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1 WHAT IS HEALTH?

Cultural and Historical Roots

LEARNING OBJECTIVES

- **1.1** Examine different ways to conceptualize health.
- **1.2** Appraise the importance of culture and cultural competence.
- **1.3** Summarize what health psychology is.

Are you healthy? Sounds like a simple question to answer, right? Take a moment to consider it. If you are like most people, you probably think that you are reasonably healthy. How did you arrive at your answer? Did you quickly drop down on the floor and see how many push-ups or sit-ups you could perform and how fatigued the exercises made you? Did you put down this book (or e-reader) and time how long it took you to sprint to the corner and back? Maybe you put a finger on your wrist and took your pulse. More than likely, if you do not presently have a cold or other illness, if you have not recently stumbled and twisted an ankle, or if you do not have any other physical ailment, you probably answered the opening question with a statement like, "Yes, pretty healthy, I guess."

Because of the COVID-19 pandemic we are all more alert to health than we have been in a long time. When it first started we paid a lot more attention to whether we had any symptoms of possible infection. Even prepandemic, for most people living in the United States, basic indicators of good health include the absence of disease, injury, or illness, and some level of physical fitness. These all represent only one general way of being healthy, one supported by Western medicine and as seen on multiple shows on streaming services such as Netflix, Hulu, and Amazon Prime. The definition of what is healthy varies from person to person and is strongly influenced by their way of thinking and their upbringing.

In this chapter, I discuss the dissimilar ways we define and measure health and culture. Next, the discussion introduces you to the field of health psychology and provides an overview of what health psychology covers. Finally, the chapter concludes with career and graduate training information related to health psychology.

MEASURING UP: HOW HEALTHY ARE YOU?

Throughout this book I present practical ways for you to assess yourself. Not only will this give you a context for the material in the chapter, it will also help you better apply your knowledge to your life. The items below are taken from the general health subscale of the 36-Item Short Form Health Survey (SF-36). RAND developed this scale as part of the Medical Outcomes Study (MOS), a multi-year, multisite study to explain variations in patient outcomes. This is a very common measure of self-rated health (Benyamini, 2016). Indicate your responses to each item below. A key to the scale follows (do not look ahead).

1. In general, would you say your health is
   - **a.** Excellent
   - **b.** Very good
   - **c.** Good
   - **d.** Fair
   - **e.** Poor
2. How TRUE or FALSE is **each** of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a. I seem to get sick a little easier than other people.	1	2	3	4	5
b. I am as healthy as anybody I know.	1	2	3	4	5
c. I expect my health to get worse.	1	2	3	4	5
d. My health is excellent.	1	2	3	4	5

3. During the **past 4 weeks**, how much of the time has **your physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?
   - **a.** All of the time
   - **b.** Most of the time

c. Some of the time
d. A little of the time
e. None of the time

KEY: This measure is relatively transparent. The closer you are to 1a, the lower numbers you had to 2b and 2d, the higher numbers to 2a and 2c, and the closer you were to 3e, the healthier you are.

PONDER THIS

How do you define health, and what signifies being healthy?

Could how you think about life be as important as the way your brain is wired?

If you like health and helping people can health psychology be the career for you?

Key Health Behaviors. Getting six to eight hours of sleep, being physically active, eating a nutritional meal, and not smoking are all important health behaviors that can prolong life. Even stretching frequently is a good thing.

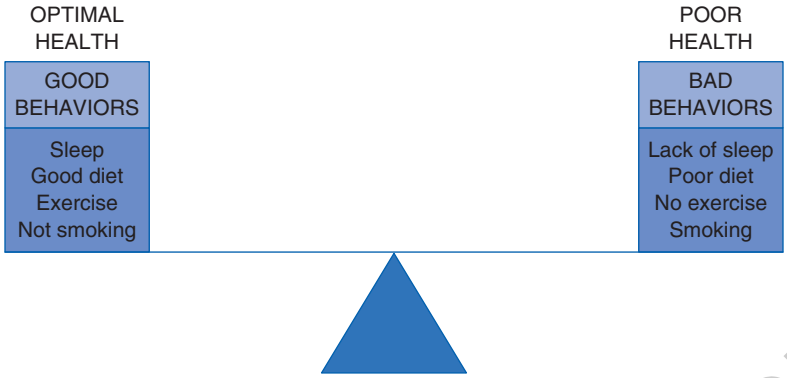
Source: iStock.com/monkeybusinessimages

WHAT IS HEALTH?

Social media shares and newspaper headlines scream the latest health findings almost every day. Eat a big breakfast (Kahleova et al., 2017), sugar causes most of society's health issues (Taubes, 2017), running barefoot might be better for you than running in shoes (Lieberman, 2021), and diets are not the answer to the obesity crisis (Mann, 2015). Not only do news agencies report on countless research efforts every day, but much of the information presented is contradictory. Much of the media blitz capitalizes on the fact that people, in general, seem to be paying more attention to getting and staying healthy. Supermarket shelves overflow with supplements to enhance quality of life, and bookstores brim with recommendations on how to live better. The answer to the question, "What is health?" depends on who you ask. Let's start with the **World Health Organization (WHO)**. This organization defines ***health*** as a state of complete physical, mental, and social well-being (WHO, 1948/2023).

As you can see, this is a general definition and encompasses almost every aspect of life. One aspect that could be added is the word *spiritual*. Definitions such as this one are relatively common when we look at books or magazines that cover health in a nonspecific way. One way to see health is as a

FIGURE 1.1 ■ Health Is a Continuum



continuum with optimal health (broadly defined) at one end and poor health at the other, sitting on two ends of a great big teeter-totter (Figure 1.1). The number of healthy things we do in life determines our relative position (closer to optimal health or closer to death) at a particular moment. The healthy things we do (e.g., eat and sleep well, exercise, and take time to relax) make the optimal health side of the teeter-totter heavier. The unhealthy things we do (e.g., get stressed, smoke, and drink excessively) make us tilt toward the poor health side of the balance.

This imagery also captures how we sometimes rationalize some unhealthy behaviors by practicing some healthy behaviors to ensure the teeter-totter is leaning in the right direction and we are moving toward the optimal end of the spectrum. Of course, this analogy can only go so far: If you have smoked for 20 or 30 years, it will be quite difficult to compensate for the balance. Furthermore, it is difficult to compare the extent to which different behaviors translate into longevity. Just because you do not smoke does not mean that you can drink excessively. Just because you exercise a lot does not mean you can afford to avoid a nutritional diet. Keeping your life tilted toward optimal health is a daily challenge and a dynamic process.

Key Health Behaviors. Getting a good night's sleep is one of the best health behaviors to practice.

Source: iStock.com/Wavebreak

RESEARCHER SPOTLIGHT

Dr. Yael Benyamini has a PhD in health and social psychology and teaches assessment at Tel Aviv University in Israel. She has a great chapter on self-rated health assessment (Benyamini, 2016; see Essential Readings).

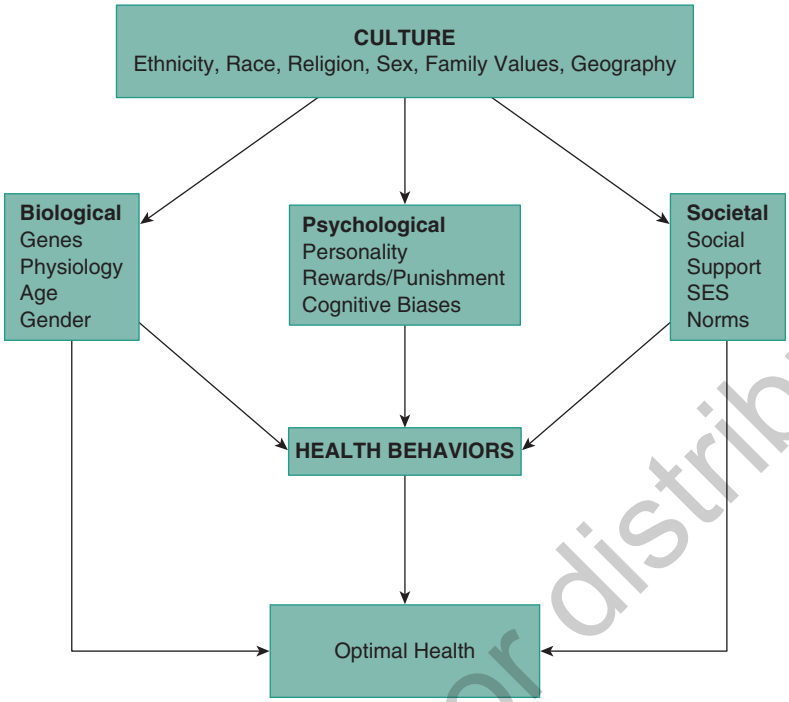
Health and Diversity

The United States is a diverse nation with approximately 332 million citizens (U.S. Census Bureau, 2021). Not all Americans are similarly healthy, a fact made even more evident during the COVID-19 pandemic. For example, Black, Hispanic, and Asian individuals had significantly higher rates of COVID-19 infection, hospitalization, and death compared to White people (Lopez et al., 2021). In general, death rates for Black Americans are significantly higher than those of Americans overall due to heart disease, cancer, diabetes, HIV, and homicide (Edwards et al., 2019). In addition to differences by race, often multiple factors such as gender and income level interact (Villarosa, 2022). For example, there are stereotypes of specific genders and certain ethnicities. What if you are a member of two or more stereotyped groups? I am a man but also Asian American. Originally focused on how different systems of oppression may interact and mutually reinforce each other, **intersectionality** (Crenshaw, 1991; Lei et al., 2022) is now studied in a variety of different contents and is a topic we will touch on at various points of the book**.** This intersectionality can amplify differences in treatment and the experience of illness (Harari & Lee, 2021).

Many Americans also have different answers to questions about health. For example, ask a child what being healthy is, and it is almost certain that their answer will be different from that of an older person. Someone earning less than $13,000 a year will probably answer differently than someone making more than $100,000 a year. A Catholic will probably answer differently than a Buddhist or a Hindu or a Muslim (Von Dras, 2017). Essentially, a person's cultural background, ethnicity, age, gender, educational level, and intersections between them, make substantial differences in how they answer. For example, an LGBTQ+ (lesbian, gay, bisexual, transgender, and queer or questioning) individuals' parental religiosity influences their own levels of depression, alcohol and cannabis use (Macbeth et. al., 2021). Furthermore, our many different actions influence our health—things that often vary by culture as well. The amount of sweetened carbonated beverages that you drink can make a difference; younger people tend to drink more of these types of beverages than older people do. What you eat, including the amount of fast food you eat, makes a difference too. As with beverage consumption, some groups tend to eat more fast food than other groups.

In fact, the answer to the simple question, "Are you healthy?" can vary according to where you live, how old you are, what your parents and friends think constitutes health, what your religious or ethnic background is, and what a variety of other factors indicate about you. If you live in California, where the sun shines most of the time, your health habits are probably different than they would be if you live in Wisconsin, where it is often cold. Though both states are leading producers of dairy products in the United States, statistically, Wisconsinites tend to weigh significantly more than Californians. Is it too much cheese? Is it the lack of sun? ***Culture*** is the term that adequately captures all these different elements that influence health. Thus, the focus of this book is on how our cultural backgrounds influence our health, shape healthy behaviors, prevent illness, and enhance our health and well-being. We will also focus on **diversity**, the many ways individuals and groups of individuals vary from one another. Culture is more often used to capture group characteristics, while diversity alerts us to the different ways groups and individuals are unlike. The schematic diagram in Figure 1.2 provides a map for the route we will take in this book.

FIGURE 1.2 ■ Health and Its Correlates



Different Pictures of Health. These individuals may seem healthy to the naked eye. It is important to also look beyond mere physiological health and the lack of disease and consider mental, spiritual, and emotional health.

Source: iStock.com/Ridofranz

Notice (Figure 1.2) how many different pathways can determine health and how culture is often the basis of biological, psychological, and societal differences. In fact, many of the health disparities, "differences in health that are not only unnecessary and avoidable, but in addition, are considered unfair and unjust" (Whitehead, 1992, p. 433), are due to cultural factors (Centers for Disease Control and Prevention [CDC], 2015; Villarosa, 2022). There are many examples of disparities: for example, Black Americans' heart disease death rates are more than 40% higher than European Americans' death rates (Edwards et al., 2019). The suicide rate among Native American is 2.2 times higher than the national average, and those living below the poverty level are significantly more depressed that those higher in **socioeconomic status** (SES; Xue et al., 2021). In general, health care, mental health, and disease

incidence rates vary significantly across cultural groups (Ruiz et al., 2019). To address this issue, medical education is changing. The Association of American Medical Colleges changed its recommendations to ensure medical educators expose their students to health disparities content (American Medical Colleges, 2019; Landry 2021). See Table 1.1 for the full recommendations. Consequently, this book takes a cultural approach to discussing health psychology.

Cross-Cultural Definitions of Health

In Western medical circles, you are healthy if disease is absent. Of course, this definition focuses primarily on the physical or biological aspect of life; this approach taken by Western medicine is often referred to as the **biomedical approach** to health. Non-Western societies have a different understanding of health. For example, in **Traditional Chinese Medicine (TCM)**, health is the balance of yin and yang, the two complementary forces in the universe (Santee, 2017; Zhang, 2020). Yin and yang are often translated into hot and cold (two clear opposites), referring to qualities and not temperatures. For optimal health you should eat and drink and live your life with equal amounts of hot qualities and cold qualities. Balancing hot and cold is a critical element of many different cultures (e.g., Chinese, Indian, and even Mexican), although some of the foods that constitute each vary across cultures. Some hot foods include beef, garlic, ginger, and alcohol. Some cold foods include honey, most greens, potatoes, and some fruits (e.g., melons, pears). Chapter 3 in this book covers a complete description of diverse approaches to health.

Other cultures also believe that health is the balance of different qualities (Table 1.2) (Galanti, 2014). Similarly, ancient Indian scholars and doctors defined health as the state in which "the three main biological units—enzymes, tissues, and excretory functions—are in harmonious condition and when the mind and senses are cheerful" (Agnihotri & Agnihotri, 2017, p. 31). Referred to as **Ayurveda**, which means knowledge of life, this ancient system of medicine focuses on the body, the sense organs, the mind, and the soul (Svoboda, 2004). Another way of looking at health is the approach of Mexican Americans, the largest non-European ethnic group in the United States. Mexican Americans believe that there are both natural biological causes for illness (similar to Western biomedicine) and spiritual causes (Tovar, 2017). Though Mexican American patients might go to a Western doctor to cure a biological problem, they trust only *curanderos*, or healers, to cure spiritual problems (Arellano-Morales & Sosa, 2018).

TABLE 1.1 ■ Association of American Medical College Recommendations to Improve Health Care Received by U.S. Racial and Ethnic Minorities and Nonminorities

RECOMMENDATIONS
Faculty Recommendations
Recommendation 1: Provide adequate cultural context beyond case-based learning.
Recommendation 2: Discuss how systemic racism and bias may result in health disparities.
Recommendation 3: Discuss demographic information in research, highlighting diversity in populations studied and how the diversity or its absence affects the quality of the study.
Recommendation 4: Practice inclusion by providing visual examples in case-based learning.
Recommendation 5: Differentiate the facts from the myths.
Recommendation 6: Eliminate standalone lectures on health equity and instead integrate health equity content across the courses.
Recommendation 7: Consider roles that current events and popular culture play in understanding of diverse patients.

Source: Landry (2021).

TABLE 1.2 ■ Some Cross-Cultural Definitions of Health

Culture	Definition
Western	Absence of disease
Chinese	Balance of yin and yang Balance of hot and cold
Indian	Balance of mind, body, and spirit
Mexican	Balance of body types and energies
American Indian	Spiritual, mental, and physical harmony Harmony with nature
Hmong	Prevention of soul loss
Ethiopian	Prevention of spirit possession

Native Americans do not draw distinctions between physical, spiritual, and social entities or between religion and medicine (Peters et al., 2014). Instead, most tribes (especially the Navajo) strive to achieve a balance between human beings and the spiritual world (Weaver, 2019). The trees, the animals, the earth, the sky, and the winds are all players in the same game of life. Most of the world's cultures use a more global and widespread approach to assessing health instead of just looking at whether or not disease is absent to determine health (as the biomedical model and most Western approaches do). We will discuss each of these different approaches to health in more detail in Chapter 3.

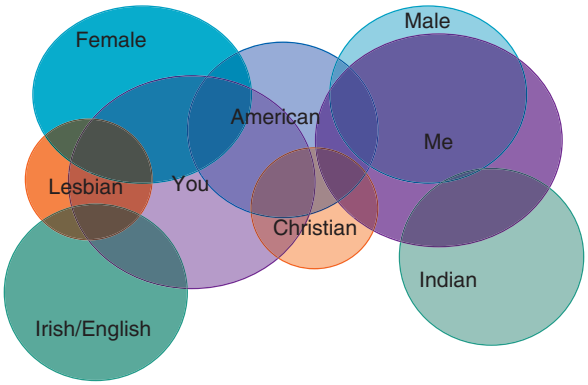
Why Is Culture Important?

One easy answer to the question, "Why is culture important?" is to explain why there are significant differences in the health of European Americans and non–European Americans. However, the cultural differences predict and relate to more than health differences and are important components in the study of the brain, human development, and health (Qu et al., 2021).

What do your mother, your best friend, and your religion have in common? They each constitute a way that you learn about acceptable behaviors. Take parents, for example. Whether we do something because they told us to (e.g., "Eat your greens!") or exactly because they told us not to (e.g., "Don't smoke!"), they have a strong influence on us. If our friends exercise, we will be more likely to exercise. Similarly, religions have different prescriptions for what individuals should and should not do. Muslims should not eat pork or drink alcohol (Amer, 2017). Hindus are prohibited from eating beef (Agnihotri & Agnihotri, 2017). Even where we live can determine our habits and can help predict the diseases we might die from as studied in detail by the area of health geography (Hazen & Anthamatten, 2019). Parents, peers, religion, and geography are a few of the key determinants of our behaviors and are examples of what makes up our culture.

If you think that there are many ways to describe health, then prepare for the challenge of defining culture. At first, it does not seem too difficult, but both trained psychologists and laypeople often mean different things when they discuss culture. Many use the words *culture, ethnicity*, and *race* interchangeably (see Figure 1.3). Beyond these specific examples, people also think culture represents a set of ideals or beliefs or sometimes a set of behaviors. Behaviors and beliefs are other accurate components of what culture is and are often amplified in cultural stereotypes. For example, the creators of the long running cartoon *The Simpsons,* and the actor Hank Azaria who was the voice of the Indian shop keeper Apu on the show, have received a lot of flak. On the show, Azaria's Apu talks in a thick, stereotypical, Indian accent. What seems to have been played for laughs and started many years ago, was offensive to many. In 2020, Azaria decided to stop voicing Apu, and in 2021 apologized to "every single Indian person in this country" (Butler, 2021).

FIGURE 1.3 ■ Defining Culture Our race, ethnicity, and nationality are all interconnected and part of our "culture."

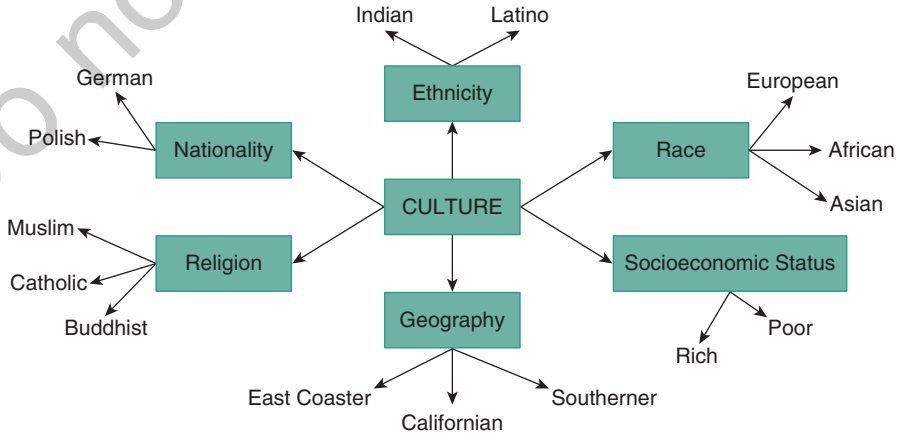


DEFINING CULTURE

Culture can be defined as "a unique meaning and information system, shared by a group and transmitted across generations, that allows the group to meet basic needs of survival, by coordinating social behavior to achieve a viable existence, to transmit successful social behaviors, to pursue happiness and well-being, and to derive meaning from life" (Matsumoto & Juang, 2017, p. 4). Culture can also include similar physical characteristics (e.g., skin color), psychological characteristics (e.g., levels of hostility), and common superficial features (e.g., hairstyle and clothing). Culture is dynamic because some of the beliefs held by members in a culture can change with time. However, the general level of culture maintains stability because the individuals change together. The beliefs and attitudes can be implicit, learned by observation, and passed on by word of mouth; or they can be explicit, written down as laws or rules for the group to follow. The most commonly described objective cultural groups consist of grouping by ethnicity, race, sex, and age. Look at Figure 1.4 for a summary of the different types of cultures and characteristics. There are more subjective aspects of culture that we cannot see or easily link to physical characteristics. For example, nationality, sex/gender, religion, and geography also constitute different cultural groups, each with its own set of prescriptions for behavior.

Although we rarely acknowledge it, culture has many dimensions. Many of us limit discussions of culture to race or ethnicity. Look at what happens if you ask someone what they think the dominant culture around them is. In most cases, they will identify an ethnic category. Someone in Miami might respond that the dominant culture in their area is Cuban. Someone in Minnesota might say

FIGURE 1.4 ■ The Variety of Cultures



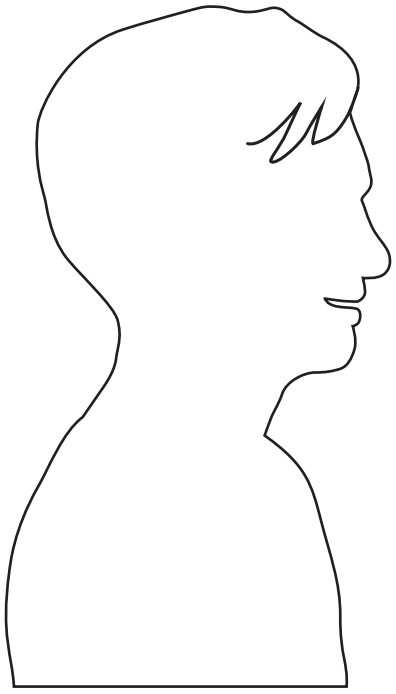
it is Scandinavian. In reality, culture can be a variety of things. In small cities such as Green Bay, Wisconsin, the dominant culture is Catholic, but people rarely realize that religion constitutes a form of culture as well. Instead people guess the main culture in Green Bay is Hmong (a group of people from near Laos in Asia) or Oneida Indian. You could also say being a Packers fan is the dominant culture Green Bay as being a Beaver fan is certainly a dominant factor in Corvallis, Oregon. Is there an American culture? What do you think?

A broader discussion and definition of culture is important for a full understanding of the precedents of health behaviors and health. Culture includes ethnicity, race, religion, age, sex, family values, geography (the region of the country), and many other features. High school adolescents belong to a different culture than do college students. Even in college, there are different cultures. Some students live in dorms, and some live in off-campus apartments. On campus, also, there are athletes and musicians, among many others; each group provides different prescriptions for what is correct behavior. For instance, it is normal for athletes to exercise a lot. Aspects of the specific culture we belong to correspondingly influence each of our health behaviors. Understanding the dynamic interplay of cultural forces acting on us can greatly enhance how we face the world and how we optimize our way of life. This book will describe how such cultural backgrounds influence the different behaviors we follow that can influence our health.

There are probably as many different definitions for culture as there are for health. For example, Soudijn et al. (1990) analyzed 128 definitions. A good way to comprehend the breadth of culture is to see if you know what your own is. For the next 30 seconds, think of all the ways that you would answer the question, Who am I? Write down or just think of every response that comes to mind in the space provided in Figure 1.5.

You will notice that you use many labels for yourself. Social psychologists call this the "Who am I?" test (not a very inventive name, obviously). They use it to measure how people describe themselves. You probably generated a number of different descriptors for yourself, and your responses provide a number of different clues about yourself and your culture. Your answers may have included your religious background (e.g., I am Lutheran), your sex (e.g., I am male), or your major roles (e.g., I am a student, a daughter, or a friend). You might have even mentioned your nationality (e.g., I am American), your race

FIGURE 1.5 ■ Who are you? Jot down the words you use to describe yourself in the space below.



(e.g., I am Black), or your ethnicity (e.g., I am Asian American). Therefore, if you really took the 30 seconds suggested, you should be staggering under the realization that you actually have a lot more culture than you previously thought and only recently has psychology focused on the intersectionality of these different components of your identity. Before doing these listing exercises, many European Americans have said things like, "I do not have any culture. I'm just White." Part of the exciting thing about life is that every one of us has different experiences and backgrounds, and we will keep these backgrounds at center stage as we discuss health behaviors and health.

Profile of a Multicultural American

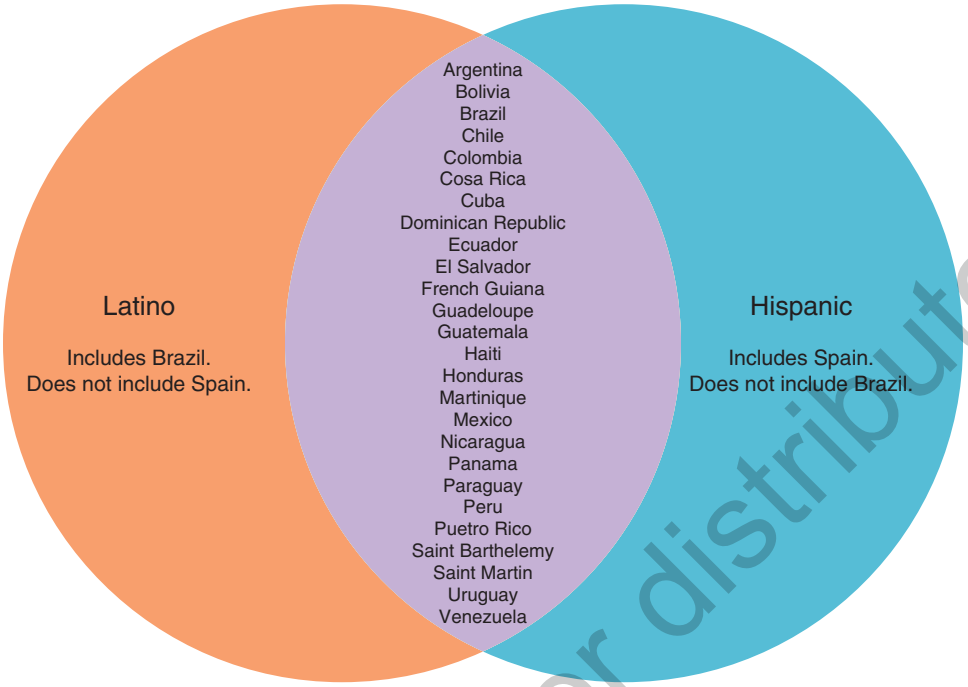
What does it mean to be American? The composition of the White House in 2021 brings race and sex, two of the most salient and visible forms of cultural diversity, to the fore. For the first time in the history of the United States, a woman, Kamala Harris is vice president. From an intersectional perspective, she is also Black and Asian American (her mother was from India). Just 8 years prior, Barack Hussein Obama served as the first African American president. The months of campaigning were often accompanied by discussions of not just positions and platforms but also gender, sexual orientation, and race and ethnicity. Pollsters paid close attention to how women, Latinx, or LGBTQ+ Americans would vote. For the first time in many years people had to confront the fact that for all of America's history presidents have been White men. Is that profile what it means to be American? Does being American mean being White? Of course, it does not, just as being male is not a component of American. American citizens have many different skin colors, religions, and styles of dressing, and that is only the beginning of our country's diversity. America consists of a variety of cultural groups; it is critical to remind ourselves that not only is the country multicultural, but we ourselves are also multicultural.

The most recent census data lists the population of the United States at approximately 332 million. That number can be broken down along different cultural lines. An example of a cultural group that most people tend to think of first is ethnicity. Of that 332 million population, approximately 14% were born outside the country, 13% are African American or Black, approximately 6% are Asian American (including Americans of different Asian backgrounds such as Chinese, Japanese, Korean, and Indian), and approximately 1% are Indigenous Americans. The remaining 72% of the population are considered European American or White and include people of Latin American and Spanish ancestry. Commonly referred to as Latinx or Latine, the preferred terms, *Hispanic* (a term applied to this ethnic group by the U.S. government in the 1980 Census) or Latinx, the truth is that people in this same group have their own names for their groups depending on which part of the United States they live in and their specific country of origin (Arellano-Morales & Sosa, 2017). For example, Texans and those in the Southeast prefer the word *Hispanic*, New Yorkers use both *Hispanic* and *Latino*, and Chicagoans prefer Latino (Shorris, 1992). Even the term *Mexican American*, part of the general classification Hispanic, includes people of Cuban descent, those from Puerto Rico, and Central or South America (Tovar, 2017). Ethnicity is just one way to divide cultural lines (see Figure 1.6).

A second type of culture is religion. When you look at our planet, the majority of humans are Christians (Pew Research Center, 2017), accounting for 31.2%. Muslims comprise 24.1%. Surprisingly, 16% are unaffiliated. Hindus comprise 15.1%. In the United States, 71% are Christian and 22.8% are unaffiliated. Importantly, some well-known religious groups are not present in large numbers: Only about 2% of Americans are Jewish. Testifying to the fact that we as human beings tend to overestimate the actual occurrence of something just based on the extent to which we hear about it (referred to as the availability heuristic), Muslims only constitute a minute part of the U.S. population (0.9%). Because of political events (e.g., trouble in the Middle East and the wars in Afghanistan and Iraq, areas whose populations are predominantly Muslim), many Americans believe that there are many Muslims in the United States (and unfortunately have prejudices against them), when in fact they are a very small minority.

We can also think about culture in terms of ethnicity, different age groups, socioeconomic status (SES), or different geographical regions. People living in different parts of the country have different health behaviors (e.g., the Southeastern states such as Kentucky and Virginia show some of the highest levels of smoking). Different age groups—children, adolescents, teenagers, young adults, or

FIGURE 1.6 ■ Culture and Ethnicity



Source: Adapted from Bustle.com.

older adults—experience different stressors. When you break down the U.S. population along different lines, you realize that there are many such groups and that each has its own specific health issues and that these change over time.

Two Key Areas of Diversity

Two of the most important aspects that define cultural groups, often discussed as diversity, are **socioeconomic status (SES)** and sex. SES, often measured by combining income and education level (e.g., Tackett et al., 2017), is becoming one of the most important and widely studied constructs in health psychology (Ruiz et al., 2019). Almost any study done on this topic shows that poverty and illness tend to go together, often linked by factors such as access to health care and insurance. SES can also influence and underlie relationships among other factors such as race, parenting, and cardiovascular health. For examples, Black men exposed to positive parenting during adolescence had more ideal cardiovascular health based on American Heart Association guidelines (Matthews et al., 2017). SES also relates to body mass index (BMI) in young adults (Bradshaw et al., 2017).

The poor (currently those with a yearly income equal to or less than $26,500 for a family of four, U.S. Department of Health and Human Services [DHHS], 2021) make up a large percentage of Americans without health insurance. If you have money, you can afford healthy food and higher quality health services. Of particular importance to taking a cultural approach to health is that the cultural make-up of those considered poor is changing. For example, the percentage of the Black Americans in official poverty dropped from 42% in 1966 to 26% in 2014, still higher than White Americans in poverty (10%, DHHS, 2016). Such changes can influence usage of health services and consequently a number of other factors that health psychologists study.

Socioeconomic status is related to a higher occurrence of most chronic and infectious disorders and to higher rates of nearly all major causes of mortality and morbidity (Ruiz et al., 2019). In fact, the different factors associated with low SES are also related to higher levels of inflammation or swelling, which are markers of disease risk (Muscatell et al., 2020). Even the neighborhood in which you live can be important (Lee et al., 2022). Neighborhood SES has been associated with poorer health practices (Petridou et al., 1997) and a variety of other health conditions such as coronary heart disease

(Walsemann et al., 2016). The relationship between SES and health is also direct: Usually, the more money you have, the better your health. This relationship is seen in children and in older adults alike.

Several ways of measuring SES have been proposed, but most include some quantification of family income, parental education, and occupational status. One common measure, the Hollingshead Four-Factor Index of Socioeconomic Status, uses parents' education level and occupational status (e.g., Matthews et al., 2017). Research shows that SES is associated with a wide array of health, cognitive, and socioemotional outcomes with effects beginning before birth and continuing into adulthood (Scott et al., 2019).

Many differences in health are due to sex, which is an innate, biological characteristic (Rosenthal & Gronich, 2019). For instance, men are more likely to die after intracerebral hemorrhages, a type of stroke (Marini et al., 2017), older women are more likely to benefit from exercise than are older men (Barha et al., 2017), men and women react differently to hospitalization (Shlomi Polachek et al., 2017), in their need for health information (Stewart et al., 2004), and to illness in general (Rosenthal & Gronich, 2019). Furthermore, it is clear we need to go beyond simple binary categorizations of sex and also better understand transgender individuals and their health concerns (Bochicchio et al., 2021), especially given the rise in discrimination of transgender and nonconforming individuals.

Sex often interacts with other elements of culture such as race and ethnicity (Alizaga et al., 2021; Zissimopoulos et al., 2017). For example, many Korean American males believe heavy drinking is associated with Korean traditions such as Poke-Tang because they encourage men but not women to drink alcohol (Sung Hyun & Wansoo, 2008). In the Latinx community, there are sex differences in relation to health seeking behavior, especially substance use (Abradio-Lanza et al., 2019).

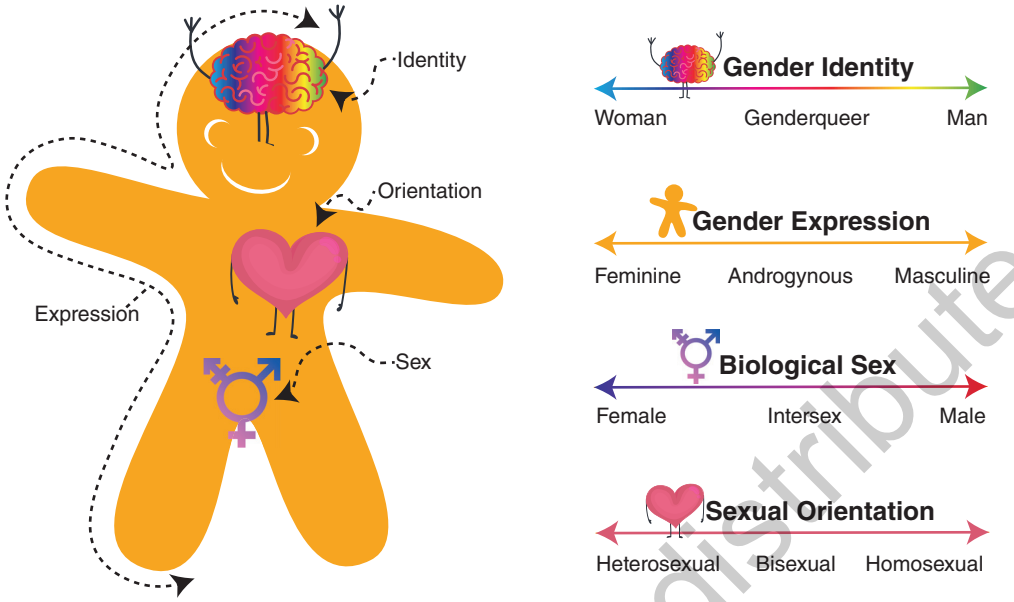
Although women live longer than men (Murphy et al., 2012), they report symptoms of illness more frequently and use health services to a greater extent (Rosenthal & Gronich, 2019). The once-common belief that women have poorer health in general than men has been challenged (Macintyre et al., 1996). There are both pros and cons to being female. The female sex hormone estrogen has a protective effect against cardiovascular illness in women younger than age 50 (Orth-Gomer et al., 1998). On the other hand, women are more likely to be victims of violence and sexual assault (U.S. Department of Justice, 2015) and have body image, eating, and diet problems (Dane & Bhatia, 2023). It is interesting to note that although body dissatisfaction is higher in girls than boys, the negative impact of body dissatisfaction on adolescents' quality of life does not differ by sex (Griffiths et al., 2017).

Boys and men are not always better off (Mitchison et al., 2017). Boys have body image issues as well, often spurred on by the media in general and some media (e.g., video gaming magazines) in particular (Harrison & Bond, 2007). Sometimes these differences are due to gender, which includes behaviors determined by socialization, and learning of social roles. For example, sociological factors related to gender include the extra demands of balancing different roles (e.g., being the primary caregiver for children and working outside the home). Most studies acknowledge these differences by statistically controlling for sex and implicitly (and sometimes explicitly) treating biological sex as a proxy for gender. Remember that sex and gender are not identical constructs, although the two are often treated interchangeably (Pryzdoga & Chrisler, 2000). In fact, biological sex is also different from sexual orientation. Figure 1.7 shows the differences between these terms.

Advancing Cultural Competence

There are many different cultural approaches to health, as you will see in Chapter 3. It is of great importance for health psychologists, health-care workers, and the administrations that support them to be culturally aware. Table 1.3 provides a summary of key recommendations for health-care administrators (Gurung, 2012). Not all clinicians and health-care workers have received the necessary instruction to be culturally competent, but there are some easy ways to be prepared. There are a number of different instruments to measure cultural competency, one study tested 21 of them (Osmancevic et al., 2021). Perhaps the most helpful model of cultural competence is the Purnell Model of cultural competence (Purnell, 2009). The model posits 12 main cultural domains that a clinician should be aware of and should attempt to learn about for each client. Chapter 3 illustrates the main domains and provides sample questions for the clinician to use to gain cultural competence.

FIGURE 1.7 ■ The Genderbread Person



Source: ItsPronouncedMetrosexual.

TABLE 1.3 ■ Recommendations for Fostering Cultural Sensitivity in Health-Care Organizations and Clinics

1.	Post pictures representing the diversity of patient and staff throughout the organization.
2.	Make cultural resources reflecting patient population available to staff.
3.	Recruit bilingual staff.
4.	Initiate diversity classes for administrators, professionals, and other care providers.
5.	Initiate mentoring programs for culturally diverse staff.
6.	Make sure culturally appropriate toys are available in pediatric settings.
7.	Provide pain scales in the language of patients.
8.	Ensure food selections are available to match cultural needs.
9.	Make cultural references readily available.
10.	Teach staff to be responsible for their own cultural education.

Source: Adapted from Purnell et al. (2011).

It is important to acknowledge that many cultural variations exist within ethnic communities. Knowing how different cultural groups approach health and having a better understanding of how factors such as acculturation are important can help clinicians, health-care workers, and others with an interest in how lifestyle decisions are made to be more culturally competent. The efforts to increase cultural competency in the treatment of mental and physical health are promising, but the wider health-care arena needs to pay attention to the causes of health disparities and the role played by multicultural approaches to health (Purnell et al., 2011). We need a better connection between health care and the community so individuals can seek out treatments that best fit their cultural needs. In so doing we can reduce the manifold health disparities.

A person's culture has a major impact on behaviors that influence health. Culture influences some explicit health behaviors. For example, how much do we exercise? Do we drink or smoke? Do we eat well? Culture also influences a whole range of behaviors that indirectly influence our health.

For example, how do we form relationships? How many close friends do we have and do we call on them when we are under stress or in need?

WHAT IS HEALTH PSYCHOLOGY?

Health psychology is defined as an interdisciplinary subspecialty of psychology dedicated to promoting and maintaining health and preventing and treating illness (Leventhal et al., 2008; Matarazzo, 1980; Taylor, 1990). Health psychologists pay close attention to the way that thoughts, feelings, behavior, and biological processes all interact with each other to influence health and illnesses ranging from chronic heart disease and cancer to diabetes and obesity (Freedland, 2017). In many ways, health psychology is greater than a subfield within the discipline of psychology, as it is built on theoretical ideas and research findings from many other areas in psychology. For example, many of the ways to understand the causes of stress and how we cope come from social and personality psychology. As previously discussed, in the evolution of psychology, even clinical psychologists such as Freud, Alexander, and Dunbar contributed to the development of the field. The biological bases of health have been studied by physiological psychologists. As we discuss in later chapters the ways in which health psychologists try to change behaviors, the influence of behaviorists such as Skinner and Watson will become apparent. Applying basic behaviorist theories (e.g., classical and operant conditioning) can help someone to stop smoking or help them to eat better or exercise more.

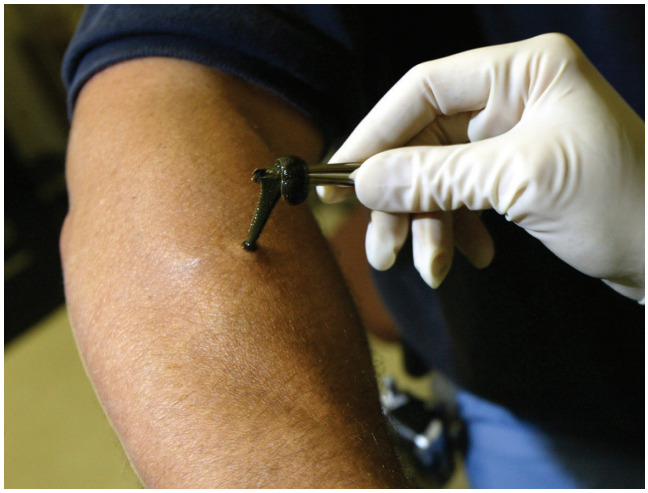
The subdivision of the American Psychological Association (APA Division 38) that focuses on health psychology is called the **Society for Health Psychology,** and is dedicated to four issues. The purpose and mission of the organization is to:

1. Advance the science of the psychology of health, which includes the promotion of health and wellbeing and prevention and management of illness and disability;
2. Support evidence-based applications of health psychology across the lifespan;
3. Promote competencies-based education and training in health psychology; and
4. Disseminate health psychology to the public, professionals, scholars, institutions, policy, and law. (Society for Health Psychology, 2021)

Unlike the Society of Behavioral Medicine (SBM) or the American Psychosomatic Society, whose members are overwhelmingly physicians, the Society for Health Psychology is a group specifically for psychologists. That fact aside, it is also open to (and is driven to foster collaborations with) members of the other health-care professions who are interested in the psychological aspects of physical and mental health.

Early Cures for Illness. Many bizarre remedies for illness, such as bloodletting, were used prior to the discoveries of modern medicine.

Source: Rapp Halour/Alamy Stock Photo



Early Cures for Illness. Using leeches to cure.

Source: Tony Savino/Corbis Historical/via Getty Images

The Evolution of Health Psychology

Health psychology is conceptualized as a discipline encompassed by the general field of behavioral medicine together with medicine and an array of public health sciences and services (Freedland, 2017). Current estimates for the emergence of health psychology as a distinct field of study in North America are in the 1960s, which saw the formal adoption of the field in North America and other parts of the world (Lubek & Murray, 2018). Today, the course is taught around the world (Stone & Gurung, 2022).

In the recent past, health psychology emerged when humans starting dying more due to chronic diseases than due to famines, infections, and communicable diseases (epidemiologic transition; Omran, 2005). Going back even farther, the first two components of the biopsychosocial approach—focusing on biology and psychology—represent a current resolution to an ancient debate.

For centuries researchers, thinkers, and philosophers have questioned if and how the mind (and psychology) and the body (and our biology) are related and whether this relationship influences health. Is the mind connected to the body? Does it reside in the body? Where is the soul? Philosophers and scientists alike have debated these questions for millennia. Modern health psychology has roots in philosophy, 19th-century scientific discovery, medical and clinical psychology, epidemiology and public health, medical sociology and anthropology, and psychosomatic medicine (Friedman & Adler, 2007; Taylor, 2010).

The earliest evidence, such as oral traditions and pictorial evidence from early civilizations, suggests that the mind and body were originally considered to be one (Ellenberger, 1981). Spirits invading the body were thought to cause illness, and gruesome solutions such as trephination—the drilling of holes in the skull to release spirits—were practiced to make people healthy. This was not a highly successful method (nor was it likely to have been extremely popular with people developing illnesses).

Many of the world's early philosophies seemed to share the view that the mind and the body were intimately connected; about 5,000 years ago both the ancient Chinese Taoist sages and the ancient Indian practitioners of Ayurveda wrote about various ways the mind could calm the body and vice versa (Agnihotri & Agnihotri, 2017; Santee, 2017). It is also certain that the rich traditions of medical practice in Egypt and the Middle East around 2000 BCE (e.g., Mesopotamia, present-day Iraq) also focused on this connection (Amer, 2017; Udwadia, 2000). Greek philosophers around 300 to 400 BCE challenged this notion and proposed that the mind and the body were separate. Greeks valued reason and rational thought—basic components of the Greek approach to life—more than the biology of the body, but hypothesized that basic bodily substances caused different diseases. For example, the Greek philosopher **Hippocrates**'s rational explanation of why people get sick concerned the balance of four major bodily fluids (something that he borrowed from Alcmaeon of Crete). He argued that people got sick or showed different symptoms if the amount of one fluid exceeded that of the others. If you had a lot of blood, you would be cheerful; if you had a lot of black bile, you would be sad or melancholic. History considers Hippocrates, who made many other contributions to the biological study of illness, the father of Western biomedicine. In fact, most doctors take an oath before they practice medicine, one of which is the Hippocratic Oath (Table 1.4) or a version of it.

Many centuries after Hippocrates the French philosopher **Rene Descartes** (1596–1650), famous for his argument, "I think therefore I am"— "je pense, donc se suis" in Descartes's original French, or "cogito ergo sum" in Latin —strengthened the Greek idea about the separation of the mind from the body. The hundreds of years that people believed that the mind was separate from the body helped medical science develop as scientists dissected dead bodies and increased our knowledge of human anatomy. The Greek **Galen** first pioneered the examination of the dead to find the cause of disease, working primarily on animals. Centuries later, the study of human anatomy was fine-tuned by Andreas Vesalius (1514–1564) and the Italian artist (and the prototypical Renaissance man) Leonardo da Vinci (1452–1519). Both drew detailed diagrams of the construction of the human body. Dissections came

TABLE 1.4 ■ The Modern Physician's Oath

I swear to fulfill, to the best of my ability and judgment, this covenant:
I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow;
I will apply, for the benefit of the sick, **all measures which are required**, avoiding those twin traps of overtreatment and therapeutic nihilism.
I will remember that there is art to medicine as well as science, and that warmth, sympathy and understanding may outweigh the surgeon's knife or the chemist's drug.
I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.
I will **respect the privacy** of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But **it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness** and awareness of my own frailty. Above all, I must not play at God.
I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.
I will prevent disease whenever I can, for prevention is preferable to cure.
I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body, as well as the infirm.
If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection hereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

Source: The Hippocratic Oath: Text, Translation, and Interpretation by Ludwig Edelstein. Reproduced with permission of JOHNS HOPKINS UNIV PRESS (B) in the format Book via Copyright Clearance Center.

to a halt when the Roman Catholic Church explicitly banned dissections, which it deemed unholy. Finally, Descartes brokered a deal with the Church resulting from a complex set of sociopolitical factors. Active antagonism had existed between the Church and science, but the declining power of the Church and the draining of Church resources due to the Inquisition made it easier for Descartes to convince the Holy Father to allow dissections. Descartes essentially argued that because the mind and body were separate, the mind and soul of a person left the body when the person died. Hence, only the biological body was left behind, and it was unimportant. The Church accepted this explanation, and human dissections began in earnest.

Cultural Influences on Behavior. Our own health behaviors are largely dependent on the health behaviors of other individuals who share our cultural group.

Source: iStock.com/monkeybusinessimages

In the early 20th century, psychology started to play a part in the examination of health. Part of the reason this involvement came so late is that psychology was not a field of study in its own right until then. If you think back to your introductory psychology class, you probably will remember that the German William Wundt founded the first psychology laboratory in 1879. The first book in psychology, *Principles of Psychology* by Harvard University psychologist **William James**, was published in 1897. In a precursor of sorts to the biopsychosocial model, James also wrote ***Varieties of Religious Experience*** (1902) that referred to spirituality, health, and psychology. Also in the late 1890s, **Sigmund Freud** first generated his ideas about the structure of the human mind. When one mentions Freud's name, people quickly think of couches, bearded psychologists, and other stereotypical Freudian artifacts. Yes, Freud did have clients lie on his couch while he sat behind them and listened to them speak. Yes, we often see pictures of him in a beard and most screen psychoanalysts are similarly bearded (e.g., *Analyze This, Girl on the Train*) unless they are women (e.g., *The Falcon and Winter Soldier*). These tidbits aside, Freud was one of the earliest health psychologists, though few would call him such (Karademas et al., 2016).

How did Freud revolutionize the way we look at illness? Freud was the first to draw attention to the possibility that illness could have psychological causes. Trained as a neuroscientist, Freud had a strong biological background. He was perplexed by clients who reported strong symptoms of illness but who lacked physical evidence of illness. He also noticed the work of Pierre Janet and of Franz Anton Mesmer, who cured cases of hysteria with hypnosis. In talking to his clients, Freud discovered that many of their physical illnesses were due to psychological issues. Once these psychological issues were resolved, the physical symptoms disappeared. This focus on the workings of the mind in disease was continued later in the 20th century by the psychoanalysts **Franz Alexander** and **Helen Flanders Dunbar.** Together they established the first formal gathering of individuals interested in studying the influences of the mind on health. This movement within the mainstream medical establishment was coined psychosomatic medicine.

The new field of psychosomatic medicine had many supporters, which led to the formation of the first society specifically dedicated to the study of mind and body connections. The American Psychosomatic Society was formed to "promote and advance the scientific understanding and multidisciplinary integration of biological, psychological, behavioral and social factors in human health and disease, and to foster the dissemination and application of this understanding in education and health care" (American Psychosomatic Society, 2018). In 1936, the New York Academy of Medicine's joint committee on religion and medicine headed by Dunbar assembled a collection of the psychosomatic medical literature,

Cultural Influences on Behavior. If many of your friends smoke and drink, you are more likely to do the same.

Source: iStock.com/efenzi

together with publications examining the relationship of religion to health. Dunbar's early collection of articles led her to organize the publishing in 1939 of the first journal for this field, *Psychosomatic Medicine*, which still publishes research today. Although the early movement faltered and received mixed attention because it was based heavily on Freudian ideas and case study methods of research, the American Psychosomatic Society (APS) survives and is still active.

Another movement within the field of medicine, **behavioral medicine**, looks at nonbiological influences on health. Doctors and health-care specialists within the medical community were probably always aware that changes in behavior and lifestyle improve health, prevent illness, and reduce symptoms of illness, although they did not focus on this fact. The Society of Behavioral Medicine, a multidisciplinary, nonprofit organization founded in 1978, is dedicated to studying the influences of behavior on health and well-being. This organization brings together different disciplines—nursing, psychology, medicine, and public health—to form an interdisciplinary team. The society's explicit mission is "promoting the study of the interactions of behavior with biology and the environment, and the application of that knowledge to improve the health and well-being of individuals, families, communities and populations" (Society of Behavioral Medicine [SBM], 2023). Similar to *Psychosomatic Medicine* for the APS, the SBM also has its own journal, the *Annals of Behavioral Medicine.* Another important resource for health psychology and clinical health psychologists in particular is the *International Classification of Diseases*, 9th revision (ICD-9), a classification of diseases and disorders. The connection between health psychology and medicine is strong. Even today, health psychology and clinical health psychologists play an important role in the practice of medicine and management of disease.

Galen. A key figure in the history of medicine who was one of the first to dissect bodies.

Source: GL Archive/Alamy Stock Photo

Other groups of individuals also began to draw attention to the fact that health issues needed to be addressed by a broader approach than the point of view taken by the medical establishment. Individuals in the field of medical anthropology are committed to improving public health in societies in economically poor nations. Based on the biological and sociocultural roots of anthropology, medical anthropologists have long considered health and medical care within the context of cultural systems, although not necessarily using the tools or theoretical approaches of psychologists. Similarly, medical sociologists are individuals working within the framework of the medical model, focusing on the role of culture and a person's environment in health and illness.

There are many fascinating studies of health and behavior conducted within these different fields that we will refer to in this book. These fields and health psychology share common interests and terms. For example, health psychology and medical sociology both are influenced by the field of **epidemiology**—a branch of medicine that studies the frequency, distribution, and causes of different diseases with an emphasis on the role of the physical and social environments. We will also be paying close attention to clear-cut outcome measures used by epidemiologists. For example, we shall look at how different biopsychosocial factors relate to the number of cases of a disease that exist at a given point in time, or **morbidity**, and to the number of deaths related to a specific cause, or **mortality**.

Descartes. A key figure who advocated for the separation of the concept of the mind from the concept of the body.

Source: GL Archive/Alamy Stock Photo

Even within mainstream psychology, researchers in social psychology, personality psychology, cognitive psychology, and clinical psychology realize that the basic theories that they derived to describe and predict behavior easily could be applied in the study of health and well-being (Taylor, 2010, 2011). Beyond simply explaining what many laypeople (especially senators in Congress who begrudge the use of government money to fund psychological studies) considered commonsensical and mundane issues, psychological theorizing can actually save lives! As we will soon discover, social psychological theories form one of the core foundations of health psychological research (Taylor, 2011), and many social phenomena can explain why we do what we do. Are children likely to start smoking? What makes a person more or less likely to exercise or eat well? The answers to each of these questions come from theories derived from basic social psychological research.

Health Psychology's Biopsychosocial Approach

An understanding of the different definitions of culture becomes a useful aid to study health and to examine why we do or do not do things that are good for us. Most behaviors that influence health—whether healthy behaviors such as physical activity and eating nutritionally balanced diets or unhealthy ones such as smoking or drinking excessively—depend heavily on the culture in which we grew up. If both of your parents exercised, there is a high probability that you will exercise as well. The fact that behavior is influenced by many different factors outside of the individual is a critical aspect on which health psychologists focus. We will discuss the exact ways that culture influences our development and health behaviors in more detail throughout this book.

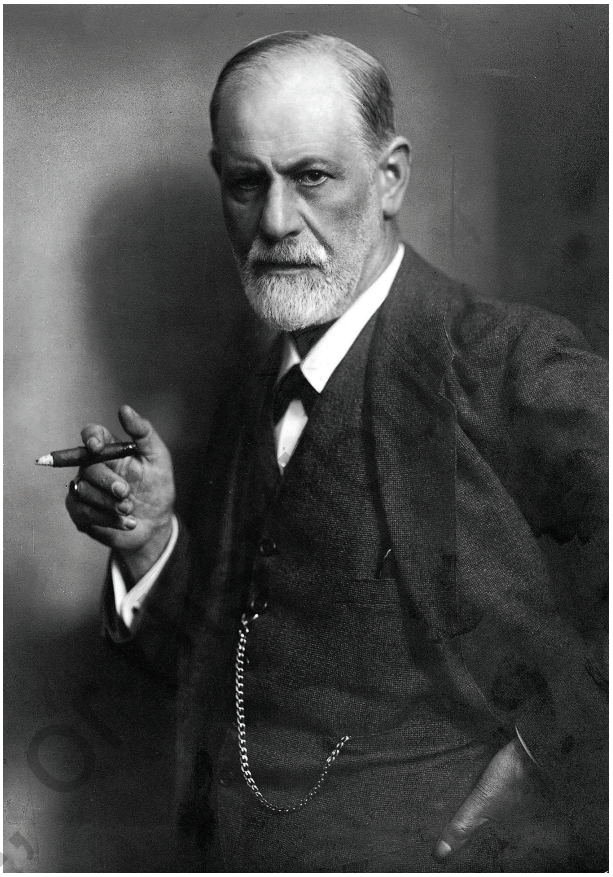
How does the culture that we come from and surround ourselves with influence our health and behaviors? Answering this question with a concerted look at sources of influence outside a person (i.e., not just their biology or psychology) is a distinctive feature of the approach taken by health psychologists in studying health. In contrast to the biomedical approach of Western medicine described previously, health psychologists use a **biopsychosocial approach** (Engel, 1977; Revenson & Gurung, 2019; Suls & Rothman, 2004). Most terms used in psychology reflect common sense, and this term is no exception. This type of approach focuses on the biology or physiology underlying health; the psychology or thoughts, feelings, and behaviors influencing health; and the ways that society and culture influence health. The term *biopsychosocial* nicely reminds us that different components go together. For example, there is an association between depression, a mental health issue, and cardiovascular disease, a physical health issue (Carney & Freedland, 2017). The biopsychosocial approach goes beyond defining *health* as simply the absence of disease and instead forces us to focus on the broader range of the critical determinants of health (Suls & Rothman, 2004).

Smoking provides a good example of how the biopsychosocial model is useful. People might start smoking for psychological reasons such as thinking it makes them less stressed or because of personality traits (extroverts are more likely to smoke). People might also start to smoke due to pressure from their social networks or because of perceived cultural norms. Finally, addictions have a strong biological component in terms of their heritability.

Main Areas in Health Psychology

The field of health psychology, as well as the contents of this book, is naturally segmented into three areas: (1) stress and coping, (2) health behaviors, and (3) issues in health care. One major area under the umbrella of health psychology is clinical health psychology, a broad specialty in professional psychology that spans the three main segments and in which clinical practitioners work (Belar, 2008). Many health psychologists are clinicians and, although we will discuss clinical issues throughout this book, especially **evidence-based treatments** (Phillips, 2012), our focus is on the wider field of health psychology.

At the psychological roots of this area of study, the first part of this book will examine the biopsychosocial determinants of stress and then investigate how these same factors can influence coping style. The next part of the book will primarily describe the main health psychological theories relating to why we act in various healthy ways using different health behaviors as examples. We will look at the good (e.g., physical activity), the bad (e.g., eating too much fast food), and the ugly (e.g., seeing what smoking can do to a person's teeth and lungs). The last part of the book will focus on different factors relating to health care. These include the complexities of dealing with chronic and terminal illnesses and the different psychological factors influencing the quality of interactions between doctors and patients. We will begin by looking at how health psychologists do research, followed by an overview of some critical biological systems and discussing how different theories of human development and cultural variations can help us understand our health-related behaviors and our health. As you continue in the book, you will also learn about some of the fascinating ways that different cultures approach health and illness.



Freud. A key figure who first explored the role of the mind in physical health.

Source: Sueddeutsche Zeitung Photo/Alamy Stock Photo

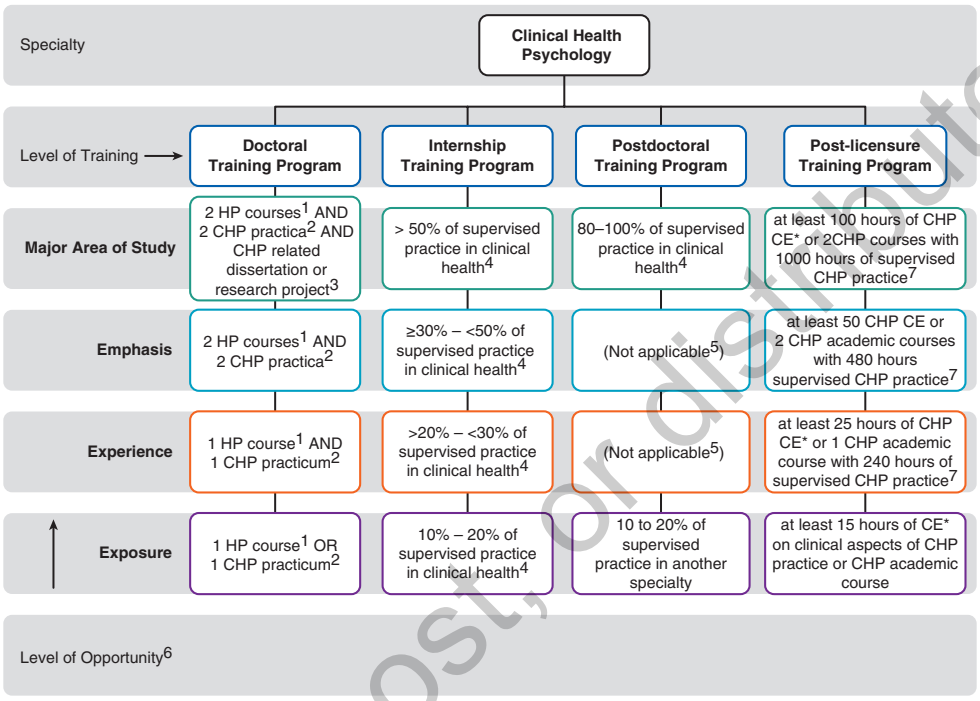
APPLICATION SHOWCASE: CAREERS AND GRADUATE TRAINING IN HEALTH PSYCHOLOGY

Health psychology enjoys growing popularity in colleges and universities (Stone & Gurung 2022). In one study, 177 out **of** 374 (48%) undergraduate psychology programs surveyed offered the course in 2005 (Stoloff et al., 2010) compared to only 112 of 400 programs surveyed (less than 26%) in a study conducted just 10 years previously (Perlman & McCann, 1999). In the most recent study on this topic, 70 percent of departments offer the course (Norcross et al., 2016). After reading this book you may want to consider working in this fascinating field and many great resources are available to help you become a health psychologist (see Revenson et al., 2020).

Most health psychologists work in either basic research settings or in applied settings. The former are academic psychologists who could be affiliated with a university or research center. The latter are clinicians who might be affiliated with hospitals or clinics. Researchers aim to determine the biopsychosocial factors involved in the many areas discussed in this book such as stress, cardiovascular diseases, cancer, and HIV. Clinical activities include conducting a variety of tests such as cognitive and behavioral assessments, psychophysiological assessments, clinical interviews, demographic surveys, objective and projective personality assessments, and various other clinical and research-oriented protocols.

Health clinicians also implement interventions to change health behaviors, reduce stress, help people cope with chronic illnesses, and increase adherence to treatment. Many psychologists work in health-care settings and many HMOs include psychologists as well. Health psychologists have also been employed in governmental agencies, rehabilitation centers, medical schools, and pain centers. Figure 1.8 shows the main types of levels of clinical health psychologists.

FIGURE 1.8 ■ Levels of Clinical Health Psychologists



[1] Clinical Health Psychology (CHP) and Health Psychology (HP) Courses and Training—Must have content congruent with *Clinical Health Psychology Education and Training and Guidelines and Post-doc-CRSPP 2011* (available on Council of Specialties in Professional Psychology website http://cospp.org/guidelines). Doctoral programs may be on quarter or semester academic calendars and a course in either system is considered equivalent. 2 semesters/3 quarters constitute one academic year.

[2] Clinical Health Psychology Practicum (CHP)—one academic year (approx. 9 months) of supervised training, at least 8 hours per week, or its equivalent (e.g., total clock hours 240 hours) with at least 50% of clinical service delivery with *health-related issues* of patient, *family members, and/or interprofessional* care teams.

[3] Clinical Health Psychology dissertation or research, project—empirical research, extended case studies, literature critiques and analyses, or capstone projects.

[4] Clinical Health supervised practice must include >50% of clinical service delivery to clinical health psychology patients, family members, and/or interprofessional care teams (e.g., assessment, treatment, consultation). The remainder of supervised experience can include seminar attendance, readings, research, provision of clinical supervision, teaching, program development and evaluation, and administration.

[5] Not applicable: By definition, postdoctoral education and training in clinical health psychology is a major area of study requiring 80% or more of time spent in this specialty area, but does allow for an exposure to other specialty areas.

[6] The term "focus" should be used to describe opportunities in non-specialty areas of training. Training programs should strive to provide explicit explanations of the type of training provided in these non-specialty areas.

[7] Supervised practice is expected with either the CE or CHP course(s) and defined as >50% of clinical service delivery to clinical health psychology patients, family members, and/or interprofessional care teams (e.g., assessment, treatment, consultation).

* CE course = must be organized CE program, APA sponsor of psychology continuing education.

Source: Reprinted with permission of the Society for Health Psychology.

Although few undergraduate institutions offer specialized programs in health psychology, a growing number of graduate programs offer a degree or at least an emphasis in health psychology. The best preparation at the undergraduate level is a psychology major with many supporting

courses in biology, statistics, and research methods. Many schools around the country are also adding an introductory health psychology course to the curriculum, but similar material may be covered in courses with titles such as behavioral health care, behavioral medicine, health behavior change, and health promotion. Because the biopsychosocial mode incorporates many different subject areas, you can cultivate your interest in health psychology by working in a variety of related fields. Many social workers, occupational and physical therapists, nutrition and exercise physiologists, dieticians, and other health-care workers also use the health psychological approach even if not the explicit label. Many county, state, and national organizations also hire students with backgrounds and interests in health psychology to work with related departments. Even within the field of psychology many social, personality, clinical, and counseling psychologists (some of the classic and traditional areas of psychology) sometimes also take a strong health psychological approach in their work.

After an undergraduate degree, most health psychologists enroll in graduate school and work toward a master of science (MS) or doctoral degree (PhD). A master's degree can take 2 to 3 years, and a doctoral degree can take 5 or more years; the content of the coursework will vary with the institution. Some graduate schools will focus more on the psychological aspects of the biopsychosocial model, including a greater number of advanced courses in psychology. Others will lean more heavily on the biological side of the model, with more courses that are specialized in biology and medicine. If you use the most traditional way to look for graduate schools—the American Psychological Association's guide to graduate study—here is something to look for. There are a small (although growing) number of health psychology PhD programs, but a larger number of clinical psychology programs that offer health psychology tracks. There are also many schools that have a health psychology emphasis within their social psychology doctoral programs (e.g., the University of California, Los Angeles [UCLA]). There are also schools with behavioral neuroscience or behavioral medicine programs whose curriculum is very close to that of health psychology programs. For one of the most up-to-date sources for programs with health psychology training, check the Society of Behavioral Medicine's health psychology education and training websites (Society of Behavioral Medicine, n.d.).

Applied health psychologists have a doctoral or master's degree and are licensed for the independent practice of psychology in areas such as clinical and counseling psychology. Applicants have access to board certification in health psychology through the American Board of Professional Psychology. Clinical and counseling doctoral students are required to complete a 1-year internship before obtaining their doctorates, and many of these programs offer some training in health psychology. After graduate school, a number of individuals choose to specialize in a particular area of the field and take on postdoctoral positions. Although these positions rarely pay much, they are excellent opportunities to work closely with experienced researchers in the field and learn much more about specific topics.

If this brief exposure of what is available to you has whetted your appetite for more information about being a health psychologist, the best place to look is the Society for Health Psychology's (APA Division 38) education and training website (https://societyforhealthpsychology.org/training/training-resources/#) or a similar site hosted by the Society for Behavioral Medicine (http://www.sbm.org/). At both sites you will find a listing of doctoral programs in health psychology, a guide to internships in health psychology, and a listing of postdoctoral programs in health psychology. Commercial job searching sites carry health psychology jobs as well, but be careful of the search terms you use. This is an expanding, exciting field with a tremendous potential to change how long and how well we live. I hope you are eager to learn more about it in the pages ahead, and consider becoming a health psychologist, too.

CHAPTER REVIEW

Summary

- There are many different definitions of health, each varying in its culture of origin. Western medicine sees health more as the absence of disease whereas other cultures see health more as a balance of opposing forces or spiritual harmony. The most common definition is that used by the World Health Organization: Health is a state of complete physical, mental, and social well-being.
- Culture is broadly defined and includes ethnicity, sex, religion, gender, and nationality. Various dimensions of culture shape our health behaviors and our general health. Individualism and

collectivism are examples of basic cultural dimensions. Socioeconomic status and sex are two of the most important cultural variables, each leading to a variety of health differences.

- Health psychology uses a biopsychosocial approach. This approach focuses on the biological, psychological, and sociocultural factors that influence health and health behaviors.
- Theorizing about the extent to which the mind and the body are connected has varied over time and across cultures. The ancient Chinese and Indians saw the two as connected, but the Greeks and other Europeans saw the mind and body as separate. Today we recognize that the two are clearly interconnected, and this connection is critical to understanding health and illness.
- Freud was the first psychologist to link the mind and body and to hypothesize psychological bases for physiological problems. His early views led to the formation of the first organization of behavioral medicine in the late 1930s, followed by further growth in the late 1960s.
- Health psychology as a unique area of psychology came to the forefront in the 1970s and has since grown. Its main goals are the prevention of illness, the promotion of health, the understanding of the biopsychosocial aspects of physical and mental illness, and the improvement of the health-care system. The main areas of health psychology are stress and coping, health behaviors, and issues in health care.
- Three major organizations cater to those using the biopsychosocial model: the Society of Behavioral Medicine, Society for Health Psychology, and American Psychosomatic Society.

KEY TERMS

behavioral medicine
biomedical approach
biopsychosocial approach
culture
epidemiology
health
health psychology
morbidity
mortality
socioeconomic status (SES)
Traditional Chinese Medicine (TCM)

ESSENTIAL READINGS

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