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Health Psychology in Context

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Abstract

Over 25 years there has been a remarkable growth of theoretical and empirical studies in health psychology. Its theoretical underpinnings have been largely derivative, its focus primarily clinical, and its subject, the individual. Relatively little attention has been paid to the cultural, sociopolitical and economic conditions which set the context for individual health experience and behaviour. Theories which do not reflect the complex interaction of these variables are unlikely to provide a satisfactory account of individual health. Multidisciplinary efforts are needed at a community level to provide effective interventions which are relevant to the exposure groups being targeted. Health psychology needs measures which are valid and relevant to the general population regardless of culture, gender, social class or age. Putting health psychology into its cultural, sociopolitical and community context is a major priority for future development.

Keywords

culture, individualism, society, sociopolitical context, theory

THE DEVELOPMENT of health psychology is remarkable for the rapidity of its growth. Over 25 years we have witnessed a dramatic growth curve as the field passed through its infancy and moved into adolescence. Thousands of psychologists across the world are researching or practising in this exciting new field of applied psychology. New textbooks, journals, courses and organizations attest to health psychology's progress. So frenetic is the pace of growth that rarely do health psychologists stop to examine critically the status of the field, evaluate its quality and review its impact upon the well-being of the population.

My purpose in this article is to provide constructive criticism of the theoretical and practical status of health psychology at its current stage of development. My aims are to place health psychology within its sociopolitical context and to argue for an interdisciplinary approach. The article addresses seven key issues in the field of health psychology:

- the derivative nature of its theories within health psychology
- the clinical focus of health psychology
- the individualistic bias of health psychology
- the detachment of health psychology from social policy
- the failure of health psychology to develop appropriate measures
- the failure of health psychology to deal with inequalities
- the lack of appropriate training for health psychologists

In each case, possible solutions are offered. The polemical nature of some of my comments is intended to stimulate discussion. Future contributors to the *Journal* are invited to provide further insight into these issues.

The derivative nature of theories within health psychology

The major theories in health psychology were developed primarily within mainstream social and cognitive psychology and subsequently applied to the study of health-related behaviour and experience. The derivative nature of health psychology's theoretical foundations means that the assumptions, methods and problems of

mainstream psychology were adopted in an uncritical and unquestioning manner.

There are many examples of borrowings and plunderings which, although clearly relevant to health and illness, are sometimes disappointing in the production of genuinely new understanding. An example of borrowed social psychological theory is Rotter's (1954) social learning theory based upon the hypothesis, originally drawn from learning theory, that the expectancy and value of reinforcement combine to increase the likelihood of the associated response. The application of Rotter's theory led to a highly productive programme of research focused upon the evaluation of 'locus of control', a proxy for expectancy (Wallston, K. & Wallston, B., 1976). However, locus of control is only one aspect of thinking about health, illness and health care, and there has been a relative neglect of value, an equally important aspect of health decisions and choices.

Another influential research programme is based on Fishbein and Ajzen's (1975) theory of reasoned action. This theory assumes that human behaviour is determined by free choice in a manner which is unrestrained by political or economic factors, an unrealistic simplification. The theory failed as an explanatory account of health behaviour or health status, and the dependent variable preferred for its convenience by almost all investigators—behavioural intention—proved to be a notoriously poor predictor of health-protective action.

Turning to theories derived from cognitive psychology, we find theories and models which appear to be similarly isolated from the real world of health and social care. Given the historical failure of cognitive psychology to account for real-world cognition, this is not surprising. Neisser (1976) had this to say about cognitive theory: 'Lacking in ecological validity, indifferent to culture, even missing some of the main features of perception and memory as they occur in ordinary life, such a psychology could become a narrow and uninteresting specialized field' (p. 7).

While there is no likelihood that the long-term prospects for health psychology could possibly parallel Neisser's pessimistic prophecy for cognitive psychology, recent theory derived from this quarter displays a sense of unreality

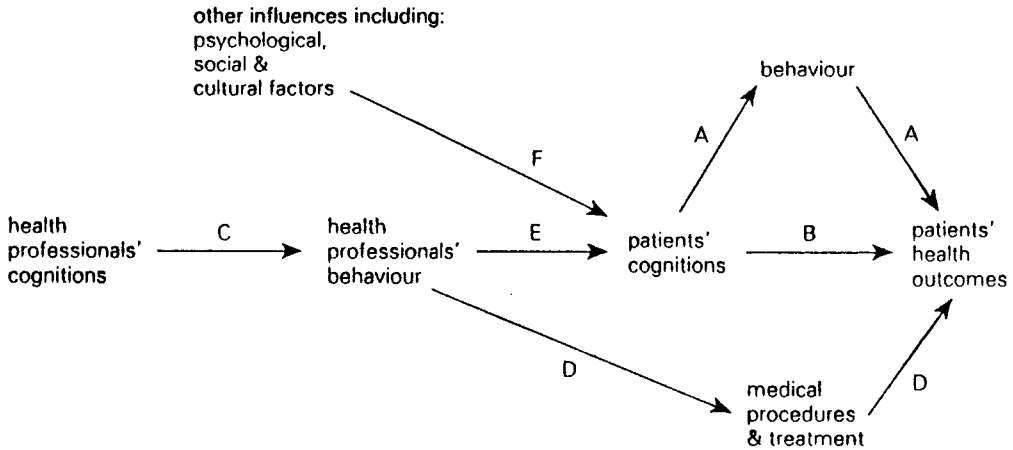


Fig. 1. Postulated relationships between patients' and health professionals' cognitions, patients' and health professionals' behaviour and patients' outcomes. (From 'Health beliefs and attributions', by Theresa M. Marteau, 1995, in A. Broome and S. Llewellyn (Eds.), *Health psychology: Processes and applications* (2nd ed., p. 13). Copyright 1995 by Chapman & Hall Ltd. Reprinted with permission.)

and a restricted focus. Marteau (1995) summarizes research on cognition, behaviour and health outcomes with the model shown in Figure 1.

While this summary model contains valid features, its overall value must be judged in terms of its comprehensiveness and its ability to provide an account of the influences on actual health behaviour and outcomes. The problems with the cognitive summary model can be identified as:

1. According to the summary model, the behaviour of health professionals is determined by their cognitions (path C), which are left unspecified. It is unclear what exactly could come under the term *cognitions*, but it is doubtful that the following, all capable of affecting health professionals' behaviour, should be included: *emotions; motivation; communication skills; class; gender; race; quality of the relationship with the patient; work habits, routines, practices; instructions from others; social context (e.g. the presence of others, and relationship with respect to those others); the availability of appropriate facilities or resources; policies governing treatment and the like*. The assumption that the behaviour of health professionals is determined by their cognitions and nothing more is untenable.

2. According to the summary model, the behaviour of patients is determined by their cognitions (path A on left). Although other influences are mentioned in the summary (including psychological, social and cultural factors) these other influences can only influence behaviour through their effect on cognitions and have no direct influence on behaviour or on other factors such as those listed under 1. This is untenable.

3. According to the summary model, patients' health outcomes are determined by three variables: the patients' behaviour (path A on right), the patients' cognitions (path B) and the medical procedures and treatments that the patients receives (path D on right). Paths A and D are non-controversial. Path B is speculative, but possible. Several key variables are neglected by this cognitive model, however, and these contribute to many (perhaps all) health outcomes: *resources in the form of social support; social class; material circumstances; personal characteristics (e.g. sense of coherence, Antonovsky, 1979); motivation; age; severity of symptoms; course of illness; previous health problems; other possible conditions and the like*.

The summary model illustrates some of the problems resulting from the derivation of a psychological theory of health from mainstream

psychological theory. Health psychology is more than a subdiscipline of psychology. Ecological and scientific validity are minimal when theories are constructed in this way. Such theory lacks any real credibility when viewed from an interdisciplinary perspective and gives health psychology an air of unreality.

Interdisciplinary approaches bring theory and knowledge from cognate disciplines into new, more powerful syntheses. *Health* is in essence a multivariate construct and lends itself to an interdisciplinary approach. *Health care* is a catch-all term applied to an infinitude of situations involving many different providers and whole populations of potential users with a vast array of different health needs. It seems inconceivable that health psychology could be constructed as a subdiscipline of psychology capable of providing a meaningful or valid account of the psychological processes involved in health and health care *without major contributions from other disciplines*. An interdisciplinary approach is a *sine qua non* for the progressive future development of health psychology.

A general framework for considering the determinants of health is presented in Figure 2. This was originally published by Dahlgren and Whitehead (1991) and Whitehead (1995).

This framework sees health determinants in an onion-like structure of layers with the individual at the centre, endowed with fixed factors of age, sex and genetic factors, surrounded by four layers of influence consisting of variable factors of individual lifestyle, social and community influences, living and working conditions and, finally, general socio-economic, cultural and environmental conditions. The framework provides a different set of perspectives from those provided by a narrowly focused model from mainstream psychology. First, it is concerned with all the determinants of health in general and not simply with the course of events during the treatment of illness. Second, it places the individual at the core but acknowledges the primary determining influence of society through the community, living and working conditions, and the surrounding socio-economic, cultural and environmental conditions. Third, it places each layer in the context of its

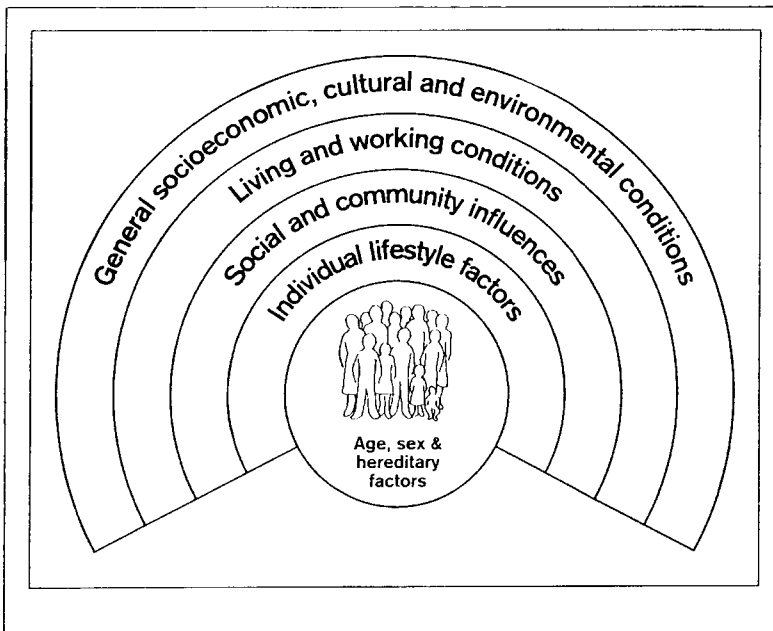


Fig. 2. A general framework for the determinants of health. (From G. Dahlgren & M. Whitehead, 1991, quoted in M. Whitehead (1995) in M. Benzenal, K. Judge, & M. Whitehead (Eds.), *Tackling health inequalities: An agenda for action*, p. 23. Copyright 1995 by King's Fund. Reprinted with permission.)

neighbours reflecting structural constraints upon change. Fourth, it has a true interdisciplinary flavour and is not merely a medical or quasi-medical model of health. Fifth, it makes no imperialist claims for any one field over others. Sixth, it acknowledges the complex nature of health determinants.

Many models and theories are necessary, varying in purpose and level of specificity as appropriate for different settings and contexts. *However, there is also a need for a general framework for theorizing and thinking about health within which more specific models can be securely nested.* Such a framework must represent in a realistic way the constraints upon, and links between individual, community and societal levels of change. Whitehead's framework provides a step in this direction.

Health psychology will progress by building bridges and becoming a solidly grounded interdisciplinary field between a fairly broad spectrum of social, biological and health sciences. Through a dialectical, evolutionary process, a new interdisciplinary approach to health psychology is being created between psychological and related fields. Psychology itself has made considerable progress as a discipline by dealing with the challenges posed by complex problems in the real world of health and health care. A core purpose of the *Journal of Health Psychology* is to build bridges between psychology and other health-related disciplines and fields.

The clinical focus of health psychology

Although most, if not all, health psychologists publicly eschew the medical model, much of their professional and scientific activity occurs within clinical settings in which there is little scope for departing from traditional *medical agendas*. The power-base and organization of health-care systems lie in the hands of those who control the use of resources, that is, medical doctors and surgeons. Health-care systems are designed for the convenience of health-care professionals (primarily doctors) as much as for the care of patients. Non-medically qualified personnel, nurses, health-care assistance, paramedics, social workers, psychologists, therapists of various kinds and others all work in systems

of health care which are primarily medically controlled.

Because their professional work depends upon referrals from medical departments or physicians, clinical health psychologists may unwittingly or unwillingly follow medical agendas with all the associated thinking, practices and technologies. The power imbalance that exists between health-care professionals is replicated in relationships with consumers having profound implications for the delivery of care (Kreps, 1996).

The *sociopolitical environment* for much of health psychology is a *medical hegemony* with a dominant medical discourse and set of practices. Although the medical sociopolitical environment is evident to all participant observers, it is rarely publicly discussed by psychologists. Why? In this context, health psychology can learn from the fields of medical sociology and communication studies. Health psychologists need to become more involved in analysing, without fear or favour, the implications of the sociopolitical environment of health care.

Textbooks of 'health psychology' are a reflection of the *clinical/medical ethos* of our health-care systems. In reality they are mostly textbooks on 'illness psychology'. Textbooks typically discuss health issues within the context of medically defined, diagnostic categories and focus primarily on clinical topics, patient behaviour and the management of illness. Textbooks typically devote more space to psychoneuro-immunology, psychopharmacology and psychophysiology than to *ethics, inequalities and values*. Journals typically devote more space to the behaviour and experience of patients in clinical settings than to theories and methods for primary disease prevention in healthy populations. Training programmes typically focus on clinical issues and the application of psychology in medical settings. Criteria for effectiveness are focused upon the outcomes of randomized controlled trials developed originally for the evaluation of drugs.

While these medical leanings are understandable, and the dramatic progress of the field to date can be attributed deservedly to research conducted in clinical settings, there is a growing and deepening need to locate health psychology within a broader sociopolitical context. This

broader context includes society as a whole with all its complex ramifications. It needs to include investigation of the nature of *well-being*, not purely from the perspective of ill health but from the perspective of health in the context of society and culture. Health experience and behaviour need to be considered in the context of structural factors in addition to the social and cognitive processes at the level of the individual. The political economy of health and health care also have potent and tangible effects on the behaviour and experience of well-being of all society's members (Doyal, 1979; McKinlay, 1984). Broadening the sociopolitical context of health psychology constitutes another core purpose of the *Journal of Health Psychology*.

The individualistic bias of health psychology

Theories in health psychology are generally designed to provide accounts of cognitive, emotional and motivational processes existing at a subpersonal level. These accounts purport to explain health behaviour and experience at the level of the individual. Health psychological theories are a mixture of cognitive and social psychology developed during a 30-year period, 1950–1980. This period was marked by a resurgence of laboratory research with human *subjects* in a wide variety of artificial experimental situations designed to reveal the mechanisms underlying human behaviour. The experimental paradigms which were extensively worked over this time were attacked by critical social and discursive psychologists (Harré, 1979; Potter & Wetherell, 1987; see Stainton Rogers, 1996) and medical sociologists (Radley, 1994). In spite of these debates, health psychologists generally have drawn theory from psychology's 'mainstream' with little concern about the in-built limitations. The individualism of health psychology is a perfect match with the medical model which represents disease as a failure in or of the individual.

One of the most visible research programmes in health psychology examines the individual personality correlates of health behaviour and health status, for example, *self-efficacy* (Bandura, 1982), *hardiness* (Kobasa, 1979), *Type A behaviour* (Jenkins, Zyzanski, & Rosenman,

1979), *sense of coherence* (Antonovsky, 1979), *health locus of control* (K. Wallston & B. Wallston, 1976) and *coping styles* (Carver, Scheier, & Weintraub, 1989). In many strands of this programme, there was an initial rush of enthusiasm with many studies followed by a realization that trait measures account for small amounts of variance in health behaviour and negligible amounts of the variance in health status. Variables drawn from other disciplines such as socio-economic status (SES) explain one or two orders of magnitude more variance than individualist variables devised within health psychology (Adler, et al., 1994; Carroll, Davey Smith, & Bennett, 1996).

Health psychologists attempt to explain SES-health gradients as a mediation process through class-related differences in social support and/or personal control, both of which can ameliorate stress (Carroll, et al., 1996). Adler and colleagues (1994) suggest that depression, hostility, stress and social ordering could be responsible for the SES-health gradients but conclude their review with the suggestion that 'The concept of individual control over existing life circumstances . . . might be a higher order variable that synthesizes or renders coherent a number of factors reviewed here' (p. 22).

Individualism is a deeply embedded value in North American and western European societies. Brownell (1991) cited a 1986 Gallup poll of a random sample of the US population which found that 93 percent agreed with the statement: 'If I take the right actions, I can stay healthy.' Over concern with personal responsibility for health can lead to victim-blaming and an atmosphere in which 'we are worrying ourselves half to death' (L. Thomas, 1979, p. 38 cited by Brownell, 1991). The study of individual characteristics in the form of 'health traits' such as Type A behaviour and interventions designed to reduce associated health risks could be detrimental to well-being especially if attempts to increase personal control are unrealistic. The 'tendency to overstate the impact of personal behaviour on health' (Brownell, 1991, p. 303) could feed the victim-blaming ethos which is already strong in western societies. Individualism as personal control theory in the context of the inequalities-in-health debate needs to be tempered by a careful analysis of the

social policy implications. Otherwise, health psychology will be buying into questionable assumptions about the determinants of health-related behaviour.

One field which goes beyond individualism is *cross-cultural psychology*. Cross-cultural psychology emphasizes cultural diversity and casts a skeptical eye over the *ethnocentrism* of mainstream psychology. This approach considers national samples as the unit of analysis rather than individuals. Previous research on cross-cultural studies of health focused on mental-health issues (Dasen, Berry, & Sartorius, 1988) and there has been relatively little attention paid to physical health.

A concept which took cross-cultural psychology by storm during the 1980s was *individualism/collectivism (I/C)* (Hofstede, 1980; Kim, Triandis, Kâğıtçıbaşı, Choi, & Yoon, 1994). *Individualism* refers to societies in which there is a tendency for loose ties between individuals who tend to look after themselves and their families while *collectivism* refers to societies in which people are integrated into strong, cohesive in-groups offering mutual protection in return for loyalty (Hofstede, 1991). The I/C construct is applied in many contexts in the social sciences, and there is a rich mine yet to be tapped by health psychologists.

Triandis (1994) suggests that 'cultural syndromes' also apply at the individual level so that societies consist of *idiocentric* and *allocentric* individuals to varying degrees in different situations. I/C is one of four ecological or culture-level dimensions revealed by Hofstede's (1980) study of 117,000 employees of a multinational business corporation in 40 nations. Hofstede's other dimensions were: *power distance*, *uncertainty avoidance* and *masculinity/femininity*.

Schwartz (1994) conducted a survey of 86 samples drawn from 41 cultural groups in 38 nations during 1988–1992 and identified seven different regions of cultural value space: *conservatism*, *intellectual* and *affective autonomy*, *hierarchy*, *mastery*, *egalitarian commitment* and *harmony*. The results were computed using a Guttman-Lingoes smallest space analysis of the mean importance ratings for each national sample. Using Schwartz's regional values, Bond and Choi (1995) provide an insightful analysis of

cultural values and health. Bond and Choi report that even when gross national product (GNP) and gross national growth (GNG) were progressively partialled out before values were entered into the regression, cultural values such as hierarchy accounted for a large portion of variance in rates of homicide, alcohol consumption, suicide, human rights observance and proportions of GNP devoted to military expenditure and education. Further studies of the health implications of different cultural values should yield valuable information regarding the relationships between culture and health.

Health psychology is culturally ridden with individualism. Theory from mainstream western social and cognitive psychology has the objective of predicting individual decisions and choices and a heavy emphasis is placed upon variables related to individual mastery, coping and control. As Winett (1985) suggested, during a time of political conservatism this can lead to the spectre of the 'contextless individual' (Sarason, 1981) and the danger of 'only becoming a *health psychology of the detached individual*' (Winett, 1985, p. 148). Winett's (1985, 1995) approach creates balance through the advocacy of ecological analyses of health promotion. It is more than a decade since Winett pointed out the 'danger in the development of the emerging field of health psychology that it will closely follow prevailing psychological paradigms and become no more than the psychology of individual health behaviour without regard to social, economic, environmental, or political context' (1985, p. 147). Sadly, little has changed, and the majority of research and practice is still being directed at the level of the individual. Yet there are so few psychologists and so many individuals who need help.

Health psychology can make a contribution at different levels of analysis: individual, family, group, community, society, culture and nation. The more collective levels are still relatively unexplored. However, there has been some progress in considering family system (Olson & Stewart, 1991; Valach, Young, & Lynam, in press), in attempting to integrate health psychology with public health (Winett, 1985, 1995), and in cross-cultural approaches (Dasen et al., 1988). More research focusing upon families, communities and cultures is needed and the *Journal of*

Health Psychology will actively promote such developments.

The detachment of health psychology from social policy

Psychologists pride themselves for what they assert is their 'value-free', 'apolitical', 'scientific' approach to human behaviour. Sadly, this often means that public and professional perceptions of psychology are that it is irrelevant, uncaring and dull. In the privacy of their ivory towers, academic psychologists may still espouse the *doctrine of pure, basic and fundamental research* regardless of whether it has anything meaningful or relevant to say about or to society. Such social detachment is less common these days in other social sciences, for example, sociology which has taken the lead in connecting research with social policy. The semiofficial detachment of academic psychology from policy issues has slowed the penetration of psychology into the health-care system. It has also harmed the public image of psychology and meant that psychologists typically lack political nous.

There are positive signs, however, that this situation is changing, at least in the USA. Readers of the *APA Monitor* and *The Health Psychologist*, the official newsletter of the APA's Division 38 (editor Kenneth A. Wallston), will have seen a growing sophistication and awareness of the power of politics and the need for policy-relevant research. Both publications have a 'President's Column' in which there is a clear signal that psychology has vacated the ivory tower without compromising its position as a profession of scientist/practitioners. This is also the clear signal sent out by the APA's Chief Executive Officer, Raymond D. Fowler, in his monthly 'Running Commentary' in the *Monitor*.

The APA's Division 38 Task Force on Health Policy (Kelty et al., 1989) considered policy relevant to health and behaviour by discussing ways in which research should be conducted and presented to maximize its usefulness to policy-makers. The Task Force recommended that policy-relevant experiences should be integrated into training programmes.

The Task Force identified the following

policy areas for health psychology: health needs of minority groups; health needs of older persons; child care; specific diseases and disorders (e.g. cancer, smoking, AIDS, accident behaviour); public safety; nutrition and model development with regard to health costs, utilization of services, quality of care and access to health services. The Task Force recommended increased participation in interdisciplinary teams addressing problems which are important to policy-formation.

Many European health psychologists remain detached from policy-relevant research and opportunities to contribute to health and social-policy issues are missed. Research programmes funded by the European Union such as 'Europe against cancer' and 'Europe against AIDS' provide excellent opportunities for interdisciplinary collaboration. There are also similar national programmes, for example, in the UK where psychologists could be contributing far more to interdisciplinary research being conducted under the umbrella of the government's health policy, *The Health of the Nation* (Marks, 1994). This policy has set measurable targets for the health of the population which require major reductions in behavioural risk factors for cancer, cardiovascular disease, accidents, mental health, sexual health, AIDS and HIV. Such initiatives invite psychologists to work in interdisciplinary teams with colleagues in epidemiology, immunology, sociology, social policy and statistics. This journal welcomes reports of policy-driven research and will provide a forum for the discussion of policy issues.

The failure of health psychology to develop appropriate measures

Health-psychology measures are needed which are valid and relevant to different populations regardless of culture, age, gender and social class. Quite often researchers use an off-the-shelf measure developed within a particular setting and with a particular population of participants, in a different setting and with a different population of participants. This may jeopardize validity which is contextually dependent.

A threefold division of contexts—college, clinical and community/worksite—and a three-

Table 1. A way of representing degrees of congruence between the contexts of validation and use of a measuring instrument.

Validating context	Participants		
	Student group (A _i)	Patient group (B _i)	Community group (C _i)
College	(1)		
Clinical		(2)	
Community			(3)

fold division of participants—student, patient and community group—provides a three-by-three table for assessing the level of congruency between the context of an instrument's original validation and that of its potential use (see Table 1).

When an instrument is developed and validated in one of these cells but used in another, incongruency problems arise. Similarly, when an instrument is developed in cell 2 with one group of patients (B_i) and used later with another group of patients (B_k) there may be incongruence, as could also be the case when a cell-3 instrument is applied in cell 2 or with another community group in cell 3.

Health psychologists place a heavy reliance on self-completion questionnaire instruments; many were developed in the USA, frequently with student samples. Problems of measurement incongruence often arise when these instruments are used in other countries, especially with patient or community samples.

A recent example of measurement incongruence occurred in the area of coping research, a complex and confusing area which has been called a 'three-car garage filled to the rafters with junk' (Taylor, 1990, p. 33). Carver, Scheier and Weintraub (1989) developed this scale using a combination of cancer patient and student samples. These coping strategies are assessed: active coping, suppression of competing activities, planning, restraint, use of social support, positive reframing, religion, acceptance, denial, behavioural disengagement, use of humour, self-distraction. A 45-item version of the COPE was administered to 61 breast-cancer patients attending an oncology unit in Barnet, North London, England, to investigate how their usage of

different coping strategies intercorrelated (Thomas & Marks, 1995).

The correlations between the nine coping variables were all positive. Apparently the COPE failed to discriminate between strategies of theoretically distinctive types. For example, active coping correlated positively with denial (.363, $p < .01$) and self-distraction with the suppression of competing activities (.552, $p < .001$). This meant that the item '*I've been putting aside other activities in order to concentrate on this*' (suppression of competing activities) correlated positively with the contradictory item '*I've been turning to work or other substitute activities to take my mind off things*' (self-distraction).

Other difficulties which may arise from measurement incongruence are a risk of inappropriateness in the framing of questions. Occasionally items occur which are inappropriate to the point of offensiveness; for example, the item from the Attribution Style Questionnaire (Peterson, 1982) which states '*You invest money in the stock market and make a profit*' is not very palatable to single parents living on state benefits in public-housing estates. There are also ethical issues concerning the cognitive overload and psychological distress which can be caused by 'questionnaire-bashing' and over-researching elderly or ill patients. There is a need to develop more user-friendly measures which are brief, non-invasive and non-threatening and single-item measures of health status (Idler 1992; Wright, in press).

The recent publication of a portfolio set of measures in health psychology provides a highly accessible and convenient pool of test materials (Johnston, Wright, & Weinman, 1995). The portfolio is likely to become a 'golden standard' or reference set of measures for the field. Teachers and research supervisors will be able to draw upon the measures and organize new projects easily and effortlessly. There is also a need for caution, as the editors note, in regards to avoiding inappropriate measurement. Using off-the-shelf measures with convenience samples can sometimes trivialize research.

We must not shy away from the task of developing new instruments and methods with full participation of the population groups who ultimately contribute the data. This will inevitably entail a mix of qualitative and quantitative

methodologies. There is a need for qualitative, semistructured approaches and open-ended questions to help to uncover new questions and issues for psychological research. Purely quantitative methods tend to put research participants into the strait-jacket of the researchers' preconceptions. New methods are needed which allow research participants to express their own ways of thinking about their experiences (e.g. Gomez, Schvaneveldt, & Staudenmayer, in press; G. Green, Platt, Eley, & S. T. Green, in press). The *Journal of Health Psychology* welcomes reports on new methods and measures for the study of health behaviour and experience.

The failure of health psychology to deal with inequalities

Inequalities are one of the most striking features of the health-care systems of the developed world. Yet, with its heavy concentration on the sick individual, health psychology has hardly begun to take this matter seriously. A publication edited by Benzeval, Judge, and Whitehead (1995), *Tackling Inequalities in Health: An Agenda for Action*, reviews compelling international evidence on health inequalities: 'People who live in disadvantaged circumstances have more illnesses, greater distress, more disability and shorter lives than those who are more affluent. Such injustice could be prevented, but this requires political will. ... Health inequalities are endemic characteristics of all modern industrial societies, but the size of the differential varies between countries and over time, indicating that there is nothing fixed or inevitable about having such a health divide' (p. xvii). This review summarizes discussions held at a seminar at Ditchley Park organized by the King's Fund and chaired by Sir Donald Acheson.

The evidence reviewed by Benzeval and colleagues (1995) is drawn from 14 countries and demonstrates in total that premature mortality rates, illness and disability are higher among the more disadvantaged sections of each national population: Australia (National Health Strategy, 1992), Belgium (Lagasse, Humblet, Lenaerts, Godin, & Moens, 1990), Finland (Valkonen, 1993), France (Desplanques, 1984), Germany (Helmert & Shea, 1994), Ireland

(Nolan, 1990), Italy (Piperno & Di Orio, 1990), the Netherlands (Mackenbach, 1993), Norway (Dahl, 1993), Spain (Kunst & Mackenbach, 1994), Sweden (Vågerö & Lundberg, 1989), Switzerland (Lehmann, Mamboury, & Minder, 1990), the UK (Fox & Benzeval, 1995) and the USA (Pappas, Queen, Hadden, & Fisher, 1993). This evidence in combination shows substantial variations in health which reflect the social and economic circumstances of individuals.

Whitehead (1995) identifies four different levels for tackling health inequalities:

- strengthening individuals;
- strengthening communities;
- improving access to essential facilities and services;
- encouraging macroeconomic and cultural change. (p. 24)

Dahlgren and Whitehead's (1992) 'onion model' suggests four layers of influence on the health of the individual with the individual's fixed endowments at the core. Health psychologists interested in tackling inequalities can contribute at all four levels although the individual level is where our expertise and experience have generally been focused. In the longer term, however, inequalities will only be reduced by adopting a thoroughly multilayered approach.

Whitehead (1995) sees 'strengthening individuals' as having as an aim

... to make up perceived deficiencies in knowledge, practical importance or stress management among people experiencing disadvantage, and to encourage the acquisition of personal or social skills to change their way of life or to be more resilient in the face of adversity. These policies see the problem they seek to address mainly in terms of personal education and development. (p. 26)

Sadly, no psychologists were present at the Ditchley Park seminar to help develop the agenda from a psychological perspective. Apparently, psychology was not seen as having anything important to say.

Whitehead herself divides interventions into two main classes: those with a behavioural focus (e.g. smoking, diet, exercise and fertility control) and those with an empowerment focus (e.g. provision of stress management, social support

and counselling). As expected, interventions aimed at tackling inequalities at an individual level showed mixed results. The reasons for this are also mixed and fall into four categories. First, it is self-evident that people living and working in disadvantaged circumstances have fewer resources (time, space, money) with which to manage the process of change. Second, health-threatening behaviours such as smoking tend to increase in difficult or stressful circumstances as they provide a means of coping (Graham, 1993). Third, Whitehead suggests that there has been an insensitivity to the difficult circumstances in which people work and live. Fourth, there has been a tendency to 'blame the victim'. Overall, efforts directed at the individual level have been inconclusive and small-scale. To the extent that they ignore adverse factors beyond the control of the individual, psychological interventions are doomed to failure. That is why there is a growing need for psychologists to work beyond the individual level, with communities, work-sites and ethnic groups.

Benzeval, Judge, and Whitehead (1995) completed their review with a discussion of 'unfinished business', which consisted of two strands:

1. Excessive attention to the health experiences of white males of working age as compared with women, older people and minority ethnic groups. Can business with these three groups ever really be finished?

2. The policy areas dealt with in detail—housing, income maintenance, smoking and access to health care—might be insufficiently comprehensive as an agenda for tackling inequalities and unemployment deserves a higher profile.

They concluded that: 'any strategy to promote social justice in general and tackle inequalities in health in particular demands a very wide-ranging and radical reshaping of economic and social policies' (p. 140); in other words, action at layer 4, encouraging macroeconomic and cultural change.

The World Bank's *World Development Report 1993: Investing in Health* contains evidence of a dramatic decline in mortality since 1950 in developing countries. These marked

improvements are attributed to policies in developing countries which made investments to:

- reduce poverty
- make health expenditure more cost-effective
- increase the effectiveness of public-health measures
- improve essential clinical services
- improve schooling, particularly for girls
- improve the rights and status of women (World Bank, 1993a).

Data from industrialized countries also show significant relationships between poverty and health. These data are summarized by Benzeval, Judge, and Whitehead (1995) and Carroll, Davey Smith, and Bennett (1996). Of particular interest is the observed relationship between equity of income distribution and health, including life expectancy (Wilkinson, 1992) and infant mortality rate (Wennemo, 1993). This has important implications, particularly for countries like the UK and the USA where there has been a widening of income differentials over the period 1980–1995. Regional studies suggest that a worsening of the health of the population occurred over this period both in the UK (Forwell, 1992; McCarron, Davey Smith, & Womersley, 1994; McLoone & Boddy, 1994; Phillimore, Beattie, & Townsend, 1994) and USA (Hacker, 1992; Rogers, 1992). On the other hand, the so-called 'economic miracle' of East Asian countries, notably Japan, has been associated with dramatically increased GNP and increased equity (World Bank, 1993b).

Further analysis is needed of the relationships among GNP, income distribution, cultural values and health. This would enable a more definitive answer to the question of how social equity and justice are related to global well-being. The psychological, social and cultural questions that such relationships unfold are fundamental and profound:

- *Are cultural values such as individualism/collectivism associated with differences in the equity of income distribution?*
- *Do cultures varying in individualism/collectivism manifest different levels of inequalities with respect to women, older people and ethnic minorities and are any such differences reflected in the health of these different population groups?*

- *How are social equity and justice mediated at community and individual levels to determine well-being?*
- *Does the enhancement of well-being at the individual level (by whatever means) help to promote forms of inter-relatedness and social support?*
- *Are interventions which are aimed at behaviour change at the individual level and which focus upon individualist values more, less or equally effective in comparison with interventions focusing upon collectivist values?*

Broadening health psychology's scope to encompass culture, values and equity generates new kinds of research questions. At present, it is easier asking questions than providing answers. That situation should change and the *Journal of Health Psychology* will encourage submissions in this area.

The lack of appropriate training in health psychology

The majority of health psychologists today has been trained in one of two ways. First, there is the academic route consisting of predoctoral, doctoral and postdoctoral research experience. Second, there is the practitioner route consisting of academic coursework and practitioner skills obtained in health-care settings. This situation is not desirable because many academics lack a practitioner skill-base and many practitioners lack advanced research skills. These two strings to the health psychology bow need to be fully intertwined so that the health psychology arrow can hit its target.

Sheridan and colleagues (1989) reporting on the task force on research and practice in health psychology on behalf of the APA Division 38 state:

There are exciting, important questions regarding health problems, health policy, and health treatment systems needing interdisciplinary research. Health psychologists are uniquely prepared to take a leadership role due to their training in both research and service delivery. (pp. 777–778)

They then continue:

... careful attention must be focused on

graduate education, where there is genuine danger—as witnessed in some traditional clinical psychology programs—to emphasize research or practice to the exclusion of the other. ... The task force did not accept models of training clinicians who will do some research or of training researchers who will do some clinical work—citing the fact that such programs create a mentality that fails to recognise the seriousness and complexity of both enterprises ... some service providers believe that the field has separated its research mission from that of the everyday world of intervention and treatment. (p. 778)

The improvement of the current arrangements for the training of health psychologists is a high priority. Only if training matches the aspirations held by both practitioners and researchers can the current rate of progress be sustained. The future demand for health-psychology services will greatly exceed supply. Other health-care professionals provide services which overlap with those of the health psychologist and psychologists need to work closely with these professionals to make a more effective contribution.

The Task Force on Health Psychology established by the European Federation of Professional Psychological Associations (EFPPA) is developing a set of minimum training standards for professional health psychologists working in European countries (Marks et al., 1995). The EFPPA Task Force parallels its US counterpart in adopting a scientist-practitioner model as the most appropriate framework for training. In the scientist-practitioner model there is a necessary two-way flow between research and practice. Only when both aspects are integrated in scientist-practitioner's training will professional health psychologists be equipped to make their maximum contribution to user groups in our national systems of health and social care.

Conclusions

Health psychology is at an exciting and formative stage of development akin to adolescence. Although its rapid growth betokens progress, a number of in-built weaknesses are identifiable.

Health psychology consists of derivative theory; focuses on illness; is individualistic; remains detached from social policy; has failed to develop appropriate measures; has made no real attempt to tackle inequalities; and has not implemented training adequate for the next generation. This article suggests some solutions to these problems. In its next stage of development, health psychology should accept its interdisciplinary nature, venture more often out of the clinical arena, drop white-coated scientism, and relocate in the richer cultural, sociopolitical and community contexts of society.

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