

Position statement

Health Psychology, back to the future

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In the early stages of health psychology, a prototypical research project started from a pragmatic question related to a health problem or disease, e.g. "What are the psychological consequences of a myocardial infarction and/or how does a patient cope with this event?" At best such a project was guided by the Lazarus and Folkman stress-coping model (which is more a frame of reference than a theoretical model). In many cases research was indeed a-theoretical, and most studies were of a cross-sectional nature. Over the last decades, this situation changed substantially. First, theoretical models, including social learning, self-regulation or social influence models are now more frequently used to understand and optimize illness management, and there has been a notable development in the area of measurement, in the sense that both the quality and the specificity of measures increased. Earlier on, available measures were generic, and thus lacked specificity for the population under study. Researchers, who wanted a better fit, had to develop their own tools for the purpose of the study. Today, many disease specific, well validated psychological measures do exist for a variety of chronic diseases or health problems, including e.g. coronary heart disease, diabetes, rheumatic diseases, chronic pain and cancer.

However, very few of these measures reflect key concepts of a relevant theoretical framework, and if they do, they only reflect part of the background theory. Examples of this last case are e.g. self-efficacy measures for self-management of specific chronic diseases or the more recently developed Illness Perception Questionnaire (IPQ) (Weinman et al, 1996). In the case of the IPQ for example, illness perceptions are an interesting, but not even the core part of Leventhal's common sense model, but the availability of a good measure is responsible for the fact that this aspect is well researched in contrast to other aspects. In other words, empirical studies frequently reflect what CAN be measured (depending on the availability of an existing measure) rather than what SHOULD be measured (components of a relevant theory). Another source of current concern relates to the nature of our measures. Many studies still exclusively rely on the use of questionnaires, without an attempt to relate these data to more objective (observational or physiological) or more qualitative measures (e.g. use of interview or diary procedures). And some people who do collect more qualitative data, erroneously think that these data should be analyzed in a qualitative, idiosyncratic and thus uncontrollable way. In this respect it would be wise to pay more attention to the use of existing statistical techniques for the analysis of categorical data (Meulman, J., Heiser, W. & SPSS, 1999).

Second, health promotion in e.g. school, work, leisure and family settings gained a lot of attention over the last few decades. In this area, models, which originated from social psychology (such as the health belief model, protection motivation theory, the theory of reasoned action, the theory of planned behaviour, the precaution adoption model or social learning theory) have been widely used for the prediction of health behaviour. While this may be seen as an early sign of scientific maturity, many of the studies based on these models were repetitive and did not really contribute to our understanding of health behaviour change. Most of these models describe indeed cognitive determinants of specific health behaviours such as sun screen use, wearing seat belts, smoking, drinking, condom use, snacking between meals or doing physical exercise, but changing these cognitive determinants seldom led to a long lasting health behaviour change. The reason for this is that (with the exception of social learning theory) they describe determinants of motivation or intention rather than determinants of active behaviour change or maintenance. As a consequence, a creator of one of these models now correctly states: "a new theory is needed to explain why some people do, and why some people do not act on their intentions"

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'The advancement of the science of health psychology undoubtedly depends on the development of theory based intervention research'

(Fishbein, Hennesy, Yzer & Douglas, 2003, p. 3).

Self-regulation theory can be considered as a more relevant theory to explain active behaviour change, by stressing the importance of planning, feedback mechanisms, feedforward mechanisms (context and capability expectations) and action control (attention and emotion control during goal pursuit) processes (Maes & Karoly, 2005). The dominant models of health behaviour, which have been used over the last few decades, also wrongly suggest that the psychological processes that guide the initiation of the behaviour do not differ from those which guide the maintenance of a healthful behaviour. However, whereas initiation may e.g. be determined by expectations about future outcomes, the decision to maintain a healthful behaviour is purportedly based on people's satisfaction with behavioural outcomes. Furthermore, there is evidence that maintenance is related to realistic expectations and to self-determination or 'ownership' of the process of change (Rothman, 2000 ; Maes & Karoly, 2005). Likewise, we should also try to gain understanding of the process of disengagement. Too many studies try to predict why people adopt a specific health goal or health behaviour, rather than to understand WHY these goals are abandoned or reformulated (Maes & Karoly, 2005).

Finally, most health psychology studies are still correlational and at best 'shortitudinal', rather than intervention studies with long term outcome measures. Although controlled studies of interventions can be considered to be the ultimate test of a model or theory of behavioural change, theory based intervention studies, with a longitudinal repeated measures design, have been relatively unpopular among health psychologists. One of the reasons for this may be that health psychologists are not always in a position to conduct such intervention studies without cooperation with other health professionals. While psychologists frequently point at the medical profession as the main culprit for this lack of cooperation, it may be rather our lack of assertiveness and lack of communication with other health care professionals that are the real causes for this isolated position. We indeed frequently fail to inform important others about our health psychology knowledge and competencies, partly because we are not very keen to participate in disseminating activities. We have for example as far as I know no accessible shortlists of advice or successes that can be used for this purpose. It would be an important initiative to start the production of small booklets, which can be disseminated via internet, containing principles, essential research findings and advice related to e.g. the prevention of addictive behaviours in schools, worksite health promotion, preparation for surgery and stressful medical procedures, pain management, doctor-patient communication, psychological interventions in patients with coronary heart disease, rheumatic diseases, diabetes, cancer and the like. The advancement of the science of health psychology undoubtedly depends on the development of theory based intervention research, but if we fail to prove that we can make a real difference in terms of health and illness, chances are low that we will get in a position to offer these interventions in health care settings.

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