INTRODUCTION

A Brief History of Health Psychology

In the era of the hunter-gatherer, cave paintings and other relics yield evidence of an early human fascination with an imagined world of spirits and magic. A key element in such icons is a desire for survival aided by communication between body and spirit with the mind as mediator. The idea of body–mind–spirit integration can be traced to the earliest period of history, circa 10,000 BC. Shamanistic healing practices of a spiritual nature survive to the present day. Contemporary concepts of healing, health and illness are founded on these ancient systems.

Early physicians, hypnotists and healers were intrigued by the mysterious ways in which the emotions affect bodily functioning. The hypnotists of the 18th and 19th centuries were aware of the power of imagination and suggestion over mental states, somatic perceptions and pain. The psychoanalysts developed theories about unconscious, emotional processes that apparently guide, not only dreams, but also behaviour and conscious experience. The field of psychosomatic medicine studies mind–body relationships in different conditions of mental and physical health. Health psychology applies psychological knowledge and techniques to health, illness and health care.

Like its parent discipline of psychology itself, health psychology has a short history but a long past. The term 'health psychology' entered the lexicon in the last quarter of the 20th century. After a gestation period in the 1970s, health psychology took its name in 1979 when the first book with the term 'health psychology' in the title was published (Stone et al., 1979). In the same year George Stone (1979), in 'Patient compliance and the role of the expert', argued that 'compliance' should be considered an attribute of the client–expert transaction rather than of the client alone.[1] Understanding the essentially social nature of client–professional transactions became a formative principle in the development of a new 'biopsychosocial' model as an alternative to the biomedical model.

The biopsychosocial model defines health and illness as: 'the product of a combination of factors including biological characteristics (e.g. genetic predisposition), behavioural factors (e.g. lifestyle, stress, health beliefs), and social conditions (e.g. cultural influences, family relationships, social support)' (American Psychological Association, 2001). This 'model'[2] is a foundation stone for the mainstream development of health psychology. The

Division of Health Psychology was founded within the American Psychological Association in 1980. The European Health Psychology Society was established in 1984 and the Health Psychology Section of the British Psychological Society in 1986.

The importance of psychological processes in the experience of health and illness is being increasingly recognised by professionals and lay people alike. Evidence for the role of behaviour in current trends of morbidity and mortality is accumulating apace. Epidemiological research shows that certain behaviours are strongly associated with morbidity and mortality (Marks, Murray, Evans and Willig, 2000). The 1980s and 1990s was a period of rapid growth for the field. Developments in clinical practice have also encompassed psychological knowledge and expertise, and health psychologists are in increasing demand in clinical and medical settings. In the USA, the single largest area of placement of psychologists in recent years has been in medical centres. Psychologists have become vital members of multidisciplinary clinical and research teams in rehabilitation, cardiology, paediatrics, oncology, anaesthesiology, family practice, dentistry, and other medical fields.

In reviewing the development of health psychology in the USA, Wallston (1993) stated:

> It is amazing to realise that formal recognition of the field of health psychology in the United States occurred less than 20 years ago. It is no longer correct to speak of health psychology as an 'emerging' speciality within American psychology; for the last dozen or so years, health psychology has flourished as one of the most vibrant specialties within the larger discipline of psychology. Not only is it recognised as a specialty in its own right, health psychology has had a profound impact upon clinical psychology, and has played a major (if not the major) role in developing and vitalising the interdisciplinary field called 'behavioural medicine'. (Wallston, 1993: 215)

The overlap with behavioural medicine in both theory and practice has been strong and, like behavioural medicine, health psychology is really an interdisciplinary field (Marks, 1996). Most of the leading causes of mortality have substantial behavioural components and these behavioural risk factors are the main focus of efforts in the area of health promotion and disease prevention, e.g. drug and alcohol use, unsafe sexual behaviour, smoking, diet, a sedentary lifestyle. Psychological methods and expertise are playing an increasing role in treatment and rehabilitation.

Contrasting Approaches to Health Psychology

Four parallel approaches to health psychology are evolving. The first is 'clinical health psychology' that is based on the biopsychosocial model and involves working within the health care system. It locates professional health psychology within hospitals and clinics and is similar in nature to (and partly overlapping with) clinical psychology. The environment for

practice is the health care market place. Outside of the clinical domain, the second approach, 'public health psychology', includes psychological aspects of health education and health promotion. This has been discussed by health psychologists (Winett, King and Altman, 1989; Bennett and Murphy, 1997; Wardle, 2001) and health promotion specialists (see Reading 20, Macdonald, 2000; Nutbeam and Harris, 1999). Public health psychology sees individual health more as an outcome of social, economic and political determinants than a simple consequence of individual behaviour and lifestyle. Public health psychology is a multidisciplinary activity involving epidemiological studies, public health interventions and evaluation. The third approach is 'community health psychology' that is based on community research and social action. This is part of community psychology, working on health promotion and illness prevention among healthy people as members of communities and groups. The fourth evolving approach is that of 'critical health psychology' which aims to analyse how power, economics and macrosocial processes influence health, health care, health psychology, and to study the implications for health psychology theory and practice. A summary of the four approaches is presented in Table 1.

All four approaches are represented in this Reader. Many health psychologists use more than one of these approaches, and some use three or even all four. The four styles of working complement each other and, when they are integrated, will be a powerful set of tools for the improvement of the health care system. Clinical psychologists have been working within the health care system for several decades. The research, training and practice of clinical psychologists focus on mental health, mental illness and mental disabilities. Health psychologists' primary interest is the psychological aspects of physical health, physical illness and physical disabilities. The two sub-fields of clinical and health psychology complement each other and, ideally speaking, they should eventually merge. Bottlenecks at entry points into clinical psychology, and the rapid expansion of training in health psychology, mean that, in another decade or two, roughly equal numbers of professionals could populate the two sub-fields. National health services will be able to recruit psychologists specialising in either mental or physical health. Guidelines for professional training programmes and ethical codes of practice have been developed in the USA, Europe and elsewhere (Marks et al., 1998; Marks, Sykes and McKinley, in press). Training programmes at both masters and doctoral level are multiplying rapidly.

The success and future progress of health psychology depend upon the ability of practitioners to help to deliver genuine health improvements and more effective treatments. This is where the absolutely crucial importance of research comes into force. The research base of health psychology must be well founded and reflect the needs of the primary users. That's you, me, everyone who will, one day, end up in a clinic or a hospital or who wants to change things for the better. But health is not simply the business of the health care system but of society as a whole. Having good health across the population is a priority for any progressive society. If health for all is to be a

TABLE 1 **The Characteristics of Clinical, Public, Community and Critical Health Psychology (Marks, 2002)**

Characteristic	Clinical health psychology	Public health psychology	Community health psychology	Critical health psychology
Definition	*'The aggregate of the specific educational, scientific, and professional contributions of the discipline of psychology to the promotion and maintenance of heath, the prevention and treatment of illness, the identification of etiologic and diagnostic correlates of health and illness and related dysfunctions, and the analysis and improvement of the health care system and health policy.'* (Matarazzo, 1982)	The application of psychological theory, research and technologies Towards the improvement of the health of the population.	*'Advancing theort, research and social action to promote positive well-being, increase empowerment, and prevent the development of problems of communities, groups and individuals.'* (Society for Community Research and Action, 2001)	The analysis of how power, economics and macro-social processes influence health, health care and social issues, and the study of the implications for the theory and praxis of health work
Theory/ philosophy	Biopsychosocial model Health and illness are: *'the product of a combination of factors including biological characteristics (e.g. genetic predisposition), behavioural factors (e.g. lifestyle, stress, health beliefs), and social conditions (e.g. cultural influences, family relationships, social support)'* (APA, 2001).	No single theory and philosophy; supportive role in public health promotion which uses legal and fiscal instruments combined with preventive measures to bring about health improvements. Working towards general theories, e.g. health literacy improves health.	Social and economic model: *'Change strategies are needed at both the individual and systems levels for effective competence promotion and problem prevention.'* (Society for Community Research and Action, 2001). Acknowledges the interdependence of individuals and communities Shares some of the aims of public health psychology, e.g. improving health literacy	Critical psychology: Analysis of society and the values, assumptions and practices of psychologists, health care professionals, and of all those whom they aim to serve. Shares some of the aims of community health psychology, but with universal rather than local constituency
Values	Increasing or maintaining the autonomy of the individual through ethical intervention	Mapping accurately the health of the public as a basis for policy and health promotion, communication and interventions	Creating or increasing autonomy of disadvantaged and oppressed people through social action;	Understanding the political nature of all human existence, freedom of thought; compassion for others

(*Continued*)

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Characteristic	Clinical health psychology	Public health psychology	Community health psychology	Critical health psychology
Context	Patients in the health care system, i.e. hospitals, clinics, health centres	Schools, work sites, the media	Familes, communities and populations within their social, cultural and historical context	Social structures, economics, government, and commerce
Focus	Physical illness and dysfunction	Health promotion and disease prevention	Physical and mental health promotion	Power
Target groups	Patients with specific disorders	Population groups who are most vulnerable to health problems	Healthy but vulnerable or exploited persons and groups	Varies according to the context: from the entire global population to the health of an individual
Objective	To enhance the effectiveness of treatments	To improve the health of the entire population: reducing morbidity, disability, and avoidable mortality.	Empowerment and social change	Equality of opportunities and resources for health
Orientation	Health service delivery	Communication and intervention	Bottom-up, working with or alongside	Analysis, argument, critique
Skills	Assessment, therapy, consultancy and research	Statistical evaluation; knowledge of health policy; epidemiological methods	Participatory and facilitative; working with communities; community development	Theoretical analysis; critical thinking; social and political action; advocacy; leadership
Discourse and buzz words	'Evidence-based practice'; 'Effectiveness'; 'Outcomes'; 'Randomised controlled trials'	'Responsibility'; 'Behaviour change'; Risk'; 'Outcomes'; 'Randomised controlled trials'	'Freedom'; 'Empowering'; 'Giving voice to'; 'Diversity'; 'Community development'; 'Capacity building'; 'Social capital'; 'Sence of community'; 'Inequalities'; 'Coalitions'	'Power'; 'Rights'; 'Exploitation'; 'Oppression'; 'Neo-Liberalism'; 'Justice'; 'Dignity'; 'Respect'
Research methodology	Efficacy and effectiveness trials; Quantitative and quasi-experimental methods	Epidemiological methods; Large-scale trials; Multivariate statistics; Evaluation	Participant action research; coalitions between researchers, practitioners and communities; multiple methodologies	Critical analysis combined with any of the methods used in the other three approaches

real possibility, the inequities, which are so evident in our streets and in our statistics, must be significantly reduced. Current trends, however, show a widening of the gaps, so there is a lot of work to be done at the policy and economic levels. The psychological aspects of health and illness must be considered in the context of the economic and social environment of people's everyday lives.

Health Psychology is Still Developing

Health psychology is dynamic field that is still developing. It is not a fixed, well-established activity with well-tried practices and formulas. All who are in the health psychology field can influence its nature and progress. There is room for new ideas, debate and dialogue. Hot topics for discussion are: theories about the nature of health and its determinants; method; and embodiment – how the material and biological body can be the location for meaning, value and intention. Individual behaviour is both socially and biologically determined. The social context of experience and behaviour, and the social and economic determinants of health, are seen as fundamental to a full understanding of the field. Economic and political changes have considerable, long-lasting influence on human well-being. Warfare and terrorism remain intermittent threats to human security. The gap between the 'haves' and the 'have-nots' widens, the Western population is ageing, and the impacts of learned helplessness, poverty and social isolation are becoming increasingly salient features of society. The health and psychological impacts of global warming and energy addiction present many challenges for the 21st century. To quote Shelley Taylor: 'The only aspect of health psychology that is more exciting than its distinguished past and its impressive present, is its promising future' (Taylor, 1986: 17).[3]

As currently defined, health psychology is the application of psychological theory, methods and research to health, physical illness and health care. Human well-being is a complex product of genetic, developmental and environmental influences. In accordance with the World Health Organisation (WHO) definition, health is seen as well-being in its broadest sense, not simply the absence of illness. Expanding the WHO definition, well-being is the product of a complex interplay of biological, socio-cultural, psychological, economic and spiritual factors. The promotion and maintenance of health involves psychosocial processes at the interface between the individual, the health care system and society (Marks, Murray, Evans and Willig, 2000).

Health psychology is concerned with the psychological aspects of the promotion, improvement and maintenance of health. The *ecological context* of these psychological aspects of health includes the many influential social systems within which human beings exist: families, workplaces, organisations, communities, societies and cultures (Dahlgren and Whitehead, 1991; Marks, 1996; Marks, Murray, Evans and Willig, 2000). Any psychological activity, process, or intervention that enhances well-being is of interest to

health psychology. Equally, any activity, process, or circumstance which has psychological components and which threatens well-being is of concern to health psychology. Interventions need to be designed in the light of the prevailing environmental conditions that contain the contextual cues for health-related behaviours.

The mission of health psychology is to promote and maintain well-being through the application of psychological theory, methods and research, taking into account the economic, political, social and cultural context. The vision of health psychology is to employ psychological knowledge, methods and skills towards the promotion and maintenance of well-being. The latter extends beyond hospitals and clinics – it includes health education and promotion among the healthy population as well as among those who are already sick.

The application of psychological knowledge, methods and skills in the promotion and maintenance of well-being is a multi-faceted activity; it is not possible to define the field narrowly. There are many different settings and situations in which psychologists may have a role in promoting and maintaining human health. The psychologist often will be working with lay people, many of whom are patients' relatives, acting as informal carers: 'People are not just consumers of health care, they are the true primary care providers in the health care system' (Sobell, 1995: 238). The psychologist will also work with communities, providing support and expertise to promote their agendas and goals and to help breakdown the barriers that are put up by more powerful factions to reduce their freedom and potential to flourish and grow.

Notes

1 For a brief biography of George Stone, see Marks (1997a).
2 In Parts I and V, we will have reasons to question the biopsychosocial model.
3 For a brief biography of Shelley Taylor, see Marks (1997b).