

Original article

Explaining American Health Psychology to Europeans: A Personal Perspective**James C. Coyne***

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Europeans are alternately fascinated, attracted, envious, or simply put off by American health psychology. Attending their first conference in America, they can be puzzled by differences from European conferences, even if they cannot say exactly what the differences are. If it is their first time at an American conference, they may be left feeling aliens and alienated, particularly as they witness some peculiar culturally specific American rituals in which they cannot bring themselves to participate. They may chastise themselves when they cannot follow the example of Americans and on the spot muster up a display of enthusiasm about their own work and succinctly explain why their results will be exciting to the larger field and improve patient outcomes. Yet, they may also come away feeling superior because they can see the obvious flaws in the research that is being presented that the American audiences seem to miss in heaping lavish praise on it.

Afterwards, they may feel in need of a beer with a sympathetic cultural interpreter who can understand their reactions and put them in context. Maybe this article could become the basis for a small pocket reference book that Europeans can consult like an interpretative guide to exotic fauna or exotic tourist destinations, but for now I can only provide some basics and some highly personal reactions.

It is helpful first to know that health psychology in the United States is thoroughly integrated with clinical psychology, starting with PhD programs that provide clinical training and preparation for licensure. There are still a few American health psychology programs in which students do not get prepared clinically, but concentrate exclusively on learning social and personality theory and developing research skills. There are some excellent older American health psychologists still around who are not clinicians or affiliated with clinical programs or working in clinical settings. But overall, American health psychologists come from PhD programs in which they do practica (or using the proper American incorrect word, practicums) before completing a full year, full time internship. They also tend to seek postdoctoral training that allows them to accumulate post-PhD clinical hours for licensure. Many Americans who call themselves health psychologists

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come out PhD clinical programs that offered a few health psychology courses, but no formal specialization. Personally, I identify myself as a clinical health psychologist, even though I had no idea during my PhD training that I would later call myself anything but a research-oriented clinical psychologist and never had a course in health psychology.

Even if they are not equipped with this background information, Europeans may quickly notice some of its profound implications. American health psychology research is dominated by work conducted by clinical psychologists, and health psychology intervention studies often evaluate interventions that would require licensure in the US to administer. Much of the “depression” research concerns depression diagnosed with a semi-structured interview, not just a self-report depression scale. There is also a growing body of research coming from clinical psychologists working in primary care settings where they deliver health psychology and mental health interventions or otherwise work to address health issues, such as improvement in physical health outcomes through improved adherence. Overall, there is much more of a clinical psychology emphasis to American health psychology, and a European clinical psychologist would probably find more of

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Original article

Coyne (cont'd)

interest in the presentations at an American health psychology conference than a European one.

In terms of sheer numbers, American psychology is dominated by clinical psychologists, and many have for their doctorate a PsyD, a more practice oriented degree with less research training than a PhD. Europeans who naively wander into the huge American Psychological Association Convention will find themselves awash in a sea of over 10,000 participants, most of whom are not research-oriented. The bulk of presentations are oriented to practice issues, like managing difficult clinical issues, prescription privileges or gripes about managed care and low reimbursement rates. Many presentations will lack a single slide with numbers. If European health psychologists go to an APA convention, it is best for them not to expect to find many research presentations of interest and they should realize that they must dash across town in buses to get from one to the next of the few research-oriented health psychology presentations that there are. It has been years since I last attended an APA convention, both because so many researchers have fled, leaving the convention to the clinicians, and because the APA health psychology division has been so tainted by its intimate connections to psychologists participating in 'enhanced interrogation' of detainees at Gitmo and Abu Ghraib.

American health psychology was formally established decades earlier than European health psychology, with the three major American health psychology organizations developing earlier and with boosts from larger, well established organizations. Thus, the American Psychosomatic Society started as the American Society for Research in Psychosomatic Problems in 1943, and initial meetings were held in conjunction with the American Psychiatric Association or the American Medical Association until a separate meeting in 1946. A name change to the American Psychosomatic Society occurred in 1948. The APS almost met its demise in the mid-1960s, because of its association with discredited psychoanalytic theories about the etiology of specific physical illness that now seem laughable. Thus, migraine headaches could be understood in terms of penis envy; they afflict women more than men and the headache is a symbolic representation of a blood engorged penis. There is an effort in the works to distance the organization even further from this past with yet another name change.

APA Health Division 38 slowly emerged over some decades until there was sufficient interest for a task force meeting at the 1974 APA convention (See

<http://www.health-psych.org/PDF/DivHistory.pdf>). Health psychology was initially a section of Division 18, Psychologists in Public Service, which also had a section for Criminal Justice. In 1978, Division 38, Health Psychology was formally established, but all charter members were already members of other APA divisions.

Development of the Society of Behavioral Medicine was rooted in the efforts of behaviorally oriented clinicians to distinguish themselves from what they viewed as the failure of psychosomatic medicine to produce valid and clinically useful interventions (See <http://tinyurl.com/behavmedhist>). A conference to define behavioral medicine was held at Yale University in 1977. The Society of Behavioral Medicine was founded in 1978 and at first arranged its meetings contiguous with meetings of the American Association for Behavior Therapy, but now its meetings are held separately.

Differences among these three organizations remain, but they can easily be overestimated. The three tend to have overlapping membership and leadership, but APS tends to have more MDs and SBM is more interdisciplinary than APA Division 38, which is limited to psychologists. The contemporary APS is more oriented to behavioral cardiology and it is debatable whether the distinction between psychosomatic and behavioral medicine still holds. There was once an effort by some health psychologists to preserve a conceptual distinction with behavioral medicine, with health psychology intended to be less narrowly behavior therapy and intervention focus. The collapsing of the distinction is seen in the rather routine transitions from editorship of *Annals of Behavioral Medicine* to editorship of *Health Psychology*, although there have been some exceptions.

Health psychology research requires access to medical settings and medically ill patients, but in the United States, this is best achieved differently than in Europe. Many American health psychologists are on medical school faculties rather than in psychology departments. Even if they are senior investigators and are tenured for life (no mandatory retirement in America) they still must earn much—often as high as 100%—of their salary from federal grants or clinical work. Furthermore, American medical schools are addicted to overhead from grants to survive in their currently bloated sizes. In addition to the direct costs of doing the research including faculty salaries, funding agencies pay indirect or administrative costs, typically provided at the rate of an additional 50-75% of the direct costs. ►

Original article

Coyne (cont'd)

Thus, researchers experience pressures not only to generate their salaries and research costs, but to contribute to keeping their universities lit and heated. This means larger, more ambitious and more expensive projects.

American health psychology research is therefore often better resourced than in Europe, but because research projects are more ambitious, they are slower in producing new findings. So at each conference, presenters must find a way to recycle things they said at the last one. And even before completing their project, senior investigators need to be applying for refunding and for funds for new projects. They need to be marketing themselves and their research output: highlighting the strength and importance of their findings to impress funding agencies and any potential reviewers who may be present. There often seems to be a conspiracy of silence among senior American investigators, a distinct stifling by which they loathe to comment on the obvious flaws in each other's work for fear that something negative will be said about theirs. European health psychologists may falsely get the impression that they are the smartest people in the room because they can see flaws in the research that is presented that apparently no one else can.

Americans can sit through sometimes outrageously bad presentations, replete with false and exaggerated claims, and then clap vigorously, even standing to deliver effusive, saccharine praise and then rush to the podium afterwards, as if the presentation was the best they have ever heard. Professor X, receives such praise at her symposium from Professor Y, and she can expect to reciprocate by giving a similar performance at Professor X's symposium hours later. New to American conferences, Europeans might infer that Professor Y's first performance was extraordinary, but spontaneous, and that Professor X's subsequent performance was an amazing coincidence. Ah, the spontaneous expressiveness and positivity of American culture bursting out everywhere!

Senior investigators also need to preserve their relationships with the funding agencies by stressing the alignment not only of their research topics, but the research findings with the priorities of funding agencies. Symposium sessions supported by funding agencies are notorious for their hype and hokum and recycling of past presentations. Seemingly impressive findings are presented, but then presented again and again, cleverly repackaged and with an increasing confirmatory spin. The choice of participants in such symposia is rigidly controlled to exclude anyone who would dissent

from the dominant positive message. Frustration with these overblown, repetitive presentations stirred me to become more challenging of what I read and hear in health psychology, as in "Ain't necessarily so...." (Coyne, Thombs, & Hagedorn, 2008) or "...Bad Science, Exaggerated Claims, and Unproven Medicine" (Coyne & Tennen, 2010). Fortunately, resources and venues have sometimes been found for what has become billed as "great debates" where conventional ideas and interpretation of data can be challenged with evidence (Coyne, Lepore, & Palmer, 2006; Manne & Andrykowski, 2006), but the very rarity of such occurrences draws a large crowd. A few of my presentations rumored to be critical have been canceled ahead of time, and most often I have not found a way to enlist the investigators who make the wildest claims in debating their interpretation of their findings. More than once, I have senior investigators write to the president of my university to get me to tone down my critiques, or even to try to silence me altogether. I certainly could not expect to publish some of the brief contributions I have made in the *European Health Psychologist* (Coyne & Palmer 2007; Coyne, 2009) in America without anticipating howls of protest and maybe another letter or two to the president of my university.

If I can give one takeaway tidbit of advice to European PhD students planning on coming to American health psychology conferences: Repeatedly practice an elevator talk, a three to five sentence summary of what you are researching, why you find it interesting, and what you expect to find. Such talks are so named because they are designed to be delivered on a few minute elevator ride down from a hotel room to the lobby and are to be enthusiastically delivered to elicit a response from Americans in the elevator; "Oh, really this is so fascinating, I must hear more, but unfortunately, I have to get to next session and so can you send me a PDF? It was so wonderful talking to you."

I grew up in America, immersed in American values, but I have come to reject its pervasive marketing orientation: the hype, crassness and commercialism of American culture at its worst. I am acutely aware of the contradictions between espoused American values and lived American culture. I spend a lot of time in Europe, have a great deal of respect for its varied lifestyles, cultures and values, but I do not yet imagine myself becoming an expatriate. Yet because I value democracy, free exchange and free expression, and because I have an American distaste for hierarchy and oligarchy, I am much more comfortable at European health psychology conferences where I can be myself, express myself, ►

Original article

Coyne (cont'd)

not worry about offending funding agencies or the powers that be, and I can remain comfortably oblivious to whatever power structure is in place, even if I am sure it is there.

So, I look forward to seeing you at the next EHPS gathering, where you are probably more likely to find me than at the next American health psychology conference. However, if you introduce yourself to me at EHPS, please have your elevator talk rehearsed. I am still an American, you know. ■

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