

original article

What is the subject matter of health psychology?

Introduction

The subject matter of health psychology is a serious issue. It can be problematic. Significant numbers of people who attend EHPS conferences or similar conferences do not label themselves as health psychologists (for a multitude of reasons). Health psychology is seeking to spread its sphere of influence, as is highlighted by a recent paper at the 2013 APA annual convention in Hawaii, where Alan Christensen argued that the subject matter of health psychology/behavioural medicine should include gun violence. Diversity is healthy and health psychology should be a voice in the current debates concerning a myriad of health related subjects. However, there is a distinction to be drawn between the actual subject matter of health psychology and the processes that guide the journey towards the subject matter. The subtle yet important difference between the two is highlighted by Mark Burton (Joint winner of the BPS 2013 Award for Promoting Equality). Burton (2013) elucidates how one particular focus on equality can have the undesired effect of ensuring that other types are ignored. One of the examples that he cites is preventable deaths of learning disabled people (Heslop, Blair, Fleming et al, 2013).

They are no neat answers to the question of what is the subject matter of health psychology. I certainly don't have one. However, we have invited some of the 'wise owls' from health psychology to tackle it. In the following article, we have contributions from David French, Alison Wearden, Christina Lee, Kerry Chamberlain,

Michael Murray, Mark Conner
and Daryl O'Connor.

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Academic institutions and accrediting organisations encourage academics to identify early with a narrow (sub) discipline – I'm a health psychologist, she's a political economist, we have nothing interesting to say to each other. Can I re-frame this question – how can health psychology connect with related fields of research, in ways that enhance our capacity to do both applied and theoretical work that reflects the world in which people live? It doesn't matter what the subject matter of health psychology is, what matters is that health psychologists adopt a question-first approach and use whatever methods and collaborations will address that question.

For example, it is fairly clear that one of the best ways to improve physical and emotional wellbeing (at least in developed countries) is to reduce the gap between rich and poor. How do psychologists contribute to that? What alliances do we need to build, whose behaviours and attitudes do we need to understand and affect, what cultural discourses do we need to understand and undermine? Questions such as these should define the field, not arbitrary

definitions of what's in and what's out.

To what degree does the content of our health psychology journals cover your answer to question one?

Academic authors assume that the content of academic journals is dictated by editors, but as an editor I am afraid that it is actually dictated by the work that people choose to submit. If you'd like to see our journals publishing work that takes a more human approach to the broad field of physical and emotional health, wellbeing, and human capacity in complex material and discursive contexts, you know what to do. Pay attention to the meaning of what you do, pay attention to effect sizes and real-world significance, pay attention to your own and others' biases and assumptions about the world and about research, place your research in context.

We know that a one-shot cross-sectional survey can't tell us anything about causation or prediction. We know that a statistically significant effect doesn't mean anything at all without an indication of effect size and human meaning. We know that reliability isn't the same as validity. We know that under-powered studies have a high rate of Type 1 errors, as well as Type 2 errors. We know that measures of cognitive variables aren't veridical indicators of some universal truth, but are what happens when research participants make up responses on the spot in reaction to researchers' questions.

More importantly, we know that if a theory purports to explain human behaviour, but doesn't situate the individual, both materially and discursively, in the world, then it will be partial at best. Research must pay explicit attention to broad social categories – gender, age, ethnicity, social class, sexuality, (dis)ability, and their intersectionality – and to the social, political and economic context – employment rates, finance systems, job security, social safety nets. This approach makes our

theories less certain and our findings less universal, but it may enable us better to engage with the human condition.

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The *British Journal of Health Psychology* (BJHP) explicitly specifies in its instructions to authors that it has the following scope:

“The aim of the British Journal of Health Psychology is to provide a forum for high quality research relating to health and illness. The scope of the journal includes all areas of health psychology across the life span, ranging from experimental and clinical research on aetiology and the management of acute and chronic illness, responses to ill-health, screening and medical procedures, to research on health behaviour and psychological aspects of prevention. Research carried out at the individual, group and community levels is welcome, and submissions concerning clinical applications and interventions are particularly encouraged. The types of paper invited are:

- *papers reporting original empirical investigations, using either quantitative or qualitative methods;*
- *theoretical papers which may be analyses or commentaries on established theories in health psychology, or presentations of theoretical innovations;*

- review papers, which should aim to provide systematic overviews, evaluations and interpretations of research in a given field of health psychology; and
- papers dealing with methodological issues of particular relevance to health psychology."

This is consistent with many standard definitions of health psychology (see French, Vedhara, Kaptein and Weinman, 2010a). Implicitly, we would tend to define health psychology as material that falls within the curriculum for professional recognition, as defined by the British Psychological Society's Division of Health Psychology. There are many textbooks that are organized around this definition, e.g. French, Vedhara, Kaptein and Weinman (2010b).

To what degree does the content of the BJHP cover your answer to question one?

BJHP is open to papers which reflect all of health psychology. The editorial we wrote when at the beginning of our editorship stated (Wearden & French, 2013):

"We will welcome excellent contributions relating to all aspects of the theory and practice of health psychology, using a range of quantitative and qualitative methods, as long as those contributions make a substantial and worthwhile contribution to knowledge and understanding"

We believe that the published content of the journal generally reflects this broad church approach. Our panel of Associate Editors has a range of expertise covering e.g. qualitative methods and psycho-neuro-immunology. It has members based in Germany, the Netherlands, Republic of Ireland, the USA, Australia and New Zealand, as well as the UK.

Our main concern is to publish high quality

material that falls within health psychology, especially on topics that are "cutting edge" and which have the potential to move the field forward. As examples, we have recently published editorials on topics such as: whether self-efficacy can be considered a cause of health-related behaviour (French, 2013), advocating more use of N-of-1 studies to more appropriately test theory (Johnston & Johnston, 2013), and development of a unified theory for adjustment to chronic illness (Moss-Morris, 2013). Other editorials by experts in the field will be published in 2014, and we currently have a call out for a special section on mixed methods, edited by Lucy Yardley and Felicity Bishop. We are trying to move away from cross-sectional studies using questionnaires, unless they are exceptional in some way, as they are unlikely to move the field forward.

There are probably some aspects of health psychology which are underrepresented in our journal, most likely due to authors submitting papers to higher impact medical journals rather than to lower impact psychology journals. Papers reporting studies with biological outcomes (such as psychoneuroimmunology studies) tend to be few and far between. Similarly, randomized controlled trials in clinical settings (for example psychological treatments for particular patient groups) tend to be sent either to specialist journals relating to the patient group in question or to prestigious general medical journals. Interventions with healthy populations or at risk populations are more likely to appear in BJHP.

Some papers that get sent to BJHP are not sent out to review because we think they are not health psychology – often we think they would be more appropriate for a clinical psychology journal. Typically, these are papers which deal with mental health issues without any reference to physical health. For example, a paper on a mental health condition (e.g. post-

traumatic stress disorder or depression) in young people following family breakdown would normally be rejected. However a paper on PTSD after an illness or injury might be considered as within the remit of the journal, although it would be right at the boundary (or point of overlap) between clinical and health psychology. Other papers which might not get sent out for review are ones which deal with the design, management or provision of health care services but either with no reference to psychological principles, or they are not about the provision of health psychology services.

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The subject matter psychology is often defined in terms of mental activity and social relations. For health psychology the field can be defined in terms of the role of psychological processes in understanding and enhancing individual and social health and wellbeing. Rather than being restricted by medical definitions, health psychology often starts with the WHO definition of health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Health is not a finished project but a work in progress both personally and socially. It is not something that resides within the individual but rather in our relationships with each other and with broader social structures which are pervaded by power differentials both material and psychological. As the philosopher Gadamer says: *“Health is not a condition that one introspectively feels. Rather, it is a condition of being involved, of being in the world, of being*

together with one’s fellow human beings, of active and rewarding engagement in one’s everyday tasks.” However, we need to go further and consider health and illness within their social, cultural, political and historical context. Health psychology is concerned with developing theories, methods and practices to further enhance our ability to both grasp the changing and varied nature of health and illness and to develop strategies for health improvement by and for individuals, communities and society.

Current journals

In the 1990s I edited the Canadian Health Psychologist/le Psychologue Canadien de la Santé (CHP/PCS). In the first issue I set out the aim of the CHP/PCS ‘to promote the interests of health psychologists throughout Canada by providing a forum for ideas and information about research, teaching and practice’. It was a cross between a journal and a newsletter including research articles, shorter reports on particular topics, summaries of conference symposia, book reviews and some business items from the Canadian Health Psychology Section. I adopted an inclusive policy including articles on psychological aspects of such clinical health issues as irritable bowel syndrome, diabetes, and asthma as well as supplements on such themes as Psycho-oncology, Child Health Psychology, and HIV/AIDS. Most importantly, I was keen to provoke discussion with articles on qualitative research, health cognitions, and narrative health psychology as well as articles about complementary medicine, working in community settings and the prostate cancer ‘epidemic’. Finally, I aimed to increase awareness of cultural and political issues with articles on health psychology in countries such as Australia, Cuba, Ethiopia, and Britain.

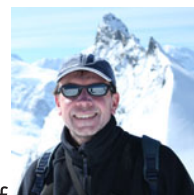
Although the CHP/PCS was a small venture it attracted substantial interest. A measure of its

success was that over the 10 issues almost 100 people contributed to its pages, membership of the Canadian Psychological Society Health Psychology Section increased by at least 25% at a time when CPA membership was declining, and I received requests from many health psychologists outside Canada for copies.

In comparison with contemporary journals the CHP/PCS aimed to promote dialogue and debate rather than being simply a place for publishing reports of research. Contemporary publications often seem somewhat complacent and divorced from broader debates about the nature of health and illness, the political challenges to healthcare and the continuing social inequalities in health. Instead they seem to be dominated by discussion about the adequacy of a limited range of so-called social cognition models to predict health practices. Paulo Freire, the literacy educator, used to criticise what he described as the banking model of education in which supposedly uncontested facts were deposited in the heads of the student. He contrasted that approach with a dynamic and critical process which actively engages with the student to provoke discussion about ideas and to increase critical awareness about the potential for change. In the same way there is a need for health psychology journals to deliberately move beyond ever more reports of predictors of health practices and to reach out to question our ways of researching health and illness, to consider the varied meanings of these phenomena and the social, cultural, political and historical context within which they are nested, and to be self-critical and open to new ways of research and practice. The aim should be to help us to better understand the everyday experiences of health and illness, how we can contribute to reducing pain and suffering, and how we can challenge health inequalities.

Mark Conner and Daryl O'Connor

Editors Psychology & Health



As Co-Editors-in-Chief of *Psychology & Health* we like to take a broad definition of what is health psychology and encourage submissions of articles across this broad field. Health

psychology is an academic discipline focused on a series of research questions concerning health and wellbeing. Central to health psychology is the biopsychosocial model. This model proposes that health and illness are influenced by psychological factors and social factors as well as biological processes. It is also a profession comprising trained practitioners who have a set of core competencies enabling them to initiate change at individual and social levels (Abraham, Conner, Jones, & O'Connor, 2011). Health psychologists seek to identify and understand the determinants of "physical, mental and social well being", focusing on physical health, rather than mental illness. The broad definition of health psychology provided by Matarazzo (1980, p. 118) still seems relevant nearly 35 years after it was written:

"Health psychology is an aggregate of the educational, scientific and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, the identification of etiologic and diagnostic correlates of health, illness and related dysfunction and the improvement of the health care system and health policy formation."

This much-cited definition highlights: (1) the overarching aims of health psychology, that is, to promote health and prevent illness; (2) the scientific focus of research in health psychology, that is, understanding etiologic and diagnostic

correlates of health; and (3) key priorities of professional practice in health psychology, that is, improving health care by focusing on delivery systems and policy (Abraham, Conner, Jones, & O'Connor, 2008).

Health psychologists seek to understand the processes which link individual perceptions, beliefs and behaviours to biological processes which, in turn, result in physical health problems. For example, how a person perceives work demands and copes with them will determine his/her stress levels which, in turn, may affect the functioning of the cardiovascular and immune systems. Health psychologists also study social processes including the effect of wider social structure (such as socio economic status) and face-to-face interactions with others (e.g., work colleagues) because these social processes shape perceptions, beliefs and behaviour. In addition, health psychologists explore individual processes that shape health outcomes and health behaviours and social processes which influence the effectiveness of health care delivery. For example, the way health care professionals communicate with their patients influences patient behaviour, including patients' willingness to take medication and adopt health-enhancing behaviours. Since, most health and medical interventions depend both on the behaviour of health care professionals and, critically, on the behaviour of patients, behaviour change processes limit the potential of health service delivery.

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The subject matter of health psychology is, and should be, very broad. As health psychologists we should be interested in anything that connects psychology to health, although the boundaries of each can be difficult to determine. At the beginnings of the discipline health psychology, (ignoring its roots in psychosomatics and behavioral medicine) a definition of health psychology was proposed for the new field. This was presented to the new APA Division of Health Psychology at their annual meeting in 1979, and essentially defined health psychology as the contribution of all the educational, scientific and professional aspects of psychology to any and all areas of physical health. The initial definition included health promotion and maintenance, illness treatment and prevention, and the role of psychological factors in health and illness (Matarazzo, 1980). Later, the definition was extended to identify a role for health psychology in improving health care services and policies (Matarazzo, 1982). And that definition has remained in general use today, at least in textbook discussions and overviews. Kaptein and Weinman (2004) refer to the components in this definition as the four "core elements of health psychology" (p. 6) and Sarafino (2005) identifies them as the four "goals of health psychology" (p. 14). However, there are some interesting constraints on these disciplinary boundaries. For instance, the extent to which health psychologists attempt the additional tasks of policy development and improving health care seems quite limited

(hence the limitation to 'four' in the comments above). Another obvious boundary on subject matter is the separation between physical health (the province of health psychologists) and mental health (the province of clinical psychologists), although this separation became more difficult to delineate once health psychology began constructing forms of specialisation, such as clinical health psychology (Christensen & Nezu, 2013; Llewelyn & Kennedy, 2005). Marks (2002) argues that four different approaches to health psychology may be identified – clinical health psychology, public health psychology, community health psychology, and critical health psychology – each tending to operate in different settings, with different values, assumptions, objectives, and research practices. Hence it can be hard to specify the subject matter of health psychology in any detailed or specific way, with people who would define themselves as health psychologists doing quite different things. This should not be regarded as a limitation, but as a strength of the discipline.

To what degree does the content of our health psychology journals cover this?

Given the breadth and scope of health psychology, the answer to this question obviously depends on where you stand in relation to the field. As a critical health psychologist, my answer would be, "not that much". If we overview the content of health psychology journals, then we quickly see that this covers 'mainstream' health psychology research for the most part. Journal content is focused very strongly on providing research evidence, where 'evidence' is defined in specific ways, focused largely around the 'big four' objectives noted above. There is nothing inherently wrong with this, but it does limit both the content of, and the discussion about,

the discipline in a range of ways. One noticeable limitation is the strong focus on 'scientific' and 'objective' evidence, which takes on very specific epistemological meanings, and the consequent rather limited presence of research using qualitative approaches. Qualitative content is increasing, but qualitative research is still the 'poor relation' in health psychology research, perhaps because we lack traditions of training for quality research in that arena, and researchers are often deficient at conducting and presenting high quality research from social constructionist positions. Qualitative research can reveal the complex and situated ways that people address, respond to, engage with health issues in their everyday lives – this is where health gets done. We need to see more of this, rigorously conducted, in our journal content. The scientific, evidence-based focus for health psychology journal content produces other important ramifications. It contributes to an ideology of practice, for both research and application, although this goes largely unexamined (Rose, 2013). Health psychologists largely presume the power of psychology, assume expertise and impose their ideas on people in need; they develop knowledge and interventions for people rather than with them (Chamberlain & Murray, 2009). Health psychology also function as a servant of biomedicine (Chamberlain, 2009), taking a biomedical rather than a critical position on many health issues; obesity provides a good example of this. The individualizing approach of psychology, adopted uncritically into health psychology, also leads the discipline to overlook or ignore important social processes affecting health, such as medicalization (Bell & Figert, 2012). Critical health psychologists are concerned with the fundamentally important question: who benefits from our activities? Critical health psychology seeks to challenge the assumptions of psychology (and its own) and to

identify how forms of knowledge and practice can empower or enfranchise people, or the reverse, disempower and disenfranchise. However, these concerns are invisible in our journal content, with the ideology of psychology taken for granted and assumed to be wholly beneficial (cf., Rose & Miller, 2013). The point of raising these issues here is not to argue for an immediate transformation of health psychology, but to note that debate on these matters is not contained within our journal content; the emphasis on evidence, and the preference for particular forms of evidence, tends to silence such debate by default. We need to recognise the value of such debates and we need more space for debate, about the nature, focus and directions of health psychology, within our journals.

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