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Part 1

History, Concepts and Methods

Health Psychology is a new discipline. This means that its boundaries are still in the process of being forged, and consequently have not been fully grasped even by many psychologists. If one is to comprehend the potential of the discipline, then an appreciation of its scientific roots is essential. However, such a stance, common in most textbook treatments of health psychology still fails to tell us the whole story of why health psychology emerged in the late 20th century. To this must be added knowledge of the social context which has driven the scientific problems that the new discipline sets out to address. A major theme of this book therefore is to set the unfolding 'drama' of health psychology against a backdrop of social concerns; rising health care costs, social and economic inequality, ageing populations and AIDS.

The story begins with the changing conceptions of health which have fuelled demands for an approach to understanding health and well-being which is centred less on the precepts of biological medicine and more on identifying dimensions of human need and responding to them. The study of quality of life is now rightly seen as a cornerstone of both health psychology and modern medicine. Knowledge of the practical and ethical dilemmas contained within it is therefore essential for anyone hoping to participate in health psychology or indeed in other branches of health science. Similarly a broad overview of the range of tools and methodologies which can inform one's thinking and practice when conducting research is a necessary prerequisite to understanding how researchers present their findings and evaluating what they mean.

Historical and Conceptual Basis of Health Psychology

‘The transition from a paradigm in crisis to a new one from which a new tradition of normal science can emerge is far from a cumulative process . . . Rather it is a reconstruction of the field from new fundamentals, a reconstruction that changes some of the field’s most elementary theoretical generalizations.’

Thomas Kuhn (*The Structure of Scientific Revolutions*, 1970)

INTRODUCTION

In order to comprehend the emergence of health psychology in the 1980s and 1990s we need first to look at the model of health – the biomedical model which was then preeminent and which still informs much of the practise of modern medicine. In it a number of key assumptions can be identified regarding the *determinants of health*, *how ill-health should be treated* and *who should treat it*. The medical model regards the human body as if it were a very complicated mechanism, and the overwhelming majority of today’s scientists likewise subscribe to a materialist philosophy which holds all life to be the manifestation of an evolving order of biological (read physico-chemical) complexity (Dennett, 1995). However, even if human beings are purely physical entities, this does not mean that it makes sense to treat them as if they exist only at the physical level of complexity and nothing more. In modern philosophical parlance, human beings are intentional agents – beings whose behaviour can at least sometimes be better predicted and explained by reference to their beliefs, goals and desires than by reference to their inner workings or design (Dennett, 1978).

The biomedical model holds that disease originates from purely physical causes, whether these be external agents such as bacteria and viruses or else precipitated internally by genetic factors or physiological changes in the body. Implicit in this formulation is the idea that deviations from optimal functioning (however defined) beyond some arbitrary point are to be considered an indication of ill-health. Health and illness are seen as irreconcilable opposites – and therefore to be healthy excludes the possibility of being ill. The idea that one’s health may benefit or indeed may depend upon bodily challenges and illnesses is not a logical consequence of this way of construing health. It follows from this that the inevitable consequences of ageing are also to be regarded as unhealthy. Within this framework it is difficult to envisage human beings able to make peace with the realities of their physical and temporal existence. It seems only in isolation from these that one can hope to attain the nirvana of everlasting health enshrined in the ideology of medicine. This is not to

deny the advantages inherent in medical practice, merely to point out part of what one perhaps unwittingly subscribes to in adhering to a strict biomedical model.

Responses to ill-health which seek to identify malfunctioning parts of the body and either restore them to their presumed normative functioning state or remove them, are entirely consistent with this philosophy of the body as machine. However, to be treated as a passive malfunctioning machine is not the sum total of what people want when they seek treatment from health professionals, and the notion that 'doctor knows best' is being increasingly called into question. The result has been less than total satisfaction with medical treatment and complaints of depersonalisation from some patients. A high proportion of patient complaints refer to poor attitudes, conduct and communication skills of attending staff (Lim, Tan, Goh and Ling, 1998; Yarnold, Michelson, Thompson and Adams, 1998), whilst analysis of physician consulting styles by Roter *et al.* (1999) has found that a narrow biomedical pattern of communication characterised by close-ended medical questions and biomedical talk accounted for almost one third of patient–physician encounters.

HEALTH AND ILLNESS

Given the aforementioned rationale for diagnosis and treatment, it follows that ill-health is best treated by medical practitioners, that is, those who subscribe to the medical model of ill-health. Whilst it may seem obvious today, it has not always been apparent that such states and processes as pregnancy, physical disability, behavioural problems or psychological disorder easily fall within its remit. That it now does so, and in fact appears to do so naturally (except perhaps for members of the above categories who are treated accordingly), is merely an indication of the psychological strength the medical model holds in the minds of people, following the undoubted political might with which the medical profession colonised these areas for itself (see, Foucault, 1965; Oakley, 1980; Szasz, 1991; Oliver and Barnes, 1998 for extended consideration of these issues).

Paradoxically, the expansionary zeal of medicine (Illich, 1977) has both directly and indirectly brought pressure to bear on traditional notions of health and illness. Directly, as we have seen above, as alternative modes of care have been brought within its boundaries, so they too have become subject to the metaphors of health and illness, which in turn has had to expand to accommodate them. Indirectly, growing awareness of the limitations of technological medicine (revealed most strongly in those areas where it is conceptually ill-equipped to deal with particular phenomena – usually those it has most recently expropriated) has brought demands to develop new means of evaluating health care and health interventions as the traditional health indicators based on physical morbidity and mortality do not accurately predict health-service usage (see Chapter 2). The development of these new health indicators has led in turn to new ideas on what constitutes health and illness (McDowell and Newell, 1987). Thus, notions of what constitutes health and illness, far from being static, have always been subject to reevaluation – perhaps more so than ever during the last one hundred years. A major transition occurred after the end of the Second World War. In the optimistic spirit of reconstruction which ensued, the World Health Organisation (WHO) set out to create a new agenda for understanding health and illness. Their oft-quoted definition states simply that,

Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. (WHO, 1946)

Accordingly, in the absence of ideal social, political or economic conditions people cannot be healthy. In the state of the world as it exists today it is therefore difficult to imagine how, given the remit of the WHO definition, anyone at all can be considered healthy. The WHO offered a more recent definition in the 1980s by emphasising the ability to function normally in one's own society – though the reference to normal standards opens up an entirely new set of problems. Seedhouse (1995) offers a radical perspective on definitions in changing the emphasis from the state of health to the process of attaining it. This is seen as requiring the removal of obstacles and the provision of the basic means by which individual goals can be achieved. This perspective poses challenging questions, though in its basic form it presupposes no inherent conflict between the pursuit of individual and social goals or indeed supposes they can be neatly separated.

HEALTH PSYCHOLOGY: WHY NOW?

A precondition for the emergence of health psychology has been this concern to reconstrue the nature of health and illness. As well as the political manoeuvres of organised medicine and the proclamations of the WHO, developments within scientific medicine itself have also played a part – developments which have a direct bearing on the subject matter which health psychology lays claim to. Both psychosomatic medicine and epidemiology have laid the conceptual foundations for studying the interaction between psychosocial and biological factors in health and illness. The idea of psychosomatic illnesses originates from the psychodynamic approach to the mind and has gained credence primarily within clinical practice. This contends that states of pain and ill-health are sometimes the body's best available means for expressing psychological distress. This does not mean, though it has sometimes been interpreted as such, that these illnesses are somehow less 'real'. Rather, it alludes to a person at some level of awareness as somehow choosing or allowing themselves to become ill in order to try and solve a particular difficulty – with on occasion the overt expression of physical symptoms able to be interpreted as an attempt to fulfill an unconscious wish. From this perspective, improved health could result from appropriate psychotherapy which addresses the underlying issues.

More concrete scientific evidence of the influence of psychosocial factors has emerged from the science of epidemiology (see Box 1.1). The problems which have been encountered here contain important lessons for psychologists seeking to establish relationships between cognitive and behavioural variables and specific health outcomes. The failure of epidemiology to successfully deal with people's experiences provides psychologists with an opportunity to bridge the gap between work which identifies risks to health and the desire to have people take appropriate action to bring about desired health outcomes. At the same time there is a danger that, like epidemiology, individuals will be conceptually removed from their social context in trying to understand how they respond to the challenges of health. In addition, as much of the evidence linking psychological and psychosocial variables to health are also associational in nature, the successes of the risk-factor approach to health and illness must not blind psychological researchers into thinking that it is unnecessary for them to establish why these associations are present and whether the psychological or psychosocial events occupy a primary position in the causal chain of events.

Risk factor A variable with a statistically significant association with some specified (health) outcome. A causal relationship is not assumed.

A further incentive for enquiring into psychological issues in health and health

BOX 1.1 What is epidemiology?

Epidemiology evolved as a branch of medical science over the last two centuries with the expressed purpose of studying the distribution of disease in human populations through the use of quantitative methods in the hope that the knowledge accrued will help in the prevention of ill-health. Two early influences were paramount. One was the introduction of statistical methodology to medicine (the growth of statistics and epidemiology are in fact closely interwoven); the other was that of campaigning movements whose efforts sought to highlight the importance of social and economic factors in causing disease (Beaglehole and Bonita, 1997).

As western societies in the twentieth century have undergone a change in the predominant causes of mortality, shifting from communicable to non-communicable diseases, the same analytic methods responsible for investigating infectious diseases have been brought to bear on the modern epidemics of cancer and heart disease. Epidemiology has thus been in the forefront of providing evidence of the damaging effects on health of specific patterns of behaviour (e.g. smoking) as well as exploring the role of psychosocial stress on health. Interpreting epidemiological evidence is far from straightforward, however, as studies tend primarily to be non-experimental (i.e. observational). However a number of core concepts exist for guiding researchers in trying to establish whether an obtained association between risk 'exposures' and disease outcome represents a causal relationship and not merely a statistical artefact. These include the following (Hill, 1965):

1. Has the association been repeatedly observed at different times, in different places, by different persons and in different circumstances?
2. Does a dose-response relationship exist?
3. Is the putative relationship confined to specific groups of people?
4. Is the relationship biologically plausible?

Despite these, several criticisms have been aired. One is that because epidemiology is not concerned with people's experiences and their attempts to make sense of the events in their lives it is likely to be less than fully effective when it comes to disease control. A more frequently voiced complaint concerns the emphasis on identifying risk factors for ill-health in the absence of any specific knowledge of biological mechanisms. Where contrary findings have been reported, it seems far from difficult to produce equally plausible biological mechanisms for each (Davey Smith, Phillips and Neaton, 1992). Furthermore Mann (1995) finds that opinion amongst epidemiologists is divided on the levels of relative risk and the degree of replication which must ensue before an association is regarded as robust. Weaker relative risks, even if representing real relationships, may be particularly difficult to accept. Of considerable importance are the technical difficulties in measuring variables with precision and ensuring that the effects of potential confounding variables on relationships of interest have been taken into account (Phillips and Davey Smith, 1991; Davey Smith and Phillips, 1992). These difficulties are likely to be the greater where studies have not been planned for the specific purpose of exploring a given topic. None of these matters are helped by the pressures on researchers to publish results early and the eagerness of the press to put these in the public domain prematurely. The risk-factor approach has been further criticised on the basis that it too easily leads to individuals being removed from their social context (Krieger, 1994).

care comes from the fact that society is becoming ever more burdened by the demands imposed by 'undesirable' behaviours, whether directly health-related or in the interpersonal domain. It is precisely in the arena of behaviour that the medical model has found itself least able to cope – both theoretically and from the perspective of managing the consequences (Orford, 1985; Boyle, 1990) (see Box 1.2). Smoking, excessive drinking, drug taking (both prescribed and illicit), gambling, sexual behaviour, all carry potentially serious consequences for health and well-being, as well as posing severe social, financial and legal problems (see for example Garcia, 1997).

BOX 1.2 Has the biomedical model failed?

Ideally, ascertaining the success or otherwise of a model should entail a comparison of its current achievements against some clear criterion. Unfortunately, explicit criteria for evaluating the biomedical model have not been clearly stated. In part this is because its function is not so much that of a potentially falsifiable theory, but more a framework for guiding and interpreting medical interventions. As such it is more akin to an ideological stance towards human health. Whilst there can be no doubting the considerable technological achievements of new surgical and pharmacological interventions and immunisation techniques, in combatting and treating a whole array of conditions, there are other counts on which the model of the person as a machine can be said to have failed. These lie predominantly in the ethical and psychological domains and include how people respond cognitively, emotionally and behaviourally to ill-health and to health interventions, as well as how these in turn affect health outcomes. The biomedical model has also had difficulty in addressing a range of recalcitrant problematic behaviours including violent antisocial behaviour and some forms of drug use. Undoubtedly, these failures to adequately address the human concerns of health and illness have contributed on occasion to undesirable levels of patient dissatisfaction.

The health consequences are well-illustrated by findings from the Alameda County Study involving almost 7000 individuals. A number of good health habits were identified by the researchers: sleeping 7–8 hours a day, being less than 10 per cent overweight, eating breakfast every day, not eating between meals, getting regular exercise, not smoking and no more than two alcoholic drinks every day. It was found that the fewer the number of these health practices reported initially, the greater the risk of mortality on follow up almost 10 years later (Belloc and Breslow, 1972). The importance of behavioural factors to health are usually summarised in stating that they are now implicated in 7 out of the 10 leading causes of death in the USA (Sheridan and Radmacher, 1992). This startling figure certainly seems to underline the importance of behaviour for health, but what does the statistic really tell us? One could be forgiven for reading into this the claim that successful psychological prevention will alter the leading causes of death – but to what? Certainly not a return to infectious diseases. It must be remembered that eventually we do have to die of something. Given the very definite limits on the human lifespan, perhaps it would be clearer for the detrimental effects of certain behaviours to be expressed in terms of their effects in reducing life expectancy.

Unhealthy behaviours carry burdens far beyond the toll they take on the physical and mental health of individuals who engage in them or those in their immediate vicinity. The financial costs of drug and alcohol use to health services and industry

for example are considerable. In the UK, around one in four people over 16 years of age are now estimated to have used an illegal drug. The costs for health services stemming from drug use have been put at over \$100 million in 1997, with the costs of drug and alcohol-related absenteeism calculated to cost British industry over US\$1 billion every year (White, 1997). To this can be added the considerable costs incurred through drug-related crime, and the United States provides a disturbing illustration of the proportions this can reach. In 1996, 16 per cent of convicted jail inmates said they had committed their offence in order to raise money for drugs (Dorsey and Dawitz, 1997). The total costs of drug and alcohol abuse in the USA are now thought to be in the region of US\$246 billion (National Institutes of Health, 1998). Additional problems arise from behaviours associated with mental disorder, as well as child abuse and violent conduct. The awareness of the effects of these behaviours on health has led to an emphasis on 'pathological' lifestyles, personalities and even genetic constitutions, and rather less on the circumstances which promote these behaviours. As we shall see throughout this book, this has led to a tension between social and situational theories/models of behaviour and ones based within the domain of individual differences. This struggle is one which is not unique to health psychology.

With this plethora of factors coalescing in the latter part of the twentieth century, it should not be considered surprising that our understanding of health, well-being and illness is undergoing a radical shift, nor that profound questions are being raised about what are the best ways to respond to illness. Having set out some of the broad strands which have led to the emergence of health psychology, it remains to determine whether health psychological reasoning really does mark a transition between old and new ways of thinking about health and to what extent the problems leading to the conceptual shake-up in health are being addressed by the new discipline. It would be unfair to attempt to answer these questions just yet. Given the spirit of the present book perhaps these are better left for the reader to consider as they read through and digest the material in the pages which follow.

AIMS OF THE BOOK

The emergence of health psychology as a separate branch of psychology is generally agreed to have occurred in the late 1970s and early 1980s. Workers such as Matarazzo (1980) emphasised the importance of psychological factors such as beliefs and behaviour in the aetiology and prevention of ill-health. This has led to claims that the model of health which it upholds – the biopsychosocial model – is a direct challenge to the biomedical model. At the end of the day these claims must be evaluated on the basis of evidence produced. At present the boundaries of the discipline are ill-defined, and rather than attempt to describe them in this opening chapter, we hope that the nature of the activities which are undertaken by health psychologists will emerge in a more coherent fashion in those that follow. We therefore have several aims:

1. To survey those areas of health-care research and practice in which psychologists have contributed.
2. Provide a guide to a range of commonly used research tools and methodologies in health psychology and the contexts in which they have been used.
3. Encourage an evidence-based approach to the evaluation of health care and theories of health and illness.

4. To situate health psychological research within the broader health and social sciences.
5. To critically examine the assumptions present in a range of psychological models applied to health and illness.
6. To critically examine the achievements and claims of the discipline.

Discussion points

- A To what extent has the development of health psychology stemmed from theoretical developments within psychology itself?
- B What do you think should be the aims for a psychology of health and health care?

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