Journal of Health Psychology

The Quest for Meaningful Theory in Health Psychology

David F. Marks

The online version of this article can be found at:

Published by:

$SAGE

Additional services and information for *Journal of Health Psychology* can be found at:

Editorial

The Quest for Meaningful Theory in Health Psychology

DAVID F. MARKS
City University, London, UK

Abstract

Theories generate questions, which in turn generate findings, which in turn generate articles. Theories in health psychology have successfully generated research activity but with inconclusive results. Avenues for more fruitful exploration are described. One of these suggests that health psychology will alter its focus from the study of what is (description) to the study of what might be (explanation), from what individuals do and say (behaviour) to what that behaviour means (contextuality), from 'social cognitions' (box ticks) to personal subjectivities (mental experience), from the status quo (demographics) to social injustice (structures of power and inequality).

977

OVER NEARLY 40 years there has been a remarkable growth in studies in health psychology. The Health Belief Model (Rosenstock, 1966), Theory of Reasoned Action (Fishbein, 1967), Theory of Planned Behaviour (Ajzen, 1985), and Transtheoretical Model (Prochaska & di Clemente, 1984) have been popular approaches to researching how 'social cognitions' influence health behaviour and how human preparedness to act is a consequence of a complex of variables and/or stages. Major research efforts have been devoted also to Folkman and Lazarus' (1980) transactional model of stress and to various scales intended to evaluate health- and stress-relevant variables.

Ajzen's (1985) Theory of Planned Behaviour (TPB) has been the focus of a lot of attention in the health psychology literature. The ISI Web of Science database lists 1981 articles mentioning the TPB, with the number per year rising continuously over the period 1978–2007 reaching 284 articles in 2007.

Recent articles have discussed methodological or theoretical questions concerning the TPB (e.g. Brickell, Chatzisarantis, & Pretty, 2006; French, Cooke, Mclean, Williams, & Sutton, 2007; Mulholland & van Wersch, 2007) as well as demonstrating modest levels of empirical support (e.g. Armitage & Arden, 2007; Christian, Armitage, & Abrams, 2007). Webb and Sheeran's (2006) meta-analysis showed that a medium-to-large change in intention led to a small-to-medium change in behaviour, suggesting that the well-known intention–behaviour inconsistency remains stubbornly resistant to model predictions. But if behaviours do not follow the intentions as their object, we are at the entrance of a looking-glass world.

Critics of social cognition theories have suggested that they are tautological and effectively irrefutable (Ogden, 2003; Smedslund, 2000). If this is true, then no matter how many studies are carried out to investigate a social cognitive theory, there will be no genuine progress in understanding, a prospect too gloomy to contemplate. Weinstein (1993, p. 324) summarized the then current state of health behaviour research as follows:

> ... despite a large empirical literature, there is still no consensus that certain models of health behaviour are more accurate than others, that certain variables are more influential than others, or that certain behaviours or situations are understood better than others.

Inevitably, in light of the issues discussed here, there has been no palpable improvement over the last 15 years.

The fact that the TPB lumps together age, class, gender, personality, and past experience, including culture, into a single box appearing at the start of a flowchart indicates, to this author, that the 'theory' is far too imprecise to serve any useful purpose other than as an heuristic device. The practical utility of the TPB as a tool in health promotion has been underwhelming. In this regard, Murray and Campbell (2003, p. 231) had some strongly critical comments on the impact of social cognition models on efforts to stop the spread of AIDS:

> Through persistently directing attention towards the individual level of analysis in explaining health-related behaviours, health psychology has contributed to masking the role of economic, political and symbolic social inequalities in patterns of ill-health, both globally and within particular countries. Thus, while some health psychologists may laud the innovativeness of subtle changes to the basic social cognition models of health behaviour it can be argued that these very models may actually be hindering attempts at improving health.

In theory testing more generally, thousands of published studies—and an imponderable number unpublished—have used null hypothesis elimination with small samples of college students or smaller samples of patients. The power, validity and generalizability of these studies is questionable, yet we do not really know their true merit because of the uncertainties about representativeness, sampling, and statistical assumptions (Marks, 2006). Rarely are alternative, and arguably superior, approaches to theory testing utilized, for example, by using Bayesian statistics, and power analyses carried out to assess the *importance* of the effects rather than their *statistical significance* (Cohen, 1994; Smedslund, 2008).

In an earlier article, the author argued that: 'Relatively little attention has been paid to the cultural, socio-political and economic conditions which set the context for individual health experience and behaviour' (Marks, 1996, p. 7). Theories which do not reflect the complex interaction of socio-economic, cultural and political conditions are unlikely to provide anything close to a satisfactory account of individual health. Furthermore, current health psychology theories are not at a level that is consistent with the cultural, socio-political, and community contexts within which individual health seeking behaviours are embedded (Marks, 2002).

This view has been echoed by others. For example, Spicer and Chamberlain (1996, p. 161) argued

that health psychology theories remain strongly individualistic, with a style of theorizing they labelled as 'flowcharting' and with a strong influence of 'metaphors and concepts from adjacent health sciences'. They suggested two broad strategies for combining psychological and social strands within health psychology theories, which they labelled as 'integrative' and 'transcendent'. In a similar vein, Bunton (2006, p. 343) argued that:

> Behaviour oriented health promotion has often relied on over-simplistic and over-deterministic models in which action emanates from individuals, not the social or economic structures they inhabit. Mainstream health psychology models are allied with official health ideology and policy, stressing self-control, self-regulation and responsible (low-cost) health citizenship.

Furthermore, Bunton (2006, p. 343) encouraged reflection and critique of health psychology's applications in public health and what he called the 'inseparability of psychology and politics'.

Stephens (2007) discussed theories of participation in different fields of practice in community health promotion. She applied Bourdieu's (1977) theory of practice of social identities structured by habitus, capital, and field to interviews with members of a deprived neighbourhood showing that people identify with their neighbourhood for some purposes but have 'different identity practices in different fields of practice' (2007, p. 949).

Avenues for further exploration have been identified by a number of authors. The first is social constructionism. Schou and Hewison (1998) argued that personal accounts can be seen as social texts, highlighting the importance of discourse in the construction of the social world. In a similar vein, Willig (1998) discussed lay constructions of sexual activity and their implications for sexual practice and sex education. Most sex education uses language to communicate messages that construct 'particular versions of reality' (1998, p. 383). Semi-structured interviews with 16 heterosexual adults included questions about sexual risk-taking within the context of HIV/ AIDS. Willig's (1998, p. 383) analysis identified lay constructions of 'sexual activity' that, she suggested, could make AIDS education more effective by addressing 'the wider discourses surrounding sexuality and sexual relationships'.

The 'wider discourses' are a key part of what we mean by 'culture' as a core constituent of health experience and behaviour, not as an optional 'add-on' under a label such as 'past experience'. Social cognition modellers do not seem to get this. Culture constitutes all that we sense, feel, believe, value, think and do. In illustrating this point, Adams and Salter (2007) focus upon African settings. The authors explored three culture-specific examples of health concerns from Africa: the prominent experience of personal enemies; epidemic outbreaks of genital-shrinking panic; and fears about sabotage of vaccines in immunization campaigns. One can envision totally different health psychologies emerging from diverse cultures such as those existing in low-income countries. The health psychology of western/northern high-income countries, as currently formulated, could well prove almost completely irrelevant to cultures existing outside of these zones.

Within a country, widespread cultural, socio-economic and ethnic group differences are evident in many aspects of health experience. Banthia, Moskowitz, Acree and Folkman (2007) measured religiosity, prayer, physical symptoms, and quality of life in 155 caregivers. The findings indicated that prayer was only significantly associated with fewer health symptoms and better quality of life among less educated caregivers.

An approach aiming to generate alternative theories, 'critical health psychology', was the subject of a recent open peer commentary article by Hepworth (2006). This article provoked a mixture of positive and negative reactions from international commentators. Hepworth identified three philosophical phases in critical health psychology's role in contributing to public and global health. These were labelled the 'Rejection of Reification', (past), 'Consensuality and Subjectivism' (present), and 'Justice and Fairness' (future). Lee (2006) argued that work to improve health on a global scale and which aims to reduce inequities is being done, but not by health psychologists. MaClachlan (2006, p. 361) suggested that the global health movement offers health psychologists an avenue to develop 'a pragmatic approach to the interconnectedness of poor health and inequality' especially in low-income countries. Vinck and Meganck (2006) argued that the important concerns of critical health psychology are better served by efforts to help mainstream health psychologists think and work more strongly from a critical perspective.

Among other concerns, critical health psychologists have called for: '*actionable* understandings of

979

the complex individual–society dialectic underlying social inequalities' (Murray & Campbell, 2003, p. 236, emphasis in original). Perhaps the strongest inspiration for a new theoretical approach has come, not from western academe, but from Martín-Baró (1994, p. 45, cited by Murray & Campbell, 2003):

> If it is not the calling of the psychologist to intervene in the socio-economic mechanisms that cement the structures of injustice, it is within the psychologists's purview to intervene in the subjective processes that sustain those structures of injustice and make them viable.

If meaningful theoretical change is going to happen, health psychology will alter its focus from the study of what is (description) to the study of what might be (explanation), from what individuals do and say (behaviour) to what that behaviour means (contextuality), from 'social cognitions' (box ticks) to personal subjectivities (mental experience), from the status quo (demographics) to social injustice (structures of power and inequality). How and when this change happens is a matter for us all.

References

Adams, G., & Salter, P. S. (2007). Health psychology in African settings: A cultural-psychological analysis. *Journal of Health Psychology*, *12*, 539–551.

Ajzen, I. (1985). From intentions to actions: A Theory of Planned Behavior. In J. Kuhl and J. Beckman (Eds.), *Action control: From cognition to behavior* (pp. 11–39). Heidelberg: Springer Verlag.

Armitage, C. J., & Arden, M. A. (2007). Felt and potential ambivalence across the stages of change. *Journal of Health Psychology*, *12*, 149–158.

Banthia, R., Moskowitz, J. T., Acree, M., & Folkman, S. (2007). Socioeconomic differences in the effects of prayer on physical symptoms and quality of life. *Journal of Health Psychology*, *12*, 249–260.

Bourdieu, P. (1977). *Outline of a theory of practice*. Cambridge & New York: Cambridge University Press.

Brickell, T. A., Chatzisarantis, N. L. D., & Pretty, G. M. (2006). Autonomy and control: Augmenting the validity of the Theory of Planned Behaviour in predicting exercise. *Journal of Health Psychology*, *11*, 51–63.

Bunton, R. (2006). Critical health psychology: Julie Hepworth. *Journal of Health Psychology*, *11*, 343–345.

Christian, J., Armitage, C. J., & Abrams, D. (2007). Evidence that Theory of Planned Behaviour variables mediate the effects of socio-demographic variables on homeless people's participation in service programmes. *Journal of Health Psychology*, *12*, 805–817.

Cohen, J. (1994). The Earth is round (*p*-less-than .05). *American Psychologist*, *49*, 997.

Fishbein, M. (1967). Attitude and the prediction of behavior. In M. Fishbein (Ed.), *Readings in attitude theory and measurement* (pp. 477–492). New York: Wiley.

Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health & Social Behavior*, *21*, 219–239.

French, D. P., Cooke, R., Mclean, N., Williams, M., & Sutton, S. (2007). What do people think about when they answer Theory of Planned Behaviour questionnaires? A 'think aloud' study. *Journal of Health Psychology*, *12*, 672–687.

Hepworth, J. (2006). The emergence of critical health psychology: Can it contribute to promoting public health? *Journal of Health Psychology*, *11*, 331–341.

Lee, C. (2006). Critical health psychology: Who benefits? *Journal of Health Psychology*, *11*, 355–359.

MaClachlan, M. (2006). Towards a global health contribution for critical health psychology: Some comments on Hepworth. *Journal of Health Psychology*, *11*, 361–365.

Marks, D. F. (1996). Health psychology in context. *Journal of Health Psychology*, *1*, 7–21.

Marks, D. F. (2002). Freedom, responsibility and power: Contrasting approaches to health psychology. *Journal of Health Psychology*, *7*, 5–19.

Marks, D. F. (2006). The case for a pluralist health psychology. *Journal of Health Psychology*, *11*, 367–372.

Martín-Baró, I. (1994). *Writings for a liberation psychology*. Ed. A. Aron & S. Corne. Cambridge, MA: Harvard University Press.

Mulholland, E., & van Wersch, A. (2007). Stigma, sexually transmitted infections and attendance at the gum clinic: An exploratory study with implications for the theory of planned behaviour. *Journal of Health Psychology*, *12*, 17–31.

Murray, M., & Campbell, C. (2003). Living in a material world: Reflecting assumptions of health psychology. *Journal of Health Psychology*, *8*, 231–236.

Ogden, J. (2003). Some problems with social cognition models: A pragmatic and conceptual analysis. *Health Psychology*, *22*, 424–428.

Prochaska, J. O., & and di Clemente, C. C. (1984). *The transtheoretical approach: Crossing traditional boundaries of therapy*. Homewood, IL: Dow Jones Irwin.

Rosenstock, I. M. (1966). Why people use health services. *Milbank Memorial Fund Quarterly*, *44*, 94–124.

Schou, K. C., & Hewison, J. (1998). Health psychology and discourse: Personal accounts as social texts in grounded theory. *Journal of Health Psychology*, *3*, 297–311.

Smedslund, G. (2000). A pragmatic basis for judging models and theories in health psychology: The axiomatic method. *Journal of Health Psychology*, *5*, 133–149.

Smedslund, G. (2008). All bachelors are unmarried men ($p < 0.05$). *Quality & Quantity*, *42*, 53–73.

Spicer, J., & Chamberlain, K. (1996). Developing psychosocial theory in health psychology: Problems and prospects. *Journal of Health Psychology*, *1*, 161–171.

Stephens, C. (2007). Participation in different fields of practice: Using social theory to understand participation in community health promotion. *Journal of Health Psychology*, *12*, 949–960.

Vinck, J., & Meganck, J. (2006). Do we need critical health psychology or rather critical health psychologists? *Journal of Health Psychology*, *11*, 391–393.

Webb, T. L., & Sheeran, P. (2006). Does changing behavioral intentions engender behaviour change? A meta-analysis of the experimental evidence. *Psychological Bulletin*, *132*, 249–268.

Weinstein, N. D. (1993). Testing four competing theories of health-protective behavior. *Health Psychology*, *12*, 324–333.

Willig, C. (1998). Constructions of sexual activity and their implications for sexual practice: Lessons for sex education. *Journal of Health Psychology*, *3*, 383–392.

Author biographies

DAVID MARKS is Editor of the *Journal of Health Psychology* and Head of the Health Psychology Research Group at City University, London.

David's current research focuses on health inequities, behaviour change, health promotion and policy.

981