevention strategies. These have usually been based upon a limited number of social-cognitive models that locate the cause of human behaviour within the individual. In a recent review of AIDS prevention programs Waldo and Coates (2000) specifically highlighted the inadequacy of this approach:

*We think that HIV prevention science too often locates problems at the individual level and interventions tend to most often be delivered through*

*individual modalities ... A primary explanation for the bias toward individual intervention lies in the predominance of psychologists in the field of HIV prevention (p. S24).*

They argued that there is an urgent need to develop more “organizational, community, and societal/cultural-level changes” if the challenge of AIDS is to be combated. There is an urgent need for health psychology to develop more community-based strategies if it is to participate in this program (e.g. Campbell & Gillies, 2001; Lykes, 2000)

### **1.5 Changing Health Psychology**

In other social sciences there is increasing awareness of the importance of socio-political processes in understanding health and illness. For example, critical health sociologists argue that power is central to our understanding of health. According to Freund and McGuire (1999):

*the power of workers over their work place; the power of people to control the quality of their physical environments; the power of various groups or societies to shape health policy or to deliver what they consider healing; the power of people of different statuses to control, receive, and understand information vital to their well-being; and the power of the mass media to shape ideas about food and fitness (p. 7).*

Further, this concern with political processes has been coupled with sustained reflection on epistemology and methodology. In particular there is a growing challenge to the value neutrality of much mainstream social science research.

In some fields of psychology, particularly community psychology, but also social and feminist psychology (e.g., Ibanez & Iniguez, 1997; Reed, 1996; Wilkinson, 1996), there has been a growing attempt to redefine the discipline and to connect the study of subjectivity with social processes. There also has been an attempt to shift psychology from its fascination with method and instead to consider the broader epistemological underpinnings of the discipline (e.g., Tolman & Brydon-Miller, 2000).

However, as yet there has been limited attempt by mainstream health psychologists to connect with this critical stream within the social sciences and the extensive tradition and experience of community and related psychologies. The next chapters considers the potential contribution of community psychology and the ongoing epistemological debate within the social sciences in creating a revitalized community-based health psychology

## Chapter 2

### DEVELOPING A COMMUNITY HEALTH PSYCHOLOGY

#### 2.1 Community Psychology

While there is some overlap in the theory and practice of community psychology and health psychology, they have developed as separate sub-disciplines within psychology. We begin this chapter with a brief review of the historical roots and definitions of community psychology and we then propose the development of a new field of community health psychology.

In the United States, community psychology grew out of clinical psychology. Some clinical psychologists were dissatisfied with the individual-centred approaches of clinical psychology that emphasized the roles of testing and psychotherapy. Also, clinical psychology was practised within medical facilities and was closely allied with the dominant paradigm of psychiatry (e.g., adopting medical model language of diagnosis and treatment). Moreover, community psychology was born in the 1960s, a time of political change in which the civil rights movement, the women's movement, and social protest against the Vietnam war were occurring. Clinical psychologists who began to create the field of community psychology were aware of how socio-political conditions impact on the competence and wellbeing of individuals. Many became active in the so-called "Great Society" programs of the 1960s, including pre-school education programs (e.g., Head Start, community mental health centres, and community action centres). Some clinical psychologists who were searching for conceptual and practical alternatives studied public health. However, most were interested in applying public health concepts of prevention and promotion to mental health, rather than physical health. In 1967 community psychology became a Division (27) of the American Psychological Association (it is now called the Society for Community Research and Action), and in 1973, Division 27 started its own journal, the *American Journal of Community Psychology*.

In Canada, community psychology activities began after World War II at the University of Toronto, largely due to the efforts of William Line (Pols, 2000). It was Line who first coined the term "community psychology" (Babarik, 1979), and as President of the Canadian Psychological Association (CPA) in 1945, Line exhorted his colleagues to resist the status quo and work for social responsibility (Pols, 2000). It was not until 1982, however, that the Community Psychology Section of CPA was formed, and one year later, the first issue of a Canadian community psychology journal, the *Canadian Journal of Community Mental Health*, was issued. While this journal has had an inter-disciplinary emphasis since its inception, the focus is on mental health, rather than broadly on health.

In a recent textbook (Dalton, Elias, & Wandersman, 2001), community psychology has been defined as follows:

*Community psychology concerns the relationships of the individual to communities and society. Through collaborative research and action, community psychologists seek to understand and to enhance quality of life for individuals, community, and society (p. 5).*

This definition suggests several features that characterize the sub-discipline of community psychology. First, community psychology is concerned not just with individuals or communities, but with the relationships between individuals and their communities. Community psychology views people in context. Second, community psychology is a research-oriented field, but the research is highly collaborative and participatory. Research is done with community members, rather than on community members. Finally, in its emphasis on improving the quality of life of individuals, communities, and society, community psychology is an action-oriented field. Community psychology strives to create social and community change that benefits individual community members and the collective.

## **2.2 Community Health Psychology**

There can be a fruitful integration between community psychology and health psychology. Our emerging view of community health psychology is one that emphasizes a critical examination of professional and social power and social change as a necessary strategy for the promotion of health. We anchor community health psychology in a critical epistemological framework (see chapter 4) and emerging critical perspectives in applied psychology (Fox & Prilleltensky, 1997; Prilleltensky & Nelson, 2000), community psychology (Prilleltensky & Nelson, 1997) and health psychology (Murray, 2000; Marks, Murray, Evans & Willig, 2000). Finally, we believe that a critical approach to community health psychology requires alliances with critical perspectives from other social science disciplines (e.g., Freund & McGuire, 1999; Poland, Green, & Rootman, 2000) and with disadvantaged community members. Thus, the community health psychology approach that we are proposing is critical, inter-disciplinary, and collaborative.

While some of community psychology and much of health psychology is closely related to clinical psychology (e.g. most U. S. training programs in community psychology have a clinical-community emphasis), the community health psychology that we are proposing strives to create conceptual, epistemological, and practical alternatives to clinical health psychology. In Table 2 we contrast clinical health psychology with community health psychology on several dimensions. Clinical health psychology, as well as the lifestyle focus of what could be described as asocial health psychology, has a highly individualistic orientation. In contrast, community health psychology adopts an ecological perspective in which individuals are seen as embedded within small systems, which are nested within larger systems. Defining problems at the individual level serves to blame the victims, even if this is not intended. Teaching people on social assistance how to better manage their finances assumes that the problem is a lack of budgeting skills, rather than a lack of financial resources. Community health psychology challenges individualistic interpretations of problems and strives to reframe problems, taking power and the social context into account (Seidman & Rappaport, 1986). As Rappaport and



Stewart (1997) stated: "The power to frame the issues, define the terms of the debate, and set the agenda for discourse is to win the game before it begins" (p. 307).

<b>Assumptions and Practices</b>	<b>Clinical Health Psychology</b>	<b>Community Health Psychology</b>
Levels of analysis	Intrapersonal or micro-systems	Ecological (micro, meso, macro)
Problem definition	Based on individualist philosophies that blame the victim	Problems are reframed in terms of social context and cultural diversity
Timing of intervention	Remedial (late)	Prevention (early)
Focus of intervention	Deficits/problems	Competence/strengths
Goals of intervention	Reduction of maladaptive behaviours	Promotion of competence and well-being
Type of intervention	Treatment-rehabilitation	Self-help/community development/social action
Role of Client	Compliance with professional treatment regimes	Active participant who exercises choice and self-direction
Role of professional	Expert (scientist-practitioner)	Resource collaborator (scholar-activist)
Type of research	Applied research based on positivistic assumptions	Participatory action research based on critical and constructivist assumptions
Ethics	Emphasis on individual ethics, value neutrality, and tacit acceptance of status quo	Emphasis on social ethics, emancipatory values, and social change
Inter-disciplinary ties	Psychiatry, clinical social work	Critical sociology, health sciences, philosophy, social work, political science, planning and geography

\* Adapted from Prilleltensky, I., & Nelson, G. (1997). *Community psychology: Reclaiming social justice*. In D. Fox & I. Prilleltensky (Eds.) *Critical psychology: An introduction*. (Pp. 166-184) London: Sage.

While clinical health psychology focuses on reactive treatments after problems have developed, community health psychology emphasizes earlier intervention that strives to prevent problems from developing in the first place. Clinical health psychology has adopted a framework that focuses on problems, pathologies, and deficits. In contrast, community health psychology assumes that people have strengths and competencies, which need support from social systems to be fully expressed (Rappaport, 1977). Similarly, while clinical health psychology is concerned with reducing "maladaptive" health behaviours (e.g., smoking, overeating, using substances,), community health psychology has more of a positive, growth

focus on the promotion of competence and wellbeing.

In clinical health psychology, intervention consists of professionally prescribed treatment or rehabilitation that have been empirically validated for the particular presenting problem. Community health psychology intervention encompasses a range of different strategies including self-help, community development, and social action. In clinical health psychology, there is a power imbalance between the professional clinician and the consumer. The clinician is presumed to be an “expert” scientist-practitioner, while the role of the client is to comply with the treatment regimen prescribed by the professional. Since community health psychology assumes that “clients” have strengths, the role of the professional is one of a resource-collaborator (or scholar-activist). Community health psychologists strive to reduce the power imbalances between themselves and the disadvantaged people with whom they work and to encourage active consumer participation, control, and choice in the intervention process.

Research in clinical health psychology is based on the assumptions of a positivist epistemology and has emphasized experimentation (randomized clinical trials) and quantification. In contrast, community health psychology research is participatory and action-oriented (Tolman & Brydon-Miller, 2000). Critical and constructivist epistemologies often underpin community health psychology research, and qualitative methods, which give voice to disadvantaged people’s experiences and challenge dominant societal and medical narratives, are often used (Murray & Chamberlain, 1999). Clinical health psychology emphasizes individual ethics (e.g., informed consent), claims value neutrality, and, in so doing, tacitly accepts the status quo of unequal power relations between disadvantaged people and professionals. In contrast, community health psychology adopts a social ethics of emancipatory values that explicitly challenge the status quo (Prilleltensky & Nelson, 2002). Finally, while both clinical health psychology and community health psychology advocate for inter-disciplinary research and practice, the types of inter-disciplinary collaboration differ. Clinical psychology typically works with other clinical professions, such as psychiatry and clinical social work. Community health psychologists often find that they have a great deal in common with colleagues from other disciplines who share a critical orientation. Moreover, since community health psychology is ecological in nature, collaboration with a range of social science and health disciplines is needed to provide a broader perspective and framework for the understanding and promotion of health.

### **2.3 The Values of a Community Health Psychology**

Historically, there has been a unity of values, research, and action within community psychology (Rappaport, 1977; Rappaport & Seidman, 2000). This approach would also typify a community health psychology. There are a number of themes that would characterize the new field of community health psychology. These themes include values and assumptions that reflect the field’s underlying moral and epistemological foundations, and analytic concepts,

which have served as building blocks for community research and action (Prilleltensky & Nelson, 1997).

### **2.2.1 Caring, compassion, and community:**

Like humanistic psychology, community health psychology shares an emphasis on caring and compassion as a fundamental value. However, community health psychology would extend this concept beyond the therapeutic relationship to higher ecological levels of analysis. The psychological sense of community (Sarason, 1988), social support (Gottlieb, 1983), community inclusion and integration (Nelson, Lord, & Ochocka, 2001), community development (Pilisuk, McAllister, & Rothman, 1996), and self-help/mutual aid (Humphreys & Rappaport, 1994) are some of the key concepts that have been used to actualize this value in community research and action.

### **2.2.2 Health promotion and prevention:**

Recognizing the limitations of micro-focussed therapeutic interventions, community health psychology draws on the field of public health and strives to create and evaluate interventions designed to promote health and competence and to prevent problems in living (e.g., health and mental health problems) on a population or community-wide basis. Community psychologists have been among the leaders of the prevention/health promotion area in research and conceptual development (e.g., Albee, 1986; Cowen, 2000). Moreover, community health psychology uses a multi-level, ecological, systems framework in analysing health problems and designing preventive interventions. The concepts of risk and protective factors and resilience have been used to examine processes that impact on health and wellbeing at multiple levels of analysis (Hawkins, Catalano, & Miller, 1992).

### **2.2.3 Oppression and empowerment:**

Community health psychologists recognize the political dimensions of human problems. Oppression of disadvantaged groups and individuals are defined both in terms of social structures and processes and internalized, psychological experiences of disempowerment (Prilleltensky & Gonick, 1996). In their interventions, community health psychologists will attempt to elaborate an empowerment framework, which emphasizes self-determination, democratic participation, and power-sharing (Rappaport, 1981, 1987). Community health psychologists recognize the need for a “power reversal” in the traditional role relationships between disadvantaged people and professionals. Thus, community health psychologists working from an empowerment orientation take direction from and help disadvantaged people to exercise and access power.

### **2.2.4 Diversity:**

Respect for diversity is seen as a cornerstone of community health psychology (cf. Rappaport, 1977). In its acceptance of the status quo of mainstream values, traditional health psychology

has emphasized “adjusting” people to socio-cultural norms and practices. In its identification with disadvantaged people, community health psychology recognizes that many problems in living stem from unreasonable and unjust standards to which people are expected to adjust. People who are different from the mainstream have historically been viewed as defective or deficient in some way (Trickett, Watts, & Birman, 1994). Women, people of colour (particularly black and aboriginal people), gays and lesbians, and people with disabilities have historically been subject to oppressive social conditions by virtue of being different. Community health psychology challenges cultural norms that are disempowering to citizens from diverse backgrounds and celebrates the value of diversity. In their research and action, community health psychologists strive to be respectful of people’s experiences, amplify the voices of marginalized people, sensitive to the unique context of individuals, and accepting of individuals’ unique identities.

### **2.2.5 Social justice:**

Community health psychologists identify with and participate in social movements and social action. They do not believe that it is useful or necessary to separate their personal, professional, and political selves. Prilleltensky and Nelson (1997) have argued that community health psychology should more actively focus on issues of economic inequality, particularly in this era of global capitalism, in which large, multinational corporations are accumulating greater shares of wealth and power world-wide at the expense of people with low levels of income, the physical environment, labour conditions, and social and health policies and programs (Barlow & Clarke, 2001).

## Chapter 3

### RESEARCH BASE

#### 3.1 Research Context

Having established the need for and the values underlying a community health psychology we now consider the nature of research and practice of such a discipline. At this juncture in history, at the beginning of the 21st Century, a contemporary curriculum in community health psychology, to be relevant, must take account of the broader socio-political context in which community health is shaped. In our view, this must include attention to the following:

- < the growing disparities between “haves” and “have-nots,” globally, nationally, and locally. This is expressed locally in the growing spatial segregation of cities along class lines, with profound impacts on the local geography of health and illness;
- < processes of economic globalization, concentration of capital, and its social and political consequences (regarding flexibility of labour, downward pressure on trade and environmental restrictions, and what Galtung (1995) has referred to as “cultural imperialism”);
- < increasing ethno-cultural diversity of the population. In some cities such as Toronto and Vancouver, whites now constitute a minority in their changing cultural mosaic;
- < growing social unrest as a result of rapid economic and social change, environmental calamity, and unprecedented population migrations;
- < developments in new information technology that continue to revolutionize how things are done in some segments of society, while leaving other segments of society aside altogether;
- < continued degradation of the natural environment resulting in pollution of the air, water and soil, global warming, and growing frequency of catastrophic weather events that impact heavily on marginalized populations living in vulnerable fringe terrains (e.g., flood plains); Deforestation, soil depletion, overcrowding and species extinction, will continue to take their toll. As competition for scarce natural resources such as fresh water escalates, the likelihood of armed conflict increases. Warfare and social unrest further impact on the health and well-being of millions of people whose fragile environments are already stressed by famine, poverty, and inadequate access to basic necessities of life;
- < the social, as well as environmental, impacts of wasteful consumerism;

- < the emergence of conservative religious fundamentalism, and its links (in North America, with the Christian Right) to neo-liberal economic policy;
- < the role of the media in setting the public policy agenda, and the social class bias and social (and political) conservatism of many influential media;
- < falling participation rates in democratic votes in North America;
- < the increasingly threadbare social fabric, and new work suggestive of a link not only between the quality of civic society and public health, but also the link between social investment and economic productivity;
- < the emergence of an “underclass” of unemployed homeless and the concurrent erosion of the social safety net, leading to the creation of a “surplus” population excluded from participation in society in multitudinous ways.

This list is by no means complete. However, it does point to a period of economic and social turbulence, the increasing interconnectedness of social, environmental, and economic problems, and the need for forward-thinking curricula that integrate a concern for social justice with a rigorous and theoretically informed understanding of how society operates, how it is structured, and processes of social exclusion and marginalization.

### **3.2 Critical Thinking**

The importance of critical thinking and communicative effectiveness as core skills that will serve students throughout their lifetime cannot be over-emphasized. This section focuses specifically on critical thinking.

There are many misperceptions about the term “critical.” In academia it is fashionable to be “critical.” Many colleagues seek to be critical of someone's work as part of the game of intellectual one-upmanship. There is also the more specific meaning embodied in the “critical appraisal” of the literature as articulated by colleagues in clinical epidemiology. In short, few would willingly claim to be un-critical, but it ends up meaning so many different things to different people. Indeed “critical” has become one of the those “plastic words” that the German historian and linguist Uwe Porksen (1988) asserts that, like “community” and “empowerment,” take on the appearance of slogans or mantras which are so charged with multiple affective meanings that, paradoxically, they become empty and almost meaningless.

Here we explore two specific meanings of the term critical: one referring to the “rigour” of systematic thinking, the other referring to a particular perspective on the nature of society (as in critical-realist) that has particular consequences for how we view science and the scholar. Emphasis in the first case is on critical thinking as a generic skill, whereas in the second case the

emphasis is on an orientation to critical thinking that is grounded in a particular epistemological and ethical stance.

### 3.2.1. Critical thinking as intellectual rigour:

Critical thinking is the art of evaluating ideas. It implies a willingness to examine assumptions and the context in which ideas are generated and discussed (Brookfield 1987). According to Richard Paul (1993) critical thinking is:

*a unique kind of purposeful thinking in which the thinker systematically and habitually imposes criteria and intellectual standards upon the thinking, taking charge of the construction of thinking, guiding the construction of the thinking according to the standards, and assessing the effectiveness of the thinking according to the purpose, the criteria, and the standards (p.21).*

These criteria, according to Paul, include integrity, humility, fair-mindedness, empathy, and courage. Each of these is explained in the article, so we do not elaborate on them much further here, except to underscore that they signal that critical thinking is as much an emotional stance as it is a rational intellectual pursuit. In short, it is about reflexivity. It is about making thinking a disciplined and rigorous activity.

There are certain core presuppositions that are held by critical thinkers. Ruggiero (1988) lists eight such presuppositions:

- < solutions that seem practical or efficacious are sometimes not;
- < human perception is often flawed and memory distorted;
- < guessing and unconscious assuming often masquerade as knowing;
- < knowledge is seldom (if ever) complete;
- < bias is a natural phenomenon and affects judgement, sometimes profoundly;
- < reasoning is often confused with rationalizing or is otherwise flawed;
- < opinions, even those of experts, can be mistaken;
- < even when solutions appear eminently practical, reasoning flawless, and opinions enlightened, other people will not necessarily perceive that they are such.

In developing a critical review of existing literature the following questions suggested by Young (1990) provide a good guide:

- < what is the main argument that the author(s) is/are putting forward? Is it a controversial subject? What are the main issues surrounding the controversy?
- < can you identify a particular theoretical perspective (e.g., Marxist, Feminist, Weberian, etc.)? Is there a particular political ideology (e.g., conservative, liberal, radical, etc.) being advanced?
- < what methods have been used to present the data/argument?

- < what data have been used to support the arguments being made? Do you think that this data can be used to answer the questions the author(s) is/are addressing?
- < what scale is being addressed? Is the topic local, regional, national or international?
- < do you agree with the argument/perspective/etc? Why or why not?
- < how does this work compare with other work on the same topic or with work that shares the same or similar perspective/theory?

Critical thinking is also about asking the right questions (adapted from Browne & Keeley, 1990) in reading and writing, and applying these to one's own written work:

- < what are the issues and the conclusion?
- < what are the reasons?
- < what words or phrases are ambiguous?
- < what are the value conflicts and assumptions?
- < what is the evidence?
- < are the samples appropriate and the measurements valid?
- < are there rival hypotheses?
- < is the data analysis methodology clear, rigorous, and defensible?
- < how relevant are the analogies?
- < are there any errors in reasoning?
- < what significant information is omitted?
- < what conclusions are consistent with the strong reasons?
- < what are your own value preferences in this controversy?

### **3.2.2 Critical thinking as deepening the social analysis:**

Critical thinking should also involve a deepening of the social analysis. This involves questioning the world around us, and our taken-for-granted assumptions about it; going beyond surface understandings, appearances; questioning popular beliefs, official truths, and so-called "expert" opinions. It is coming to understand how society operates, how resources and power are distributed, and specifically who benefits from prevailing social, political and economic arrangements. Deepening the social analysis is preoccupied by the fairness of these social arrangements. In other words, it is oriented toward social justice. According to Disman (199x):

*Social justice [is] a concept based on the belief that each individual and group within a given society has a right to civil liberties, equal opportunity, fairness, and participation in the educational, economic, institutional, social and moral freedoms and responsibilities valued by the community.*

Extending this definition and paraphrasing from David M. Smith in R. J. Johnston (1993):



*Social justice: the distribution of society's benefits and burdens, and how this comes about. A theory of social justice is a theory about the kind of social arrangements that can be defended (Barry, 1989, p.3). While social justice is a very broad concept, attention is often focussed on the distribution of income and other sources of need satisfaction on which the material conditions of a population depend. [Specifically,]... it is the inequality or unequal treatment that requires justification.*

Social analysis: (a) is informed by historical perspective/analysis (sees that things have not always been as they are, and points to the contingency of social phenomena); (b) moves back and forth from the personal/individual to the social/structural, to show the dialectical relationship between the two; and (c) looks for root causes of health and social problems embedded in social structures and social practices.

Key aspects of society, according to Czerny et al. (1994), that social analysis focuses on include: (a) symptoms like social malaise, inequalities in health, etc. and what they point towards; (b) reification/commodification of people and prerequisites in health, with consequences for inequitable distribution of prerequisites to health (basic needs as fundamental rights); (c) social costs of seemingly individual or purely economic decision making (e.g., plant relocation, etc); (d) structures (social, economic, religious, etc.) as relatively enduring systems of social arrangements.

The search for root causes and deepening the social analysis reflects a particular world view, called critical realism, that we share with a number of other scholars, but which differs markedly from several other more conventional paradigms of scientific inquiry. Before describing these and how they differ, it's helpful to clarify terms and concepts like "epistemology" and "ontology."

### **3.3 Epistemology**

The nature of the questions that we ask about the world embody a number of assumptions that fundamentally drive research and practice in community health psychology. These questions are framed in the context of assumptions about what constitutes "evidence," the purpose of research, how we "do" science; many of which are taken for granted or codified in methodological prescriptions. The more reflexive we can be about our presuppositions, and those of others, the more adept we can be in discerning the impact of hidden agendas, ideology, and values in the work that people do in this field. In collaborative and interdisciplinary team research, its becoming necessary to openly negotiate the perspectives that will inform the collection and analysis of data, as well as the organization of practice. In community-based and participatory research, community groups are demanding these be made explicit.

Key skills for unpacking the hidden assumptions that drive research and practice in community health psychology include critical thinking (including the ability to deepen the social analysis)

and an awareness of basic paradigms of inquiry, including a critical social science perspective on the determinants of health. It is suggested that any curriculum in community health psychology should be organized so as to enable students to:

- < appreciate the relevance and importance of critical thinking for research and practice in community health psychology, as a core aspect of reflexivity;
- < recognize that research and practice is never entirely neutral, that the claim to objectivity masks a particular set of value commitments that is itself a political and ideological stance;
- < see how one can use critical thinking to “unpack” and expose hidden epistemological, political, and ideological commitments and how these influence research, theory and practice in community health psychology;
- < identify key features of critical thinking, and see how they might be applied in one's own work;
- < understand the concept and practice of “deepening the social analysis”;
- < recognize the influence of epistemological foundations on the conduct of science, and describe the broad contours of three primary paradigms in which most community health research (and practice) is grounded;
- < better understand the nature, strengths and limitations, of a critical social science perspective on public health, and it's applicability to understanding social inequalities in health.

### 3.4 Osophies and Ologies

Before we proceed to develop particular proposals for training it is useful to clarify certain theoretical concepts. *Ontology* refers to a theory of existence and assumptions about what is real and what is knowable. Bhaskar (1979) identifies three broad ontological traditions:

*Empiricism/positivism* - what is knowable is what is directly observable empirically measurable, quantifiable; focus on testing of hypotheses (laws) based on the study of observable patterns and statistical associations; “hard” science imitates the natural sciences; emphasis on objectivity, reliability, replicability of methods;

*Idealism* - what is knowable is only in and via the mind, socially constructed, world of meanings; emphasis on understanding subjectivity especially through use of qualitative methods;

*(Critical) realism* - focus is on explanation, with an emphasis on uncovering the (real) underlying root causes of a phenomenon (which may not always be directly observable) using a combination of methods, but theory-informed

*Epistemology* refers to a theory of knowledge, assumptions about how we come to know what we know (how knowledge is acquired). It refers to how knowledge is generated, its validity, methods and scope. *Theory* refers to a formal explanation of a phenomenon or set of related

phenomena. *Methodology* refers to a set of rules and procedures that indicates how research is to be conducted; not just methods, but the rules for their application and validity. Methodology specifies the relationship between theory and method. *Methods* are specific data collection and analysis procedures/techniques. We note in this context that polemical debates about issues of method (e.g., qualitative versus quantitative) often have more to do with their epistemological roots. Methods (for data collection) themselves are relatively neutral epistemologically, and can be employed from different vantage-points. The connections between ontology, epistemology and methodology are explained further in Table 3 that is derived from Poland (1998).

An example of the application of these paradigmatic differences in practice may be illustrative. Using the example of smoking, we can point to the different types of questions that would be posed from each vantage-point. From a conventional positivist perspective (typical of the bulk of research in tobacco control), smoking is often seen as a failure of reason (non-rational response to available evidence). Smoking is defined primarily as major cause of illness, based on epidemiological evidence. Questions are framed in terms of knowledge and attitudes towards smoking and quitting, as determinants of behaviour, with the focus being the development of predictive models of factors statistically associated with smoking uptake, cessation, and relapse. Qualitative methods informed by this epistemological paradigm tend to focus research on why people smoke or why they quit (to model behaviour); are used to enhance survey design, or interpret survey findings. In short, positivist research on smoking seeks to discover what makes smokers “tick,” in order to fine-tune models and interventions.

**Table 3 – Ontological Traditions**

<b>Dimensions</b>	<b>Positivist</b>	<b>Interpretive</b>	<b>Critical realist</b>
<b>Ontology</b>	those things we accept as existing are those things that have been firmly established as existing by verifiable evidence	what exists is what people perceive to exist	what really exists cannot be ascertained simply through empirical research, except with the assistance of social theory
<b>Thus reality is ...</b>	<i>Stable</i> : reality is made up of facts that persist long enough to be generalizable	<i>dynamic</i> : reality changes with changes in people's perceptions; reality is socially constructed	<i>contested</i> : struggle for power to define reality <i>hidden</i> : underlying structured and practices that maintain status quo may be obscured by the taken-for granted
<b>Epistemology</b>	knowledge is gained through experience, but experience must be firmly established as verifiable evidence on which all will agree	knowledge is obtained by participating subjectively in a world of meanings (not verifiable facts) created by individuals; emphasizes the subjectivity and social construction of all knowledge	the world of appearances (what we experience) does not necessarily reveal the world of mechanisms (what causes the world of experience or appearances)
<b>View point</b>	<i>outsider</i> : reality is what quantifiable data indicate	<i>insider</i> : reality is what people perceive it to be	<i>insider or outsider</i> : reality is both objective and subjective
<b>Purpose</b>	<i>prediction &amp; control</i> : seeks causes and effects of human behaviour	<i>understanding</i> : seeks to understand people's interpretations/ perceptions	<i>emancipation</i> : seeks to bring about social change
<b>Values</b>	<i>value-free</i> : values can be controlled with appropriate methodologic procedures (neutrality)	<i>value bound</i> : values will have an impact and should be understood and taken into account (disclosure)	<i>value-driven</i> : values determine the nature and extent of social change (commitment)
<b>Focus</b>	<i>particularistic</i> : selected predefined variables are studied	<i>holistic</i> : a total or complete picture is sought	<i>penetrative</i> : attempt to reveal hidden interests, assumptions, structures
<b>Orientation</b>	<i>verification</i> : predetermined hypotheses are tested	<i>Discovery</i> : theories and hypotheses are evolved from the data collected	<i>explanation</i> : attempt to link theories with empirical lived experience
<b>Theory</b>	takes the form of scientific law: formal & predictive e.g. functionalism, behaviourism, problem-specific conceptual models (Theory of reasoned Action, etc.)	Theory as capturing an understanding of people in their environments; reconstruct and account for the reality experienced by people; empathic understanding of other people's lives, e.g. social constructionism, symbolic interactionism, phenomenology, grounded theory	theory attempts to explain underlying structures that influence phenomena: either/both objective facts and subjective meanings: can be either predictive or interpretive, but prediction is not validated by probabilities but by internal consistency/coherence, e.g. critical realism, political economy, feminist theory(ies), post-modernism critical theory(ies), some psychoanalytic theory, Marxism
<b>Methodology</b>	verifying actual statements about phenomena: scientific or hypothetico-deductive method	Investigation of subjective "lifeworlds"; do not emphasize replicability or absolute "truth"	constructing explanations to account for what is observed, but which may not be empirically testable

<b>Data</b>	<i>objective</i> : data are independent of people's perceptions	<i>subjective</i> : data are perceptions of the people in the environment	<i>objective &amp; subjective</i> : 'real' structures can only be known through contestable perceptions of situated actors
<b>Typical methods</b>	survey research, mathematical modelling (correlational analysis)	depth interviews, focus groups, observational research	may use mix of quantitative and qualitative, or just one cultural analysis, some discourse analysis, postmodern deconstruction, critical feminist research, institutional ethnography
<b>Instrumentation</b>	<i>non-human</i> : preconstructed tests, records, questionnaires, and rating scales are employed	<i>human</i> : the human person is the primary data collection instrument	<i>both human and non-human</i>
<b>Conditions</b>	<i>controlled</i> : investigations are conducted under controlled conditions, and/or controlled for during analysis	<i>naturalistic</i> : investigations are conducted under natural conditions	<i>usually naturalistic</i>
<b>Results</b>	<i>reliable</i> : the focus is on design and procedures to ensure accuracy and replicability	<i>valid</i> : the focus is on design and procedures to gain 'authentic', 'rich' accounts	<i>useful</i> : the focus is on completing and insightful explanations that become catalysts for social change

Source: Poland, 1998 (Columns 1 and 2 are adapted from David Butz, Department of Geography, Brock University)

From an idealist/social constructionist perspective, smoking is framed primarily in terms of identity and becoming. Researchers steeped in this tradition ask questions such as what does smoking mean to those who smoke? (What does it really mean that someone would say that a cigarette is her “friend”? What does it mean when someone says they are not “ready” to quit? What does it mean to be “ready”? How does someone know when they are “ready”?). They seek to understand what makes it attractive. They might compare and contrast how legislators, tobacco control advocates, tobacco industry representatives, smokers, etc. perceive the issues; and seek to better understand the symbolic and social context of smoking (its social functions, from an anthropological perspective).

From a critical realist perspective, one would be drawn to inquire into the social and material conditions under which disadvantaged groups smoke (for example, can it be seen as a symptom of a lack of control over life conditions?). Smoking might be framed in terms of resistance. Researchers steeped in this epistemological tradition might be drawn to ask which agendas are served by framing smoking as a problem of individual ignorance rather than as a problem of poverty and disadvantage, or perhaps not as a problem at all. They might examine the tendency in many societies towards the purification of public space, social exclusion framed in discourse of “risk” and “risk management” (but with class bias). Qualitative research in this tradition could seek to understand experiences of social exclusion, marginalization and suffering caused by inequitable social structures and processes; studies of hegemony/ideology; and how people make sense of the structures that keep them “in their place.”

There are, of course, differing perspectives on what constitutes a critical social science perspective on health. As already indicated, both quantitative and qualitative research can be informed by critical thinking, an orientation towards deepening the social analysis, and/or a critical realist epistemological paradigm (with or without explicit reference to critical theory). Some approaches to a critical social science perspective on health (e.g. Eakin et al., 1996) derive inspiration primarily from a breed of social theories that are “big C” critical (sometimes also referred to as conflict theories). Unlike *functionalist* theories (which focus on the mechanisms by which society functions as a cohesive entity), or *symbolic- interactionist* theories (which focus on the nature of interpersonal relations and the development of shared social systems of meaning), *critical* theories view the world in terms of the mechanisms (ideological or other) which permit some social groups to have power over, and to exploit, others (Eakin et al., 1996; Held, 1980).

Regardless of the specific orientation taken, a commitment to social justice and to socially relevant research is the hallmark of community health psychology. In this sense, methodological and theoretical pluralism can be consistent with a critical perspective on health, the determinants of health, and interventions designed to ameliorate unfavourable conditions and to improve health prospects. Explicit attention to the epistemological foundations of research is an essential component of a rigorous training program in community health psychology.

## Chapter 4

### TRAINING OPPORTUNITIES

#### 4.1 Training Opportunities in Applied Health Research

In spite of past federal health reports, such as Lalonde's (1974) *A New Perspective on the Health of Canadians* and Epp=s (1986) *Achieving Health for All: A Framework for Health Promotion*, which called for an emphasis on health promotion, most health services continue to follow the medical model of treatment of diseases. One of the barriers to the implementation of health promotion approaches has been the lack of trained researcher-conceptualizers of alternative approaches.

Opportunities for graduate-level training in community based approaches to promoting health are limited. The 16 medical schools in Canada (12 anglophone, 4 francophone) all offer training programs in Community Medicine/Epidemiology. The orientation of these programs is towards epidemiology and biostatistics. Some of these departments also offer training programs in health social science and health promotion. A limited number of departments of sociology and anthropology offer advanced training in medical sociology and anthropology (see Appendix 3 for further details).

#### 4.2 Training Opportunities in Community and Health Psychology

In 1980, Nelson and Tefft (1982) conducted a survey of graduate education in community psychology and found that while 20 Canadian universities offered a graduate course in community psychology, that there were very few complete programs in community psychology. At most universities, opportunities for training in community psychology were highly dependent on one or two faculty members. In 1992, Walsh-Bowers (1998) updated these survey results and found a similar number (19) of universities offering a graduate course in community psychology. These surveys also found that while there are two Francophone universities that offer a PhD program in community psychology (Laval and UQAM), the only community psychology graduate training program in an Anglophone university is the MA program at Wilfrid Laurier University.

Currently, there exists no distinct separate training program in health psychology in Canada. Instead, health psychology is generally taught as a track within most clinical psychology training program. As such, its growth is conditioned by the approach and assumptions of clinical psychology. In many universities health psychology is often taught as a free-standing undergraduate course by clinical or social psychologists.

In 1996, Gordon Butler surveyed the interests of members of the CPA Health Psychology Section. Approximately one third reported that they were primarily clinicians, one third primarily researchers and the remainder a mixture of teachers and administrators. The main areas of interest of the respondents were cancer, pain, stress management, chronic illness and AIDS/HIV indicating the clinical orientation of the respondents. In a more extensive survey of section members and professional psychologists registered with the CRHSPP Graff and Martin (1996) reported similar findings.

### **4.3 Training Opportunities in Other Countries**

The clinical/individual orientation of health psychology is not particular to Canada. In the United States it is the mainstream approach. Indeed, the American Psychological Association decided to name its speciality clinical health psychology to emphasize its distinction from any community-oriented approaches. Admittedly, there are more opportunities for training in community and applied social psychology in the United States. This has provided some students with an opportunity of specializing in community health psychology. The Society for Community Research and Action has a sub-group on community health psychology.

In Latin America, participatory community-based approaches are much more widespread within graduate programs in applied psychology. Indeed, this has contributed to the development of a more political version of community psychology known as liberation psychology (Martin-Baro, 1994). In practice this approach adopts a variety of community-based strategies designed to raise social consciousness and to develop community strategies to help resist or alleviate various forms of social oppression. These ideas have fed back into different strands of community psychology in North America. Health psychologists in Latin American have often followed the dominant clinical/individual approach of North America. However, in those centres where there is a strong base for community psychology there has been the opportunity to develop more community-based health psychology.

Cuba is a particular example of a Latin American society that has developed a distinctive approach to health psychology. Here the orientation in training is to produce psychologists who will work in community-based poly-clinics with a variety of other health professionals. However, although the orientation is towards the community the character of both practice and research is more clinical/individual.

It would be valuable for future training programs in community health psychology to connect with these other programs.



## Chapter 5

### TRAINING NEEDS

#### 5.1 Research Methodologies

The key defining characteristics of research in community health psychology are: a) its use and application of psychological theories to research questions related to health, health care, and health promotion; b) its location in communities rather than in laboratories (i.e., it is most appropriately referred to as community-based research); and c) its applied orientation.

The first characteristic delineates this sub-discipline as located within psychology and aligns it with the sub-disciplinary area of health psychology. The second characteristic locates this form of health psychology within communities. The third makes it “answerable” to the needs of communities (i.e., driven by community needs and agendas in the area of health, health care, etc.). The second and third, together, align this sub-disciplinary area with community psychology. Together these have implications for defining topical areas, locations, and methodologies of research.

Four issues are central to the research methodologies of community health psychology:

##### **5.1.1 Identification of an appropriate epistemological stance and fully understanding its implications for one’s research methodology and relation to communities:**

As we described in Chapter 3, there are three competing epistemologies underlying research in community health psychology. Because each epistemology has different implications for conducting research, each needs to be understood prior to embarking on developing a research program. These rival epistemologies lead to asking different research questions of the same phenomena, using different approaches and strategies for sampling, data collection and interpretation, and for addressing concerns with methodological rigour. Before venturing into community health psychology it is essential that the researcher become thoroughly familiar with these competing epistemologies and decide which is consistent with her/his own ontological, axiological, and epistemological orientation. Attempting to become a good researcher working within an epistemology that is not one’s own has a high probability of resulting in poor quality results.

##### **5.1.2 Skills in working in partnership with communities and understanding the different forms of partnership and their implications:**

Community health psychology research is grounded in the community and demands that researchers work in partnership with community members. Researchers need to have skills in forming partnerships that make meaningful research possible and beneficial to community

members. Nelson, Prilleltensky, and MacGillivray (2001) have defined value-based partnerships as “relationships between community psychologists, oppressed groups, and other stakeholders that strive to advance the values of caring, compassion, community, health, self-determination, participation, power-sharing, human diversity, and social justice for oppressed group. These values drive both the processes and the outcomes of partnerships that focus on services and supports, coalitions and social action, and research and evaluation.” The tradition of participatory action research provides a framework for working in partnership with community members, particularly those who are disadvantaged (Nelson, Ochocka, Griffin, & Lord, 1998; Ochocka, Janzen, & Nelson, in press; Prilleltensky & Nelson, 2002; Tolman & Brydon-Miller, 2000). But it is not easy to work in partnership with disadvantaged people who are deeply mistrustful of researchers and who have seldom benefited directly from any research in which they have participated.

Thus, as well as technical and methodological skills, community health psychology researchers need to have skills in the area of community development, team work, group process, consultation, human relations, taking the perspective of the “other,” etc.. Developing the skills required to work with and in communities is essential to community health psychology. Research cannot proceed without good community partnerships. Academic training and the requirements for success in academic may be antithetical to the development of such skills making it especially important to teach and provide opportunities to practice such skills as part of the training of community health psychologists. This is the area where there is perhaps the most work to be done in developing guidelines for competencies and methods for developing them. Dalton, Elias and Wandersman’s (2001) text includes perhaps the most comprehensive chapter outlining the requirements and characteristics of community-research collaborations. Other sources include the methodological report on doing research on and with sex workers by Lewis and Maticka-Tyndale (2000), VanVugt’s (1994) collection of community-based research related to AIDS, and the brief description of researcher-community partnerships that were formed as part of the *Ethnocultural Communities Facing AIDS* project funded by Health Canada in 1992-1996 (e.g., Adrien et al, 1996: p. S6-S7; in particular the description of the communication strategy associated with this partnership on p. S8; and the reflections of community partners on the experience Willms et al., 1996).

### **5.1.3 Skills in developing a diversity of community-appropriate materials based on research results (i.e., translating research results into useful products):**

This too is a skill that is not typically taught as part of academic training. Together with the previous issue, it is also not something that is expected of or rewarded in university-based researchers. However, without the production of materials for community use, communities are unlikely to partner with researchers. These products can include informative, accessible ‘pamphlets’, summary bulletins, and progress reports (e.g., Samis & Whyte 1999); programs, processes, and strategies (e.g. Elkins et al. 1996; Maticka-Tyndale et al., 1994; and various examples in VanVugt, 1994); and videos, drama productions, and stories. While it may be possible for researchers to contract with associations or individuals who can develop

appropriate materials (e.g., PATH, International), the conceptualization of what needs to be done based on the research findings still rests with the researcher.

#### **5.1.4 Skills in specific research methodologies appropriate to the community-based focus:**

In quantitative methodologies, a quasi-experimental approach is likely to be most appropriate, requiring that more time be spent in training on quasi-experimental designs, methodologies, their specific challenges (e.g. sampling and generalization) and appropriate statistical procedures. Qualitative methodologies have been consistently identified as potentially more appropriate to community-based research than quantitative methodologies, yet these are rarely the focus of methodological training and will require more development (see Creswell 1998 as well as the series on qualitative methodologies produced by Sage Publications). In addition, training in action research, participatory research and participatory action research is essential. Sage Publications has several relevant sources, in particular Stringer (1999) and Whyte (1991). In addition, Hart and Bond (1995) and DeKonning and Martin (1996) take the participatory and action forms of research into the health arena.

## **5.2 Core Competencies**

Training programs for community health psychology need to be based upon an awareness of the key competencies for graduates of such programs. Such competencies derive from an understanding of the theoretical basis of the sub-discipline and of the potential opportunities for the graduates of such a program.

### **5.2.1 Values, social ethics and the ability to think critically:**

In Chapter 2, we reviewed the value base of community health psychology, and in Chapter 3, we discussed the importance of skills in critical thinking. Values, social ethics, and critical thinking are fundamental competencies in community health psychology (Prilleltensky & Fox, 1997). Without a firm foundation in values and social ethics, community health psychologists run the risk of becoming technicians who are unaware of the values that underlie their research and action. Closely related to values social ethics are skills in critical thinking. A critical thinker is constantly questioning, challenging assumptions, and examining the premises on which research and action are based. As we argued in Chapter 4, critical thinking is about scrutinizing and deepening the social analysis of health issues. Some important values and critical thinking skills are as follows:

- < awareness of the core values of community health psychology and how these frame our questions, methods and interventions;
- < understanding the consequences of emphasizing some values over others;

- < the ability to help others to clarify their values and to use those values as a vision for guiding their actions;
- < skills in translating values into actions that are congruent with and advance those values in research and practical applications of knowledge;
- < the ability to understand what is constructed as evidence (and why some forms of evidence are privileged while others are not);
- < the ability to identify implicit assumptions, including ethical and value commitments, hidden behind technical or ideological statements;
- < skills in examining how arguments are constructed based on world view, beliefs, and the selective use of evidence; and
- < being aware of how one's social positioning, life history, personal experiences, and socialization (embedded in, for example, race, gender and class) affect how we see things.

### **5.2.2 Knowledge**

Trainees should have a working knowledge of the following:

- < broad social determinants of health and various methods used to examine these determinants;
- < psychological and social science theories used to understand individuals within environments. This includes, but is not limited to, theories from social psychology (including social influence, attitude and inter-group conflict and relations) and organizational dynamics (including management and leadership styles, change, and decision-making);
- < theories from community health psychology used to understand the behavioural and social factors that contribute to the etiology of health and illness and the subjective experiences of health and illness;
- < theories and interventions concerning prevention and competence promotion, community-building, citizen participation, and empowerment and how these can be used to promote and maintain health or prevent and treat illness;
- < broad range of methods and approaches to community research, program evaluation, and evaluation of social interventions as well as their strengths and limitations to address various questions or problems;

- < the importance of examining the social, political, and historical contexts of health, health care and health delivery;
- < the Canadian health care system and the social system; and
- < health and social policy analysis.

### **5.2.3 Skills:**

Trainees need to demonstrate skill in the following areas:

- < critical reviewing and synthesizing of the literature;
- < designing and implementing a research study (or a program evaluation), analysing the data, identifying its strengths and limitations, and drawing valid conclusions;
- < communicating effectively (written and orally);
- < partnership skills, including program development, community development, consultation, team work, human relations, group process;
- < providing appropriate consultative services to a variety of settings including health organizations, advocacy groups, and governments; and
- < applying concepts and methods to work with stakeholders and decision-makers to examine or to improve health and health care systems or reform health delivery.

### **5.2.4 Professional issues:**

Trainees require an understanding of the following:

- < the Canadian Psychological Association's Code of Ethics and its relationship to their work;
- < principles of the Community Development Society for good practice
- < legal and statutory obligations and restrictions; and
- < the importance of working in an interdisciplinary and multidisciplinary field and the importance of professional identity and respect for others.

### **5.3 Forms of Training**

In developing a new area of advanced training in applied health research we considered the various options available for training. These include:

#### **5.3.1 Graduate programs:**

The ideal option would be for a freestanding graduate program in community health psychology. This would require a single institution offering a full program in the sub-discipline. However, we accept that in the early stages that this would not be feasible. Options would encourage collaboration between institutions, possibly on a regional basis. One model is that currently encouraged by the Canadian Health Services Research Foundation (CHSRF). The CHSRF has recently provided funding for the establishment of four regional consortia of institutions who would offer a shared graduate training program. Although students would be enrolled at particular institutions they would share courses which would either be offered through the Internet, through summer schools or through exchange of students.

#### **5.3.2 Specialized options**

There are currently a limited number of programs in community psychology. Offering specialized options in community health psychology could augment these programs.

#### **5.3.3 Summer institutes**

These would be designed to provide linkages between the different sites where students are pursuing graduate work in community health psychology.

The working party reviewed these different options and developed an integrative proposal. This is included as an appendix.

## Chapter 6

### RESOURCES FOR TRAINING

#### 6.1 Teaching Materials

##### 6.1.1 CD-ROMs:

It is intended to develop a series of CD-ROMs to follow this report. These CD-ROMs will contain:

- a) Key lectures
- b) Summary of key points
- c) Links to important Internet resources

It is intended to link them closely with other written and Internet material.

##### 6.1.2 Books:

The list of references contains a list of important resources. Key essential books would include:

Dalton, J. H., Elias, M. J., & Wandersman, A. (2001). *Community psychology: Linking individuals and communities*. Stamford, CT: Wadsworth Thompson Learning.

DeKonning, K. & Martin, M. (1996) *Participatory Research in Health: Issues and Experiences*. Atlantic Highlands, N.J.: Zed Books

Fox, D., & I. Prilleltensky, I. (Eds.). (1997), *Critical psychology: An introduction*. London: Sage.

Freund, P., & McGuire, M. (1999). *Health, illness, and the social body: A critical sociology*. Upper Saddle River, N. J.: Prentice Hall.

Murray, M., & Chamberlain, K. (ed.) (1999). *Qualitative health psychology, Theories and methods*. London: Sage.

Poland, B.D., Green, L.W., & Rootman, I. (Eds.) (2000). *Settings for health promotion: linking theory and practice*. Thousand Oaks, CA: Sage.

Prilleltensky, I., & Nelson, G. (2002). *Doing psychology critically: Making a difference in diverse settings*. London: MacMillan.

Tolman, D. L., & Brydon-Miller, M. (Eds.).(2000). *From subjects to subjectivities: A handbook of interpretive and participatory methods*. New York: New York University Press.

### **6.1.3 Internet material:**

A website has been developed for this project ([www.med.mun.ca/tchp](http://www.med.mun.ca/tchp)). The cover page is included in the appendices. This webpage contains links to a wide variety of potential resources which were also listed in the appendices.

## **6.2 University Resources**

### **6.2.1 Studentships:**

Students will enrol for graduate programs if there are studentships. For this reason it is essential that a limited number of core studentships be established.

### **6.2.2 Research chairs:**

A key point in the development of training sites for community health psychology is the establishment of a number of chairs in the sub-discipline. These could be shared between schools of psychology and public health.

### **6.2.3 Exchanges:**

Other countries have established training programs that contain courses in community health psychology. It is essential that faculty have the opportunity of visiting these centres and of beginning to establish collaborative programs.



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## APPENDIXES

### **A.1 Courses offered in a selection of related graduate programs**

Details of these courses were extracted from websites. Individual universities will offer additional courses within their programs but this selection gives an idea of the broad content areas of different programs.

#### **1. Community Health**

- Principles of community health
- Biostatistics
- Epidemiology
- Community health research methods
- Health care systems
- Occupational and environmental health

#### **2. Clinical psychology**

- Psychopathology
- Neuropsychology
- Psychological assessment
- Interviewing and counselling
- Psychotherapy
- Ethical and professional issues
- Clinical research methods
- Statistics

#### **3. Community psychology**

- Principles
- Research in community settings
- Social interventions
- Human service organizations
- Social and cognitive psychology
- Statistics

#### **4. Health sociology**

- Sociological theory
- Research methods
- Statistics
- Sociology of health and illness
- Sociology of ageing



## **A.2 Masters of Health Science in Health Promotion - University of Toronto Statement of Core Principles and Core Competencies**

### **Preamble:**

Based on a review of program documents, Society of Public Health Education criteria, results of a survey of alumni, and deliberations in committee, a sub-group of the External Advisory Committee for the MHSc program in Health Promotion at the University of Toronto (comprising faculty, alumni, and current students), drafted the following statement of core principles and core competencies. These were developed to guide curriculum review (the prioritization and development of new course offerings, as well as review of existing course offerings).

### **Core Principles:**

- (1) value adult learning, self-directed learning
- (2) variety of learning formats (in-class, practicum, volunteer work, personal experience, mentorship, etc...)
- (3) strong links with community
- (4) focus on health promotion *practice* (theory-informed but *applied*)
- (5) make the program accessible and equitable while also maintaining academic rigour
- (6) seek to advance the field of health promotion

We felt that these principles must be reflected consistently in the program's "core business" - in its courses, governance structure, recruitment policies, etc.

### **Core Competencies:**

A combination of skills and knowledge base that all graduates of our program would have at least some foundation in, regardless of their specific area of specialization.

### **Generic skills:**

- < solid appreciation of the broad social determinants of health
- < critical thinking
- < communicative effectiveness (oral & written)
- < literature search skills (using online and offline resources)
- < navigating/searching the net (handling new information technologies)
- < critical appraisal of the literature (research evidence, argumentation)
- < capable of being informed consumers of research
- < research skills (using a variety of methods of data collection & analysis)
- < ability to integrate theory and practice (application of theory to practice, and revision of theory in light of practice)
- < ability to deepen the social and political analysis
- < well developed ethical stance w/emphasis on equity & social justice

(A list of more specific skills like proposal writing, small group facilitation, etc, could also be developed)

Knowledge base:	Theory	Evidence	Method	Cutting edge issues*
<b>Assessment</b>	<ul style="list-style-type: none"> <li>• definition &amp; measurement @ individual, community &amp; population levels</li> <li>• Definition and measurement of health promotion 'needs',</li> <li>• social construction of 'need'</li> <li>• capacity orientation to community health assessment</li> </ul>			
<b>Planning/ Implementation</b>	<ul style="list-style-type: none"> <li>• behaviour change theory and practice; coalitions, intersectoral collaboration;</li> <li>• harm reduction;</li> <li>• community development &amp; working with community groups;</li> <li>• evidence-based practice; policy analysis &amp; policy change;</li> <li>• advocacy &amp; activism; health communication, social marketing,</li> <li>• media advocacy; adult education, theory &amp; practice;</li> <li>• learning organizations,</li> <li>• organizational change; small group work/group process, group facilitation skills;</li> <li>• settings approach;</li> <li>• grant proposal &amp; budget writing;</li> <li>• Precede-Proceed model, etc</li> </ul>			
<b>Evaluation</b>	<ul style="list-style-type: none"> <li>• qualitative &amp; quantitative evaluation tools;</li> <li>• cost-effectiveness;</li> <li>• (see also research skills, evidence-based practice, etc)</li> </ul>			
<b>Values/ethical</b>	<ul style="list-style-type: none"> <li>• values clarification;</li> <li>• health promotion ethics;</li> <li>• developing an ethical stance that includes social justice, equity, etc.)</li> </ul>			
<b>HP history/ </b>	<ul style="list-style-type: none"> <li>• historical shifts in discourses on health principles &amp; on the determinants of health;</li> <li>• distinguishing health promotion from health education from disease prevention etc;</li> <li>• familiarity with conservative &amp; radical critiques of health promotion;</li> <li>• making a case for health promotion;</li> <li>• key milestone reports/documents (e.g. Ottawa Charter)</li> </ul>			

\* cutting edge issues include (but are not limited to): (these will change over time) harm reduction; health of marginalized groups; inequalities in health (incl. explanations, responses); understanding the broad determinants of health (incl. salient concepts like social capital; social cohesion & their relationship to health); evidence-based practice; environmental hp; international health; healthy public policy

### **A3 Training application**

#### **LETTER OF INTENT FOR A TRAINING PROGRAM IN COMMUNITY HEALTH PSYCHOLOGY**

##### **1.1 Objectives**

Future developments in population health research, theory, and practice urgently require an explicit engagement with theoretical and methodological advances in the social and community sciences. This training initiative deliberately brings together researchers working in community health, community psychology and related social sciences to develop an innovative integrative training approach. Community health psychology develops an understanding of health as being immersed in social, institutional and professional power structures and articulates methods for the promotion of health connected to different strategies for social and community change. Theoretically it derives from critical perspectives in applied psychology and social science and emphasises an active participatory approach to health research rooted in collaborative community-based partnerships particularly with disadvantaged and marginalised groups. It addresses core population health issues, e.g. social inequalities in health, in a unique and innovative way. It is deliberately designed to be transdisciplinary, linking micro (individual/experiential), meso (community), and macro (structural) levels of analysis and intervention. Currently a number of universities offer aspects of training but there is as yet no dedicated centre for comprehensive training in community health psychology. This initiative draws expertise and resources of ten different universities to develop a program to provide training in a) theoretical issues in community health psychology and b) community-based research methods related to the enhancement of health.

##### **1.2 Location**

This training program will be centred on five institutes with collaboration from five more institutions in Canada and two elsewhere. Administratively, the program will be centred at Memorial. Trainees will be enrolled in one of the graduate programs (MSc/PhD) in Community Health or Applied Psychology (Memorial), Public Health (Toronto), Community Psychology (Wilfrid Laurier or Ottawa) or Social Science (Windsor). They would choose to specialise in community health psychology. The trainees would participate in a) summer institutes, b) jointly taught courses available via the internet, c) web-based discussion groups, d) exchanges with different sites, and e) opportunities for community-based research in a wide range of settings both in Canada and elsewhere. Although this program will be primarily aimed at graduate students it will be flexible to provide opportunities for post-doctoral and mid-career training. It will be participatory in structure such that graduates with experience in different community health settings will be encouraged to share their expertise. Both graduate and other students in the program will have the opportunity of availing of the expertise of all of the faculty and of spending extended periods of time at one of the lead institutions and shorter

periods at one of the other institutions. A mechanism for the joint accreditation of courses offered by different institutions will be established.

### **1.3 Faculty/ Resources**

The training team includes faculty drawn from community health, social psychology, community psychology and other social sciences. Currently, these faculty offer graduate courses in community health, qualitative research methods, community psychology, health promotion, program evaluation, social theory, etc. It is intended to pool the resources of these different courses and to develop a training program that addresses the social, economic, and community determinants of health and illness. Through the internet it is intended to establish a shared library of material for students. In addition, the structure and content of the program will be developed in partnership with community organisations and health planners. Students will have the opportunity of spending placement periods working with these partners.

## **2. Need for training program**

The nature of community health research is shifting from one based upon a top-down approach that emphasises surveillance and control. The alternative bottom-up approach emphasises participatory and emancipatory research strategies developed in partnership with different groups and communities. The theoretical and practical implications of such a shift are still underdeveloped. The issue is less one of method than it is the ability to bring a critical perspective to both quantitative and qualitative methodologies, including an awareness of power relations within the context of a focus on social justice and social inequality. There is an urgent need to develop a training program to build the capacity of new researchers in this area.

This training program builds upon the report *Training in community health psychology* that was prepared by a working party with funding from the MRC/CIHR Opportunity Fund. That report argued that the development of community health research is hindered by the location of most of its theory and training within a positivist paradigm. Instead it argued that there is a need to connect community health research with the theories and methods of community psychology and the growing critical debate about theories and methods within social science. The establishment of this program will provide substance to the informal network of researchers that has emerged from this working party and will also enable the faculty to expand their theoretical and research skills and to develop collaborative research strategies.

## **3. Expertise of team members**

The key mentors have extensive experience in training graduate students to both the masters and doctoral level. They have published relevant books, chapters and research articles and participate actively in a variety of research organisations. They will be joined by selected trainers from other universities in Canada and from outside Canada who have substantial relevant experience.

<b>Key mentors</b>	<b>Position</b>	<b>Expertise</b>
Michael MURRAY	Professor of Social & Health Psychology, Community Health, Memorial University of Newfoundland.	Critical social and health psychology; Qualitative research methods; Literacy action; Community health research; Narrative and social representation theory
Geoff NELSON	Professor of Community Psychology, Wilfrid Laurier University	Critical community psychology; Housing, self-help, and innovation in community mental health; Prevention and wellness enhancement for children and families.
Blake POLAND	Associate Professor Public Health Sciences, University of Toronto	Community development in health; Critical social theory; Qualitative research methods; Lay perceptions of tobacco control
Tim AUBRY	Associate Professor of Community Psychology, University of Ottawa (Bi-lingual program)	Community mental health; Homelessness; Populations facing social exclusion; Program evaluation of social interventions
Eleanor MATYCKA-TYNDALE	Professor of Sociology, University of Windsor	Medical sociology; Human sexuality; HIV/AIDS; Developing countries

<b>Trainers</b>	<b>Position</b>	<b>Expertise</b>
Lorraine FERRIS	Public Health Sciences, University of Toronto	Health psychology; Program evaluation; Women's health; Health services research
Roy CAMERON	Health Studies, University of Waterloo	Population health; Health promotion; Socio-behavioural cancer research.
James FRANKISH	Health Promotion, Univ of British Columbia	Health promotion; Community development
Michael McCUBBIN	Population Health, University of Regina	Policy sciences; Population health; Social theory; Mental health policy; Ethics.
Camil BOUCHARD	Psychologie, UQAM (to be confirmed—on leave)	Community development; Prevention programs with children and families
Catherine CAMPBELL	Social Psychology, London School of Econ.	Societal psychology; Health promotion; Social capital; HIV/AIDS
Brinton LYKES	Community Psychology, Univ of Witwatersrand	Community development; Liberation psychology; Human rights

The initiative will also involve expertise from community-based organisations, health institutions, and individuals from both national and international organisations. These include the CPHA, CPA and additional faculty from universities in Canada, USA, Europe and Latin America (Cuba and Chile).

#### **4. Innovative features**

- The transdisciplinary nature of this initiative is enhanced through partnerships with both community groups and health planners. Students will have the opportunity to develop research skills for working with disadvantaged communities such as homeless people and native communities. It is also designed to link trainees with health care providers and planners to enable them learn how to connect their community based research skills to healthcare planning and policy development.
- A variety of teaching methods will be employed ranging from face-to-face classroom teaching, web-based teaching, CD-ROMs and special workbooks. These materials will be developed with the students and be made available to other institutions for teaching. An important feature is the direct participation of trainees with different community partners.
- The initiative is designed to provide core training in community health psychology with also an opportunity for specialised options (e.g. community development theory, working with immigrant groups) that will be offered through the network. Students who would like to specialise in certain topics would have the opportunity of moving to different sites and of accessing different network members as supervisors.
- The initiative is national in scope drawing on faculty and resources from all regions of the country and enabling students to access courses and expertise in both English and French. It will also connect with related programs in other countries. It will provide students with the opportunity of advanced training for working with minority populations and in developing countries.
- Students will be recruited through the current graduate programs at the different institutions. Advance information will clearly identify the particular track in community health psychology. Foreign students will be recruited through the extensive network of collaborators. Graduates of the program will become part of a network and will have the opportunity of ongoing participation in the training initiative.