Means and Meanings in Health Psychology

Marie Johnston

Marie Johnston

Health Psychology Group
& Institute of Applied
Health Sciences
University of Aberdeen
Scotland

Developments in European Health Psychology over the last 20 years can be characterised by changes in the theoretical frameworks and methods used. Two developments are noted. First, we are increasingly focussed on a smaller set of theories, which makes the discipline more cohesive and potentially more successful as a cumulative science. Second, our research is gaining a greater degree of emphasis on intervention rather than simply observation, with resulting changes to the research designs and methods we use.

Meanings: Theoretical frameworks

Change in the profile of theory can be characterised by increasing agreement over the key models involved. Twenty years ago, there was no pattern of theoretical focus nor even clarity about what kind of theories might be relevant. Now it is apparent, from both journal and conference papers, that the focus is on self-regulation models. While there are still a large number of these models in use (Abraham et al 1998), there are three dominant models, Leventhal's Common Sense Self-Regulation Model (CS-SRM), Bandura's Social Cognitive Theory (SCT) and Azjen's Theory of Planned Behaviour (TPB). These models have overtaken the Lazarus and Folkman model by focussing on specific parts of the process: the CS-SRM has clarified cognitions relevant to the illness situation, and how these appraisals interact with existing schema making the individual ready to act; the TPB has focussed on the behaviours appropriate to a particular situation, identifying the cognitions that develop the motivation and prepare the individual for these specific actions; and SCT has been most successful in identifying cognitions, especially self-efficacy, that make action more likely, independent of the specifics of the situation and the potential behaviour.

This theoretical focus is a sign of increasing maturity of the field. Successful academic disciplines typically show this narrowing range of theoretical perspectives, not necessarily because the theories are more accurate reflections of the 'truth'. Rather, the smaller range of perspectives makes it possible for the discipline to succeed. It facilitates the integration and comparison of findings, making a cumulative science possible. It allows people in other disciplines to recognise and have expectations of health psychology and health psychologists, an important issue given the close relationship of health psychology to other fields. At the simplest levels, it means that other disciplines, by recognising coherent theoretical frameworks, can see a need for the subject and encourage its development in an interdisciplinary context. In grant awarding situations, an applicant's proposal is less likely to be challenged theoretically if adopting a mainstream theory.

Nevertheless, we continue to have a large number of theoretical constructs, many of which overlap and duplicate each other. And improved methods of qualitative research are likely to generate even more constructs. While it is possible to reach agreement on reducing the constructs to a smaller number of construct domains (Michie et al., 2005), we need to develop methods of ascertaining when a construct is 'new' so that we can avoid meaningless proliferation.

The tendency to use one model while ignoring others increases the likelihood of duplication of constructs. Schwarzer (1992) has suggested that some models could be integrated into a single framework describing the process of self-regulation through motivational and action phases.

Alternatively, the relative merits of the models can be compared and redundant constructs eliminated by using competing models in parallel in the same investigation; for example, we have recently compared the above three models in explaining health professionals use of specific evidence-based practices in the management of specific clinical conditions (Walker et al., 2003).

Means: Methods of Investigation

The purpose and methods of investigation are increasingly to change behaviour rather than simply to understand. Health psychologists are attempting to change behaviour in all three domains identified in the definition of health psychology, 'the study of psychological and behavioural processes in health, illness and healthcare' (Johnston, 1994). There are many studies which aim to change health behaviours in healthy people, which try to change the behaviour of ill people with the aim of secondary or tertiary prevention, and which target the behaviour of healthcare professions with the aim of achieving delivery of care compatible with evidence of effectiveness. While other fields of psychology frequently investigate the effects of interventions on intrapsychic processes such as emotional states or cognitive changes, the dependent variable in health psychology is frequently behaviour per se. This emphasis on behaviour and behaviour change is appropriate in this, the American Psychological Association's 'Decade of behaviour', and it has affected the theory and methods we use.

Marie Johnston was president of the EHPS from 1992 to 1996. She is member of the editorial board of *Rehabilitation Psychology* and the *British Journal of Health Psychology* and she was co-editor of *Psychology & Health*. She gave keynote addresses to the EHPS in 1998 and 2005.

Many behaviour change methods were developed in the context of clinical behavioural problems where it was likely that there was motivation for change. By contrast, methods arising in social psychology have focussed more on changing motivation, and investigated behaviours that are within the repertoire of the participants. Health psychology requires development of methods of enhancing both motivation in the unmotivated and action in the motivated. In order to achieve this, we will need to look to the evidence base for behaviour change, using evidence from other fields including clinical and educational psychology, as well as from basic, including animal, research.

The increasing emphasis on behaviour change is changing the research designs used, with more use of experimental rather than observational studies, and increasing use of longitudinal rather than cross-sectional designs. The randomised controlled trial not only gives evidence of effective interventions, it is also a means of testing theory. In order to advance effectively and securely, we may need to make increasing use of alternative experimental designs such as 'N of 1' trials (like those used effectively by Fordyce in the 1960s) or interrupted time-series designs, before progressing to full RCTs. The need to show some evidence of effectiveness before proceeding to RCTs of possible complex interventions has been recognised by the UK MRC (Campbell, 2000).

However, progress on behavioural interventions will depend on clear and specific descriptions of behaviour change techniques used. No definitive trial of effectiveness is justified until the components of the intervention can be specified clearly enough to be replicated. Otherwise, an intervention shown to be effective cannot be reproduced in practice and, perhaps more worryingly, it might be impossible to avoid using methods shown to be harmful. We urgently need a clear inventory or taxonomy of behaviour change techniques so that we can specify the hypothesised active components of an intervention. Beyond the simple inventory, it would be useful if techniques could be associated with particular theoretical constructs and/or particular types of behaviour, as well as likely modes of delivery.

Marie Johnston

Means and Meanings in Health Psychology

Conclusions

Over the past 20 years, health psychology has achieved a consensus about the use of theoretical models but persists with overlapping and redundant theoretical constructs. Increasing emphasis on investigating methods of behaviour change are driving the field to use more experimental, longitudinal research designs but we need to improve our ability to specify replicable behaviour change interventions. The quality of our theoretical frameworks and methods of investigation will determine our success: in working with other disciplines, obtaining funding to conduct our research, answering our research and practice-based questions and in developing a cumulative science.

References

Abraham, C. & Johnston, M. (1998) (editors) Self-Regulation and Health. Special issue of *Psychology & Health,* 13.

Campbell, M., Fitzpatrick, R., Haines, A., Kinmonth, A. L., Sandercock, P., Spiegelhalter, D. & Tyrer, P. (2000). Framework for design and evaluation of complex interventions to improve health. *British Medical Journal,* 321, 694–696.

Johnston, M. (1994) Current Trends in Health Psychology. *The Psychologist*, 7, 114–118.

Michie, S., Johnston, M., Abraham, C., Parker, Lawton, R., & Walker, A. (2005) Making psychological theory useful for implementing evidence based practice: a consensus approach. *Quality in Health Care,* 14, 26–33.

Schwarzer, R, (1992) Self-efficacy in the adoption and maintenance of health behaviours: Theoretical approaches and a new model. In R. Schwarzer (ed) Self-Efficacy. Thought Control of Action. Washington: Hemisphere.

Walker, A., Grimshaw, J.M., Johnston, M., Pitts, N., Steen, N. & Eccles, M.P. (2003) PRIME: PRocess modelling in ImpleMEntation research: selecting a theoretical basis for interventions to change clinical practice. *BMC Health Services Research 2003,* 3: 22

Challenges and Prospects for a Socially Activist Health Psychology

Michael Murray

Michael Murray

Division of Community Health
Memorial University of Newfoundland

In reflecting on the current state and future prospects for health psychology it is necessary to start with a broad canvas. The broad aim of health psychology is to promote the health of society and especially the health of the weak and the vulnerable. It means challenging the gross inequities in health and healthcare that exists in our societies. This challenge can take place at different levels although much of health psychology has focused at the individual and clinical level. In this short contribution I would like to argue that there is a need to expand our interest to the community and societal dimensions of health and illness.

Since its inception health psychology has had as its primary aim the development of theories and methods to contribute to a healthier society. Unfortunately this contribution has been limited by a very narrow definition of the social (Campbell & Murray, 2004). Health promotion has been defined and practiced in a proscriptive and controlling sense as being techniques to encourage more individuals to desist from unhealthy behavioural practices such as smoking, excessive eating and drinking and to encourage healthy practices such as healthy diet and exercise. The focus was on the individual whose behaviour was largely under the control of certain cognitive processes. Although this in turn might be influenced by various social norms its meaning within the broader social and cultural context has tended to be ignored. There is a need to expand our focus from cognitive processing to consider the social meaning of health and illness and the social, material and political world within which we live.