Editorial: Health Psychology and Public Health—Bridging the Gap

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Background

THE MOST recently published World Health Report—World Health Report 2002: Reducing risks, promoting healthy life (WHO, 2002)—has again identified the fundamental importance of health behaviours, and risk factors under behavioural control, as causes of much of the world’s burden of disease. Indeed, the report states that the 10 leading preventable risks to global health include unsafe sex, smoking, abusive alcohol consumption, low fruit and vegetable intake, physical inactivity, both underweight and overweight, high blood pressure, hypercholesterolaemia and iron deficiency (p. 91), each of which has behavioural underpinnings. The key disease and illness threats to global health to which these factors contribute include ischaemic heart disease, cerebrovascular disease, lung cancer and chronic obstructive pulmonary disease, AIDS and unipolar depressive disorders. The report states that overall, these threats account for an estimated 54 per cent of the 56 million deaths that occur world-wide each year, and a third of the global loss of healthy life years. There is clearly no doubt that disease prevention and health promotion have a very important role to play in improving global health in the years ahead.

In this context, health psychology has, by definition, much to offer, as is evident in Matarazzo’s milestone explication:

Health psychology is the aggregate of the special educational, scientific, and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, the identification of the etiologic and diagnostic correlates of health, illness, and related dysfunction. (1980, p. 815)

This was amended by APA by adding ‘...and the analysis and improvement of the health care system and health policy formation.’ (cf. Matarazzo, 1982, p. 4), and subsequently adopted by most health psychology organizations and textbooks.

This definition has set the stage for health...
psychology to focus particularly on individual, personal and interpersonal processes contributing to individual health, drawing broadly from the social and behavioural sciences. In contrast, public health has traditionally focused more on those environmental, institutional and societal processes that enhance the health status of populations, drawing upon a large range of scientific disciplines and using a range of different methods (Last, 1995, p. 134). Notwithstanding this traditional difference between health psychology and public health, it is clear that over time health psychology is becoming more important as one of the key fields underpinning the practice of public health, as is behavioural medicine (Oldenburg, 2002).

More specifically, health psychology makes an important contribution to the practice of public health at three different levels:

1. At a theoretical and conceptual level, health psychology’s contributions are quite diverse. This discipline contributes to our understanding of health and illness, among other things by proposing and studying quality of life as an important objective of efforts to improve health (Kaplan, Mccutchan, Navarro, Anderson, Atkinson, Chandler, Grant, & the HNRC Group, 1994; O’Boyle, 1997), by reinforcing a more positive view of health (Taylor, Kemeny, Reed, Bower, & Grue newald, 2000) and by examining possible negative effects of health care (e.g. Lerman, Trock, Rimer, Boyce, Jepson, & Engstrom, 1991). It also expands our understanding of determinants of health and illness: it provides us with a strong and growing evidence base for understanding the role of, among others, lifestyle, chronic stress, social relations and, more recently with the role of positive emotions, optimism and spirituality (Thore sen, 1999). It assists, furthermore, with the elaboration of models for understanding behaviour and behavioural adaptations. In this respect social-cognitive models have been very important and are gradually being complemented by more socio-ecological models. Finally, it expands our knowledge of health behaviour by exploring new aspects of health-related behaviour, like the link between health motives at an individual and at a social level (Kals & Montada, 2001), or by looking at health-related behaviours that were until recently neglected, such as political participation (von Lengerke, 2001; see also Rütten, von Lengerke, Abel, Kannas, Lüschen, Rodríguez Díaz, Vinck, & van der Zee, 2000).

2. At the level of application and interventions, health psychology’s sound base of knowledge about health behaviours and other steps in the multilevel causal chain to health can be used to guide efforts at changing behaviour. For instance, the field has contributed to numerous intervention strategies in health education, with techniques for modifying behaviour, and enhancing motivation and learning for health. More recently, multilevel intervention models, including environmental and policy variables, are being increasingly proposed and tested (e.g. Winett, Anderson, Whiteley, Wojcik, Winett, Rovniak, Graves, & Galper, 1999). These latter approaches have a lot to offer in order to further our understanding of measures that have originated from other public health disciplines, such as policy (e.g. tax policies) and environmental (e.g. healthy cities) approaches to health promotion, which can thereby be used to develop and implement more appropriate programmes.

3. Finally, health psychology can contribute to the promotion of health and prevention of disease by the development and application of methodological and analytic standards that have been inherited from the associated fields of statistics, general methodology and test theory, which can also be used to complement more traditional epidemiological methods (Raphael & Bryant, 2002). For instance, multivariate analysis techniques such as factor analysis are routinely employed in psychology; also, the relative contributions that can be made to our knowledge by quantitative and qualitative research methods, and how these yield pieces of information that complement each other (Murray & Chamberlain, 1999), is a relevant case in point. Moreover, psychology’s rich armamentarium of diagnostic instruments, tests and assessment tools may contribute to many public health tasks such as health surveillance. Finally, it can also contribute to the discussion about the nature of ‘evidence’
in health promotion and public health (McQueen, 2001).

Following a symposium which examined various aspects of the relationship between health psychology and public health, held as part of the Scientific Programme of the 2001 European Health Psychology Society Conference in St Andrews, Scotland, we set out to bring together colleagues that share an interest in promoting the collaboration between health psychology and public health. This Special Issue of the Journal of Health Psychology is the result of this ongoing interaction, and we hope it will stimulate further interest in, and dialogue on, the complex relationships between these two fields. But first, we should examine what has been achieved so far.

Health psychology and public health—what has been achieved so far?

The emergence and broadening of the fields of health psychology, behavioural health and behavioural medicine from the late 1970s through to the 1990s has helped to develop and strengthen the psychological underpinnings of disease prevention and health promotion with a specific focus on key health behaviours like smoking, sedentary lifestyle and dietary behaviours. This followed the steady increase in evidence emanating from the large prospective epidemiological studies related to heart disease, cancer and other conditions, in the years following the Second World War. Collectively, the results from these studies have enhanced our understanding of the interplay of biological, psychological, behavioural, social and environmental factors associated with the development and pathogenesis of many different diseases and conditions.

In this process a number of things have been achieved. In the first place the social and behavioural sciences, including health psychology, have helped to generate many of the theories and models—e.g. Social Cognitive Theory (SCT)—that have provided an important link between understanding the modifiable determinants of disease and health, and development, implementation and evaluation strategies for disease prevention and health promotion (Oldenburg, 2001; see also Bandura, 1998). Second, a strong evidence base was built that confirms the contribution of psychosocial factors, such as a ‘sense of control’, social support networks, personal resilience, family environment and chronic stress, to a wide range of health and social problems. Third, since primary prevention and health promotion almost always involve behaviour change, behavioural theories and behavioural interventions, whether directed at the individual or societal level, have been elaborated. Some of the theories which have been used most frequently in the field of prevention include, besides SCT, the Health Belief Model, the Theories of Reasoned Action and Planned Behaviour, Protection Motivation Theory, Health Locus of Control-Theory and stage theories such as the Transtheoretical Model of Change (see Conner & Norman, 1996; Glanz, Rimer, & Lewis, 2002). As noted by Winett, King and Altman:

The health psychology field brings with it a rigorous scientific method for understanding human behavior, a tradition of delineating the individual contexts of health and disease, and a burgeoning armamentarium of techniques and approaches for modifying behavior and enhancing motivation and learning. (1989, pp. 27–28)

A number of large primary prevention trials targeting health risk factors for cardiovascular disease have been based on concepts and principles derived from such theories. The Stanford Three Community Study (Farquhar & Maccoby, 1977) demonstrated the feasibility and effectiveness of mass media-based educational campaigns and achieved significant reductions in cholesterol and fat intake. The Minnesota Heart Health Project (Mittelmark, Luepker, & Jacobs, 1986), the Pawtucket Heart Health Program (Lefebvre, Lasater, Carleton, & Peterson, 1987) and the Stanford Five-City Project (Farquhar, Fortmann, Flora, Taylor, Haskell, Williams, Maccoby, & Wood, 1990) used interventions aimed at raising public awareness of risk factors for coronary heart disease (cholesterol, obesity, cigarette smoking), and changing risk behaviours through education of health professionals and environmental change programmes such as grocery store and restaurant food labelling.
The North Karelia Project in Finland (Puska, Tuomilehto, Nissinen, & Vartianen, 1995) was initiated in response to research demonstrating that Finland had one of the highest rates of heart disease in the world in the 1940s. The prevention strategies were broad, diverse and multilevel, including tobacco taxation and related restrictions, televised instruction in skills for non-smoking and vegetable growing and extensive organization and networking to build an education and advocacy organization. After 10 years, results indicated significant reductions in smoking, blood pressure and cholesterol, and a 24 per cent reduction in coronary heart disease mortality among middle-aged males. Between 1972 and 1992, cardiovascular disease mortality declined in Finland by 55 per cent among men and 68 per cent among women, which was primarily attributed to dietary change.

Of course these are only a few of the most well-known examples of how health psychology has already made a substantial contribution to public health efforts. However important and rich this tradition, we believe that this still does not realize the full potential of health psychology’s contribution to disease prevention and health promotion.

Health psychology and public health—how can we proceed?

We feel that some characteristics of mainstream health psychology hinder both its actual and potential contributions to public health efforts because health psychology has traditionally restricted its scope to an individually or group-focused approach and to a restricted range of intervention strategies; furthermore, health psychologists have tended to feel uneasy with some important aspects of a population health approach. We propose the following directions for the future of health psychology:

1. Health psychology should expand its scope to include a much stronger population perspective. Over the last decade, several authors have drawn attention to the fact that the main scope of health psychology has been restricted largely to the individual and small group levels, and that this is unfortunate (Chesney, 1993; Ewart, 1991; Marks, 1996; Winett, 1985). This individual approach is less problematic for ‘clinical’ health psychology, where a large proportion of work is done with individual clients. The problem with an individualistic approach becomes evident, however, when it comes to prevention and health promotion. In prevention, risk groups are sometimes very large portions of the population, as is the case with obesity, physical inactivity or smoking. This population perspective is even more prominent in health promotion; here the population is the target as well as the active force of health promoting efforts, like, for example, in the Healthy Cities-movement.

2. Health psychologists have to learn to use a broader range of interventions, drawing on determinants of behaviour at multiple levels. In health psychology there was, until recently, a strong tendency to rely primarily on health education interventions based on social-cognitive models, with much less attention for other very relevant factors, e.g. environmental factors (Chesney, 1993; Orbell, Norman, Ogden, Abraham, Bennett, Conner, & Sheeran, 1994; Vinck & Chesney, 1996; Winett et al., 1989). In recent years, there has been an increasing number of efforts reported which have aimed to incorporate a broader range of social-environmental strategies (Burgoyne & Jason, 1991; Chesney, 1993; King, Stokols, Talen, Brassington, & Killingsworth, 2002; Stokols, Allen, & Bellingham, 1996; Winett, 1995; Winett, King, & Altman, 1989, 1991).

It has indeed become very clear that behaviour cannot be understood when it is isolated from the context in which it is enacted; in other words, there is a need for a more ecological approach to behaviour (Sallis & Owen, 2002). This implies that important determinants of behaviour are situated at an environmental and societal level and that lasting changes in the behaviour of the population will not occur unless these environmental and societal determinants (e.g. road infrastructure, legislation in relation to smoking, pricing of alcohol and healthy food) are changed (see Hill & Peters, 1998, for a similar argument regarding obesity).

The tendency to fall back on traditional intervention strategies may be partly related to the relative shortage of descriptions in the professional literature of intervention techniques from an ecological and motivational
perspective, making them less well known. So when time pressure is high—which is virtually always the case—practitioners easily fall back on, and restrict themselves, to the well-known health education theories and interventions. Regardless, many of the principles of behaviour modification at an individual level can also be translated to interventions at a population level (e.g. Burgoyne & Jason, 1991; Winett et al., 1999).

3. Health psychologists should turn to new target populations and adapt to working in complex systems.

Working with environmental and community variables implies that health promotion professionals largely stop working directly with the ultimate target population, and instead work with systems and with those having control over the environmental determinants of the target population’s behaviour (e.g. politicians, the food industry, local communities—see Heller, 1990; Nathan, Rotem, & Ritchie, 2002; Runyan, 1985). This type of public health practice is often quite different from the professional practice and experience of health psychologists (Simpson, Oldenburg, Owen, Harriss, Dobbins, Wilson, Vita, Salmon, & Saunders, 2000). More research is required on how to work most effectively with such economic and policy systems (Bryant, 2002; DeLeon, Frank, & Wedding, 1995; Lorion, Iscoe, DeLeon, & VandenBos, 1996; Rütten, Lüschen, von Lengerke, Abel, Kannas, Rodríguez Díaz, Vinck, & van der Zee, 2000).

Of course, working at these ‘higher’ levels is complex and health psychologists often feel uneasy managing this complexity with the available resources and feel unable to keep enough control over what is going on to get scientific results. Here we need further work on how to think systematically about these matters (e.g. Boyce, 2002; Hancock, 2001; Sallis, Owen, & Fotheringham, 2000).

Remedies for the problems we have briefly discussed are situated at different levels, and there can also be major differences both within and between countries. For example, there can be profound differences in training and education, professional organization and the ways in which research is funded and conducted.

**Overview of Special Issue**

This Special Issue begins with a number of more general manuscripts. Murphy and Bennett present the state of the art in health promotion, and review areas of public health in which psychological theory is applied and could be developed. Kaplan and colleagues take a critical look at the traditional biomedical contribution to public health, whereas Hepworth reflects on how the educational and professional basis of health psychology should be further consolidated in terms of a public health psychology.

A second group of articles relates to health—and social—psychology’s contributions to public health promotion. While Pinheiro and Spink explore social psychology’s input to integral health care in the promotion of what they term ‘collective health’, Uutela and colleagues demonstrate how health psychology can contribute to large-scale health promotion programmes, taking as their example one of the very first of such undertakings, the North Karelia project. Subsequently, Kok and colleagues present ‘Intervention Mapping’ as a protocol for the use of theories in the development of theory- and evidence-based health promotion programmes.

A third group of articles expands the perspective of the Special Issue by examining public health issues with specific relevance to middle-income economies and giving special attention to the role of socio-economic and cultural aspects. On one hand, from former socialist and now transforming Central-Eastern Europe, both Kopp and colleagues and Piko examine the situation in Hungary, focusing on psychological processes that mediate between relative socio-economic deprivation and morbidity (Kopp et al.), and community orientations and health behaviours (Piko). On the other hand, from the point of view of a rapidly developing South-American economy, Sato and colleagues discuss ways in which psychology has contributed to public health services concerned with workers’ health in the State of São Paulo, Brazil.

Finally, one more group of contributions expands health psychology’s traditional perspective by exploring different aspects of the relationship between health policy and health behaviours. Sykes and colleagues identify specific discourses in the 1996–2000 EU Health
Promotion Programme, and their possible influences on how people think, feel and act, as well as on health promotion practices. Becker and colleagues provide evidence that individual meat consumption on one hand and socio-political commitments regarding general meat production on the other share a common motivational basis. Last, von Lengerke and colleagues, in a multilevel analysis across six European countries, report positive associations of health behaviours with health policy perception both on individual and aggregate levels, suggesting that positive policy appraisals operate as a social climate factor that may foster health behaviours.

As a final point, it is important to remind the reader of some of the relationships between health psychology and public health that, for reasons of time and space, are not taken up in this Special Issue. First, the protection of the environment as a strategy of health promotion is not addressed. Second, no article specifically addresses health issues in low-income economies (i.e. in so-called ‘underdeveloped countries’), which points to the need of intensifying co-operations of scholars from across the globe; also, and relating to the world-wide perspective as well, globalization remains—like for virtually all (at least social) sciences—a challenge to health psychology and public health not dealt with in this issue. Third, empirical assessment of the specific virtues of public participation in health promotion planning, implementation and evaluation represents a task that will expectantly call for substantial efforts. Fourth, the relative unavailability of practical descriptions of behaviour modification techniques at an ecological level remains to be dealt with. Last, ethical questions related to prevention and health promotion are only peripherally dealt with in this Special Issue.

Notwithstanding these limitations, we hope that this Special Issue will find the interest of many involved in health research and promotion, and ultimately make an important contribution to bridging the gap between health psychology and public health.

References


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