International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 09 Issue 11 November 2026
DOI: 10.47191/ijcsrr/V9-i11-23, Impact Factor: 8.048
IJCSRR @ 2026
www.ijcsrr.org

Health, Power, and Ideology: Reclaiming Health Psychology Beyond Neoliberal Individualism

Vijay Kumar Yadavendu
Professor, Department of Psychology, Patliputra University, Patna, India.
Orcid: https://orcid.org/0000-0003-1847-213X

ABSTRACT

Objective: Health psychology has increasingly emphasised individual responsibility, lifestyle choices, and self-regulation in explaining health and illness. Although these perspectives offer insights into health-related behaviour, they risk detaching individual experience from the social, economic, and political conditions that shape health inequalities. This paper critically examines the limitations of this individual-centred orientation.

Methods: This conceptual paper critically analyses the epistemological and methodological assumptions of mainstream health psychology. Drawing on historical debates in social psychology, critiques of reductionism, the Frankfurt School, and contemporary critical health psychology, it situates psychological explanations of health within broader discussions of neoliberalism, responsibilisation, and the social determinants of health.

Results: The analysis identifies a persistent tendency to privilege behavioural interventions, including self-help, behaviour modification, and lifestyle management, while underestimating the structural conditions shaping health outcomes. By foregrounding individual choice and self-regulation, mainstream approaches risk obscuring the effects of poverty, employment insecurity, environmental disadvantage, and institutional power. The discourse of responsibilisation further transfers accountability for health from collective institutions to individuals, reinforcing neoliberal assumptions about autonomy, personal choice, and market rationality. Consequently, health inequalities may be interpreted as failures of individual conduct rather than expressions of wider social relations and unequal distributions of resources and power.

Conclusions: The paper advocates a critical reorientation of health psychology that moves beyond individualistic and reductionist explanations. Integrating historical, political, economic, and social analysis into psychological theory and practice can illuminate the structural production of health inequalities. By challenging the depoliticisation of health and examining the relationship between agency and structure, critical health psychology can reclaim health as a collective concern and strengthen psychology's contribution to social justice and transformative health policy.

KEYWORDS: Critical health psychology, Neoliberalism, Methodological reductionism, Responsibilisation, Social determinants of health, Structural inequalities.

1. INTRODUCTION

Psychology has long been characterised by internal fragmentation. Subfields such as social, cognitive, and mathematical psychology share a disciplinary lineage yet often operate in isolation, with distinct objects, methods, and assumptions. Health psychology, emerging in the late twentieth century, reflects these tensions. Mainstream psychology's variable model, which treats phenomena as measurable or potentially measurable variables and builds theory from statistical relations, frames much of health psychology's science and practice. Within this paradigm, Joseph Matarazzo's influential definition describes health psychology as "the aggregate of the specific educational, scientific, and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, and the identification of etiologic and diagnostic correlates of health, disease, and related dysfunction (Matarazzo,1980),"[1] a definition he later expanded to include contributions to health-care systems and policy.[2]

This consolidation occurred as the epidemiological landscape shifted. By the mid-twentieth century in industrialised countries, the leading causes of mortality were no longer acute infectious diseases but chronic conditions, cardiovascular disease, cancer, and diabetes, often linked to lifestyle and behaviour within consumer cultures.[3] Parallel developments in psychology amplified this

International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 09 Issue 11 November 2026
DOI: 10.47191/ijcsrr/V9-i11-23, Impact Factor: 8.048
IJCSRR @ 2026
www.ijcsrr.org

individual focus: behaviour modification promised targeted change through reinforcement; biofeedback and self-regulation techniques aimed to help individuals control physiological processes such as heart rate or muscle tension. These currents braided together: (a) behaviourist principles and protocols, (b) technics of self-regulation, and (c) a lifestyle framing of risk. The result was a durable alignment between psychology and medicine around managing individual risk and responsibility.

Yet this emphasis risks narrowing our explanatory vision. In recent decades, scholarship on the social determinants of health (SDOH) has shown that the circumstances in which people are born, grow, live, work, and age, together with distributions of power, money, and resources, exert profound effects on health and health equity, often outweighing access to medical care. Contemporary global syntheses (e.g., WHO's 2025 World Report on Social Determinants of Health Equity) argue for upstream, structural action on inequities and non-medical root causes.[4–6] These developments challenge any approach that treats health primarily as a function of individual choices or psychological dispositions and relocate health psychology's object within histories of inequality, political economy, and institutional arrangements.

At the same time, critical currents within psychology have grown. Over the past three decades, an alternative critical health psychology (CHP) has emerged, questioning positivist assumptions, scrutinising power, and treating health as historically and politically situated rather than merely intrapsychic. While mainstream health psychology continues to foreground individual behaviour and cognition, CHP places greater weight on context, discourse, institutions, and justice. This article retains the core narrative of your original text while (a) clarifying how reductionism functions as a limiting lens, (b) tracing the historical oscillations of social psychology between the personal and the social, and (c) outlining a critical social psychology, drawing on the Frankfurt tradition and contemporary debates, that can re-situate health within structure, history, and power.

2. REDUCTIONISM IN HEALTH PSYCHOLOGY

Mainstream health psychology often narrows context to the personal environment, the immediate sphere of relations and behaviour, rather than the broader social milieu of class, policy, labour, gender, racialisation, and environment. Russell Jacoby's critique remains apt: contemporary psychology frequently translates context into "psychological atmospheres," reducing social relations to the interpersonal and erasing how "society seeps in." [7] The upshot is a methodological individualism that treats risk as a property of persons, not of social orders.

Don Ardell's high-level wellness rhetoric exemplifies this privatised framing: how one organises a bedroom or workspace, cultivates friendship networks, or invites feedback becomes central to "wellness." [8] Self-responsibility is the master principle, the "philosopher's stone" of lifestyle change. This ideal can empower those with resources but presumes freedom to choose while neglecting constraints imposed by poverty, precarious work, discrimination, pollution, or housing insecurity.

Robert Crawford named the ideology healthism, which medicalises daily life and normalises a moralised surveillance of the self. [9] Within a neoliberal policy regime, this moral economy of self-care dovetails with governmental techniques that make individuals responsible for managing structural risk. Thomas Lemke described responsibilisation as a key mechanism of neoliberal governmentality: the state devolves risk management to individuals, who are incited to govern themselves as entrepreneurs of health. [10] Vincent Navarro's political-economic critique sharpened this point: lifestyle politics complement capitalist power by channelling dissent into private conduct while leaving economic and political structures intact. [11]

This individualisation of risk can license coercive or technocratic interventions. India's 1970s family planning efforts, for example, deployed knowledge-attitude-practice (KAP) studies to shape "motivation" and acceptance of contraception among low-income groups, illustrating how behaviourist tools can become instruments of social engineering rather than vehicles of empowerment. The behaviourist extremes of Watson and Skinner reduce human functioning to measurable inputs and outputs; while experimentally fertile, such reductionism strips action of history, meaning, and agency. [12,13] Meanwhile, purely intrapsychic frameworks such as classical psychoanalysis risk detaching the psyche from social conditions by treating unconscious drives as primary movers. In short, mechanical behaviourism and inward-turned metaphysics miss the mediated relation between person and world.

Contemporary debates further expose the limits of responsibilising frames. Analyses of commercial determinants of health (CDOH) argue that morbidity and mortality are powerfully shaped by corporate strategies (e.g., product design and marketing; lobbying; regulatory capture) across sectors such as tobacco, alcohol, ultra-processed foods, and fossil fuels. A 2023 Lancet Series synthesised how "market fundamentalism" magnifies health harm and inequity, prompting calls to regulate corporate power, not just nudge individual choice.[14,15] Systematic reviews and frameworks (e.g., Petticrew et al.; Mialon; Ralston et al.) further map how commercial

International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 09 Issue 11 November 2026
DOI: 10.47191/ijcsrr/V9-i11-23, Impact Factor: 8.048
IJCSRR @ 2026
www.ijcsrr.org

actors structure exposure and constrain choice environments.[16–18] In short, the problem is not only that some individuals "choose badly," but that political economies and corporate practices saturate life worlds with risk.

Finally, the COVID-19 crisis crystallised how illness clusters with inequality. Richard Horton argued early that COVID-19 should be approached as a syndemic, a synergistic interaction among infection, chronic disease, and social conditions, which requires structural remedies, not purely biomedical or behavioural fixes.[19] Others refined or critiqued the syndemic framing across contexts, but the central insight stands: vulnerability tracks social gradients.[20,21] Reviews of health inequalities during and after the pandemic (e.g., Marmot's Build Back Fairer review) detail how austerity, labour insecurity, and housing conditions magnified COVID-19 harm, underscoring the inadequacy of a psychology of the self without a politics of structure.[22,23]

3. HISTORY OF SOCIAL PSYCHOLOGY

Social psychology has oscillated between collective and individual explanatory poles since its inception. Turn-of-the-century theorists such as Emile Durkheim, Gustave Le Bon, Edward Ross, Gabriel Tarde and Wilhelm Wundt advanced notions of collective representations, crowd psychology, and "group mind," insisting that society is more than the sum of its parts. [24–28] In contrast, William McDougall grounded social behaviour in instinct; Floyd Allport later displaced instinctivism with an individualistic behaviourism that made laboratory studies of persons the discipline's core.

Frederic Bartlett's studies of remembering influenced both methods and theory (schemas, reconstruction) and informed Allport & Postman's classic work on rumour.[29,30] Yet canon formation marginalised contributions outside Euro-American centres. Indian psychologist Jamuna Prasad's elegant research on rumour during the 1934 Bihar earthquake, anticipating concerns later associated with Karl Festinger and others, analysed how anxiety, uncertainty, salience, and norms shaped rumour transmission. [31], Prasad's early integration of social context into psychological process was largely ignored in mainstream histories.

By mid-twentieth century, experimental social psychology (ESP) crystallised. ESP often models interpersonal influence in dyads or small groups and treats context as a manipulable variable within ahistorical designs. Critics argue that translating social structures into variables strips them of meaning and renders findings nomothetic and decontextualised. Tolman contended that ESP isolates the "lawful" transformation of immediate influences into behaviour while excluding the societal and historical dimensions that constitute those influences. [32] Holzkamp and others argued that the "social" becomes an empty placeholder for controlled interaction, rather than a lived structure of constraint and possibility.

Against this, symbolic interactionism, drawing on Mead, Cooley, and Blumer, emphasised how self and mind emerge through symbolic interaction and internal dialogue. [33–35] It contributed lasting insights into meaning-making and reflexivity but has been criticised for being insufficiently historical or economic and for sometimes reducing society to a backdrop of face-to-face encounters. Because the patterned organisation of institutions can recede from view, constraints can appear as accidental obstructions to subjective meaning rather than structured power.

Sociological social psychology (SSP) centres institutions and social structures, linking them to personality and action. Marx analysed how relations of production shape social being; Weber examined how status, authority, and value orientations animate social change; Durkheim explored moral regulation and anomie. [36–38] Yet even in SSP-influenced psychological work, social factors often get relegated to independent variables whose meanings are unexamined. Tajfel famously noted that studies "socialise" inputs but ultimately report averages of individual responses, collapsing macro processes into micro-outcomes. [39]

Two meta-themes emerge. First, social psychology repeatedly swings between empiricist/positivist and interpretive/structural poles; second, mainstream practice essentially privileges the former. Erich Fromm lamented that modern psychology had become "a science of alienated man studied by alienated methods," [40] a formulation that captures the distance between lived social worlds and depoliticised laboratory situations. These tensions set the stage for a critical social psychology that explains and challenges the social conditions of its own knowledge.

4. THE FRANKFURT SCHOOL

A critical social psychology must do more than invert the mainstream's emphasis on individuals; it must analyse how mediating processes connect institutional orders to subjective life, and how knowledge practices participate in power. The Frankfurt School's Critical Theory offers an early, ambitious blueprint. Horkheimer proposed that critical theory be explanatory (diagnosing domination), normative (articulating emancipatory aims), and practical (oriented to transformation). [41]

International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 09 Issue 11 November 2026
DOI: 10.47191/ijcsrr/V9-i11-23, Impact Factor: 8.048
IJCSRR @ 2026
www.ijcsrr.org

Erich Fromm developed an analytic social psychology in which social character, the patterned structure of psychic energy moulded by a given society, mediates the relation between economic base and ideology. [42,43] Distinguishing life-affirming from artificial needs cultivated by consumer capitalism, Fromm sought to diagnose how social systems shape desire and personality. He insisted on clinical grounding, criticising purely speculative extensions of psychoanalysis to society.

Herbert Marcuse emphasised how advanced capitalism manufactures false needs and integrates individuals into consumption, culture industries, and technocratic rationality. Domination, for Marcuse, includes overt coercion but also the production of compliant subjectivities through advertising, managed culture, and the narrowing of imagination, which is a "one-dimensional" life. [44] While Fromm and Marcuse re-linked psyche and society, critics such as Philip Wexler argue they left under-specified the intermediate processes, interaction, organisation, and institutional practice that translate structure into subjectivity and vice versa. [45]

Here, contemporary critical health psychology (CHP) extends the project. CHP is less a single method than an ethical-political orientation: it examines health phenomena through power, context, and inequality; uses plural methods (discourse and narrative analysis, participatory and community-based research, ethnography, and quantitative designs); and aims for participant benefit and social justice.[46–48] Organisations such as the International Society of Critical Health Psychology (ISCHP) foreground reflexivity, pluralism, and solidarity; open educational resources and recent handbooks map how CHP interrogates taken-for-granted categories ("health," "problem," "intervention") and resists the psychologization of social suffering.[49,50]

Recent debates push CHP toward political economy and regulatory politics. The commercial determinants of health literature documents corporate practices, marketing, supply chains, lobbying, and litigation that shape population risk and frustrate public-interest regulation. Lancet's 2023 Series and follow-ups argue for reframing prevention around governance of corporate power; state-of-the-art reviews propose systems-thinking tools and cross-industry strategies. [14–18, 51,53] This work complements SDOH syntheses and illustrates why individual responsibility is an inadequate fulcrum for prevention.

Parallel strands interrogate neoliberal subjectivity directly. Card and Hepburn's 2022 study during COVID-19 found heterogeneous effects of neoliberal beliefs: valorisation of "personal wherewithal" tracked some positive outcomes, while anti-government beliefs correlated with poorer well-being and social trust, evidence that the ideology's components carry divergent health implications.[54] Conceptual analyses and measurement work (e.g., emerging scales of neoliberal orientation) try to capture how competitiveness, self-regulation, and "public divestment" are internalised as virtues.[55] Critical scholars also highlight responsibilising public campaigns (e.g., Norway's "Only You") that address citizens as solitary self-managers of mental health.[56] Such messaging resonates with the wellness discourse critiqued earlier and sits uneasily with evidence of structural drivers.

Finally, critical psychology increasingly engages decolonial and liberation approaches that contest Eurocentric canons, attend to coloniality in knowledge production, and align research with community struggles. This includes re-reading global mental health agendas through power, questioning export models of evidence-based interventions, and evaluating projects by their psychopolitical validity, their engagement with power and liberation rather than only proximal symptoms. These moves re-embed psychology in civic life and reposition health as a collective, political achievement rather than an individual commodity.

5. CONCLUSION

Mainstream health psychology remains constrained by reductionism. It prescribes solutions grounded in behaviour modification, self-help, and lifestyle change, abstracting individuals from their social location. This orientation aligns neatly with neoliberalism and market-primacy doctrines, replacing structural analysis with moralised self-surveillance. In practice, it reinforces biomedical and individual-centric paradigms, obscuring how political economy, institutions, labour, housing, environment, and histories of inequality shape health.

A critical health psychology can realign the field. Drawing on the Frankfurt School, contemporary CHP, political-economy analyses of commercial power, and decolonial and liberation frameworks, it insists that explanation and intervention must engage mediating processes, organisations, policies, narratives, and solidarities through which structure meets subjectivity. It treats evidence as plural and situated, not solely experimental; it evaluates projects by their contributions to equity and emancipation, not only by proximal behaviour change. In concrete terms, this means moving beyond responsibilisation toward (a) regulating commercial determinants of harm; (b) designing participatory, context-anchored interventions; (c) investing upstream in the social determinants of health; and (d) continually scrutinising how our own psychological concepts and methods may reproduce the very inequalities. Only by reconnecting the psyche to the polis can health psychology fulfil its promise, not merely to explain individual variance but also to help build worlds where health is collectively possible.

International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 09 Issue 11 November 2026
DOI: 10.47191/ijcsrr/V9-i11-23, Impact Factor: 8.048
IJCSRR @ 2026
www.ijcsrr.org

Finally, health psychology cannot remain confined to the psychology of individuals while neglecting the political economies within which individuals become healthy or ill. Reclaiming health psychology therefore requires more than methodological innovation; it demands an epistemological reorientation that reconnects psychological inquiry with history, power, and social justice.

Acknowledgments
I am thankful to the anonymous reviewers for their excellent suggestions and reflections on an earlier draft of this article. Any failures of omission or commission, of course, belong to me.

Conflict of Interest
The author declared no potential conflicts of interest concerning this article's research, authorship, and/or publication.

Funding
The author received no financial support for this article's research, authorship, or publication.

Ethical Declaration
The author declared no potential conflicts of interest concerning the research, authorship, and/or publication of this article.

REFERENCES

1. Matarazzo JD. Behavioural health and preventive medicine: psychology's contribution. *Am Psychol*. 1980;35(9):807-817. https://doi.org/10.1037//0003-066x. 35.9.807.
2. Matarazzo JD. Behavioral health and behavioral medicine: reclamation, integration, and the health system. *Am Psychol.* 1982;37(1):1-14. https://psycnet.apa.org/doi/10.1037/ 0003-066X.37.1.1.
3. Sencer, DJ. Chronic diseases: 21st-century public health challenge. CDC Museum in Association with Smithsonian Institution. https://www.cdc.gov/museum/online/story-of-cdc/chronic/index.html.
4. World Health Organization. *World Report on Social Determinants of Health Equity*. Geneva: WHO; 2025. https://www.who.int/teams/social-determinants-of-health/ equity-and-health/world-report-on-social-determinants-of-health-equity.
5. World Health Organization. Social determinants of health (fact sheet). https:// www.who.int/news-room/fact-sheets/detail/social-determinants-of-health
6. Centers for Disease Control and Prevention. Social determinants of health (SDOH). 2024. https://www.cdc.gov/about/priorities/why-is-addressing-sdoh-important.html.
7. Jacoby R. *Social Amnesia: A Critique of Contemporary Psychology*. Boston, MA: Beacon Press; 1975.
8. Ardell D. *High Level Wellness*. Emmaus, PA: Rodale Press; 1977.
9. Crawford R. Healthism and the medicalization of everyday life. *Int J Health Serv.*10 (3): 365-388. https://doi.org/10.2190/3h2h-3xjn-3kay-g9ny.
10. Lemke T. Foucault, governmentality, and critique. *Rethinking Marxism.* 2002; 14(3): 49-64. https://doi.org/10.1080/089356902101242288
11. Navarro V. Political and ideological determinants of health. *Int J Health Serv.* 1976;6(4):127-144.
12. Watson JB. *Psychology from the Standpoint of a Behaviorist.* Philadelphia: Lippincott; 1919.
13. Skinner BF. The operational analysis of psychological terms. *Psychol Rev.*1945; 52 (5):270-278. Doi:10.1037/h0062535
14. Gilmore AB, Fabbri A, Baum F, et al. Defining and conceptualising the commercial determinants of health. *Lancet.* 2023;401(10383): 1194-1213. *Doi:10.1016/S0140-67 36(23)00013-2.*
15. Friel S, et al. Commercial determinants of health: future directions. *Lancet.* 2023;401(10383):1229-1240. https://doi.org/10.1016/s0140-6736(23)00011-9.
16. Petticrew M, Glover RE, Volmink J, et al. The commercial determinants of health and evidence synthesis (CODES): Methodological guidance for systematic reviews and other evidence syntheses. *Syst Rev.* 2023; 12:165. https://doi.org/ 10.1186/ s13643-023-02323-0
17. Mialon M. An overview of the commercial determinants of health. *Glob Health.* 2020;16(1):74. DOI: 10.1186/s12992-020-00607-x.

International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 09 Issue 11 November 2026
DOI: 10.47191/ijcsrr/V9-i11-23, Impact Factor: 8.048
IJCSRR @ 2026
www.ijcsrr.org

18. Ralston R, Godziewsky C, Brooks E. Reconceptualizing the commercial determinants of health: Bringing institutions in. *BMJ Glob Health.* 2023;8(11): e013698. *Doi: 10.1136/bmjgh-2023-013698.*
19. Horton R. Offline: COVID-19 is not a pandemic. *Lancet.* 2020;396(10255):874. Doi: 10.1016/S0140-6736(20)32000-6
20. Mendenhall E. The COVID-19 syndemic is not global: Context matters. *Lancet.* 2020;396(10264):1731. *Doi:10.1016/S0140-6736(20)32218-2.*
21. Courtin E, Vineis P. COVID-19 as a syndemic. *Perspectives.* 2021;9. Doi: 10.3389/fpubh.2021.763830
22. Marmot M, Allen J, Goldblatt P, Herd E, Morrison J. *Build Back Fairer: The COVID-19 Marmot Review.* London: UCL Institute of Health Equity; 2020. https://www.Instituteofhealthequity.org/resources-reports/build-back-fairer-the-covid-19-marmot-review
23. Health Foundation. *Build Back Fairer: The COVID-19 Marmot Review.* 2020. https://www.health.org.uk/reports-and-analysis/reports/build-back-fairer-the-covid-19-marmot-review.
24. Durkheim E. *The Division of Labour in Society.* New York: Free Press; 1987.
25. Le Bon G. *The Crowd: A Study of the Popular Mind.* London: Fisher Unwin; 1903.
26. Tarde G. *The Laws of Imitation.* New York: Henry Holt; 1903 (orig. 1890/1899).
27. Ross EA. *Social Psychology.* New York: Macmillan; 1908.
28. Wundt W. *Elements of Folk Psychology.* London: Allen & Unwin; 1916 (orig. 1912).
29. Bartlett, F.C. *Remembering.* Cambridge: Cambridge University Press; 1932.
30. Allport, G. W., & Postman, L. *The Psychology of Rumour.* New York: Henry Holt, 1947.
31. Prasad, J. (1935). The psychology of rumour: A study relating to the great Indian earthquake of 1934. *Br J Psychol.1935;*26(1),1-15. https://doi.org/10.1111/j.2044-82 95.1935. tb00770.x.
32. Tolman C.W. *Psychology, Society, and Subjectivity.* London: Routledge, 1994.
33. Mead, G.H. *Mind, Self, and Society.* Chicago: University of Chicago Press, 1934.
34. Cooley, C. H. *Human Nature and the Social Order.* New York: Scribner, 1902.
35. Blumer, H. (1991). George Herbert Mead. In K. Plummer (Ed.), *Symbolic Interactionism*, Vol. 1, *Foundations and History.* England: Edward Elgar Publishing.
36. Marx, K. *Capital*, Vol. 1. London: Penguin; 1977 (orig. 1867).
37. Weber, M. *Economy and Society.* Berkeley: University of California Press; 1978 (orig. 1922).
38. Durkheim E. *Suicide.* Glencoe, IL: Free Press; 1951 (orig. 1897).
39. Tajfel, H. *Differentiation Between Social Groups.* London: Academic Press; 1978.
40. Fromm, E. *The Crisis of Psychoanalysis.* New York: Holt, Rinehart and Winston; 1970.
41. Horkheimer, M. *Critical Theory: Selected Essays.* New York: Continuum; 1982.
42. Fromm, E. *The Sane Society.* New York: Rinehart; 1955.
43. Fromm, E. *Psychoanalysis and Ethics.* New York: Holt, Rinehart and Winston; 1959 (repr. 1970).
44. Marcuse, H. *One-Dimensional Man.* Boston: Beacon; 1964.
45. Wexler, P. (1983). *Critical Social Psychology.* London and New York: Routledge and Kegan Paul.
46. Rogers, W. S. Critical approaches to health psychology. *J Health Psychol.* 1996;1(1):27-42. Doi: 10.1177/135910539600100106.
47. Murray. M., Chamberlain K, eds. *Health Psychology and Qualitative Research.* London: Routledge, 1999.
48. Lee, C. Critical health psychology: What is it? *J Health Psychol.* 2006;11(3):355-359. Doi: 10.1177/1359105306063303.
49. International Society of Critical Health Psychology (ISCHP). About ISCHP. 2024-2025. https://ischp.net
50. Morison, T., Renzaho, A.M., eds. *Critical Health Psychology* (OER). 2025. https://oercollective.caul.edu.au/critical-health-psychology/
51. *de* Lacy-*Vawdon C*, Vandenberg B, *Livingstone* CH. Recognising the elephant in the room: Towards a definition of the commercial determinants of health. *BMJ Glob Health.* 2022;7(2): e007156. Doi: 10.1136/bmjgh-2021-007156.
52. Maani, N., McKee, M. The commercial determinants of health: The mini-budget is a consequence of foundational forces medicine must bear witness to. *BMJ.* 2022;378: o2327. https://doi.org/10.1136/bmj.o2327.
53. McCartney, G., Hearty, W., Arnot, J., Popham, F., Cumbers, A., McMaster, R. Impact of political economy on population health. *Am J Public Health.* 2019;109(6): e1-12. https://doi.org/10. 2105/AJPH.2019.305001.

International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 09 Issue 11 November 2026
DOI: 10.47191/ijcsrr/V9-i11-23, Impact Factor: 8.048
IJCSRR @ 2026
www.ijcsrr.org

54. Card, K.G., Hepburn, K.J. Is neoliberalism killing us? A cross-sectional study of the impact of neoliberal beliefs on health and social wellbeing in the midst of the COVID-19 pandemic. *Int J Soc Determ Health Health Serv.* 2023; 53(3):363-373. DOI: 10.1177/ 0020731 4221134040.
55. Girerd L, Jost J.T., Bonnot V. How neoliberal are you? Development and validation of the Neoliberal Orientation Questionnaire. *Int Rev Soc Psychol.* 2023;36(1):1-20.
56. "Turken, S., Carlquist, E., Phelps, J.M. Only You": Neoliberal responsibilizing through a public health campaign in the Norwegian welfare state. *Annu Rev of Critical Psychol. 2024;*18:560587.

Biography: Dr Vijay Kumar

Yadavendu is a professor in the University Department of Psychology, Patliputra University, Patna, India. He holds a doctorate in public health from the Centre of Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University, New Delhi. His academic interests encompass critical psychology, critical health psychology, the philosophical and historical foundations of public health, and public health ethics. His research critically examines the relationship between health, power, ideology, and social inequality. His scholarly work engages with broader debates on the social determinants of health, political economy, and the role of structural and institutional forces in shaping health outcomes. He is the author of ***Shifting Paradigms in Public Health: From Holism to Individualism*** **(Springer, 2013).** His research has appeared in academic journals, including *Economic and Political Weekly* and *Current Science, International Journal of Psychology, Journal of Health Services Research & Policy, Journal of Health and Development, Howard Journal of Criminal Justice, and Global Journal of Medicine and Public Health and International Journal of Social Determinants of Health and Health Services and chapters in many edited volumes.* His work seeks to advance theoretically grounded and socially engaged approaches to psychology and public health, emphasising the importance of structural analysis, social justice, and collective responsibility in understanding health and human well-being.

Cite this Article: Yadavendu, V.K. (2026). Health, Power, and Ideology: Reclaiming Health Psychology Beyond Neoliberal Individualism. International Journal of Current Science Research and Review, 9(11), pp. 5754-5760. DOI: https://doi.org/10.47191/ijcsrr/V9-i11-23