DETERMINANTS OF HEALTH

1.PSYCHOLOGICAL ASPECTS

1.1 HEALTH PSYCHOLOGY

- Health psychology is a relatively recent yet fast growing sub-discipline of psychology.

- It is best understood by answering the following questions:
  - What causes illness and who is responsible for it?
  - How should illness be treated and who is responsible for treatment?
  - What is the relationship between health and illness, and between the mind and body?
  - What is the role of psychology in health and illness?

- Human beings are complex systems and illness can be caused by a multitude of factors, not just a single factor such as a virus or bacterium.

- Health psychology attempts to move away from a simple linear model of health and looks at the combination of factors involved in illness – biological (e.g. a virus), psychological (e.g. behaviours, beliefs) and social (e.g. employment).

- This approach reflects the **biopsychosocial** model of health and illness that was developed by Engel (1977, 1980).

- Because, in this model, illness is regarded as the result of a combination of factors, the individual is no longer simply seen as a passive victim of some external force, such as a virus.

- Acknowledging the role of behaviours such as smoking, diet and alcohol, for example, means that the individual may be held responsible for their health and illness.

- According to health psychology, the whole physical changes that occur due to ill health.

- This can include **behaviour change, encouraging changes in beliefs and coping strategies, and compliance with medical recommendations**.

- Because the whole person is treated, the patient becomes partly responsible for their treatment.

- From the health psychology perspective, health and illness exist on a continuum; rather than being either healthy or ill, individuals are considered to progress along a **continuum** from healthiness to illness and back again.

- Health psychology also maintains that the **mind and body interact;** it sees psychological factors as not only possible consequences of illness (after all, being ill can be depressing), but as contributing to all the stages of health, from full healthiness to illness.

Behaviour and mortality

- It has been suggested that 50 per cent of mortality from the ten leading causes of death is due to behaviour.

- If this is correct, then behaviour and lifestyle have a potentially major effect on longevity.

- For example, Doll and Peto (1981) estimated that tobacco consumption accounts for 30 per cent of all cancer deaths, alcohol 3 per cent, diet 35 per cent, and reproductive and sexual behaviour 7 per cent.

- As health behaviours seem to be important in predicting mortality and longevity, health psychologists have attempted to increase our understanding of health-related behaviours.

- In particular, based on the premise that people behave in line with the way they think, health psychologists have turned to the study of **health beliefs** as potential predictors of behaviour.



Behaviour can have a major effect on longevity: for example, around 90 per cent of deaths from lung cancer are attributable to cigarette smoking. (Fig. 19.1)

The role of health beliefs

Attribution theory

- The origins of **attribution theory** lie in the work of Heider (1944, 1958), who argued that **individuals are motivated to understand the causes of events as a means to make the world seem more** predictable and controllable.

Health locus of control

- The issue of **controllability** emphasized in attribution theory has been specifically applied to health in terms of the **health locus of control.**

- Individuals differ in their tendency to regard events as controllable by them **(an internal locus of control) or uncontrollable by them (an external locus of control).**

- It has been suggested that health locus of control relates to whether we change our behaviour (by giving up smoking or changing our diet, for instance), and also to our **adherence** to recommendations by a health professional.

- However, the literature regarding this question is mixed.

Unrealistic optimism

- Weinstein (1983, 1984) suggested that one of the reasons we continue to practice unhealthy behaviours is our **inaccurate perceptions of risk and susceptibility.**

- He gave participants a list of health problems to examine and then asked: ‘Compared to other people of your age and sex, are your chances of getting [the problem] greater than, about the same as, or less than theirs?’

- Most participants believed that they were less likely to experience the health problem.

- Clearly, **this would not be true of everyone**, so Weinstein called this phenomenon **unrealistic optimism.**

- Weinstein (1987) described **four cognitive factors that contribute to unrealistic optimism:**

  1. lack of personal experience with the problem;
  2. the belief that the problem is preventable by individual action;
  3. the belief that if the problem has not yet appeared, it will not appear in the future; and
  4. the belief that the problem is infrequent.

- These factors suggest that our perception of our own risk is not a rational process.

- In an attempt to explain why individuals' assessment of their risk may go wrong, and why people are unrealistically optimistic, Weinstein (1983) argued that individuals show selective focus.

- He claimed that we ignore our own risk-increasing behaviour and focus primarily on our risk-reducing behaviour.

- He also argued that this selectivity is compounded by egocentrism.

The stages of change model

- The stages of change model (also known as the transtheoretical model of behaviour) was originally developed by Prochaska and DiClemente (1982) as a synthesis of 18 therapies describing the processes involved in **behavioural change.**

- These researchers suggested a new model of change which has been applied to several health-related behaviours, such as smoking, alcohol use, exercise and personal screening behaviour such as going for a cervical smear or attending for a mammograph.

- If applied to giving up cigarettes, the model would suggest the following stages:

1. Precontemplation: I am happy being a smoker and intend to continue smoking.
2. Contemplation: I have been coughing a lot recently; perhaps I should think about stopping smoking.
3. Preparation: I will stop going to the pub and will buy lower tar cigarettes.
4. Action: I have stopped smoking.
5. Maintenance: I have stopped smoking for four months now.

Integrated models

- Attribution theory and the health locus of control emphasize attributions for causality and control, unrealistic optimism focuses on perceptions of susceptibility and risk, and the stages of change model stresses the dynamic nature of beliefs, time, and costs and benefits.

- These different perspectives on health beliefs have been integrated into structured models.

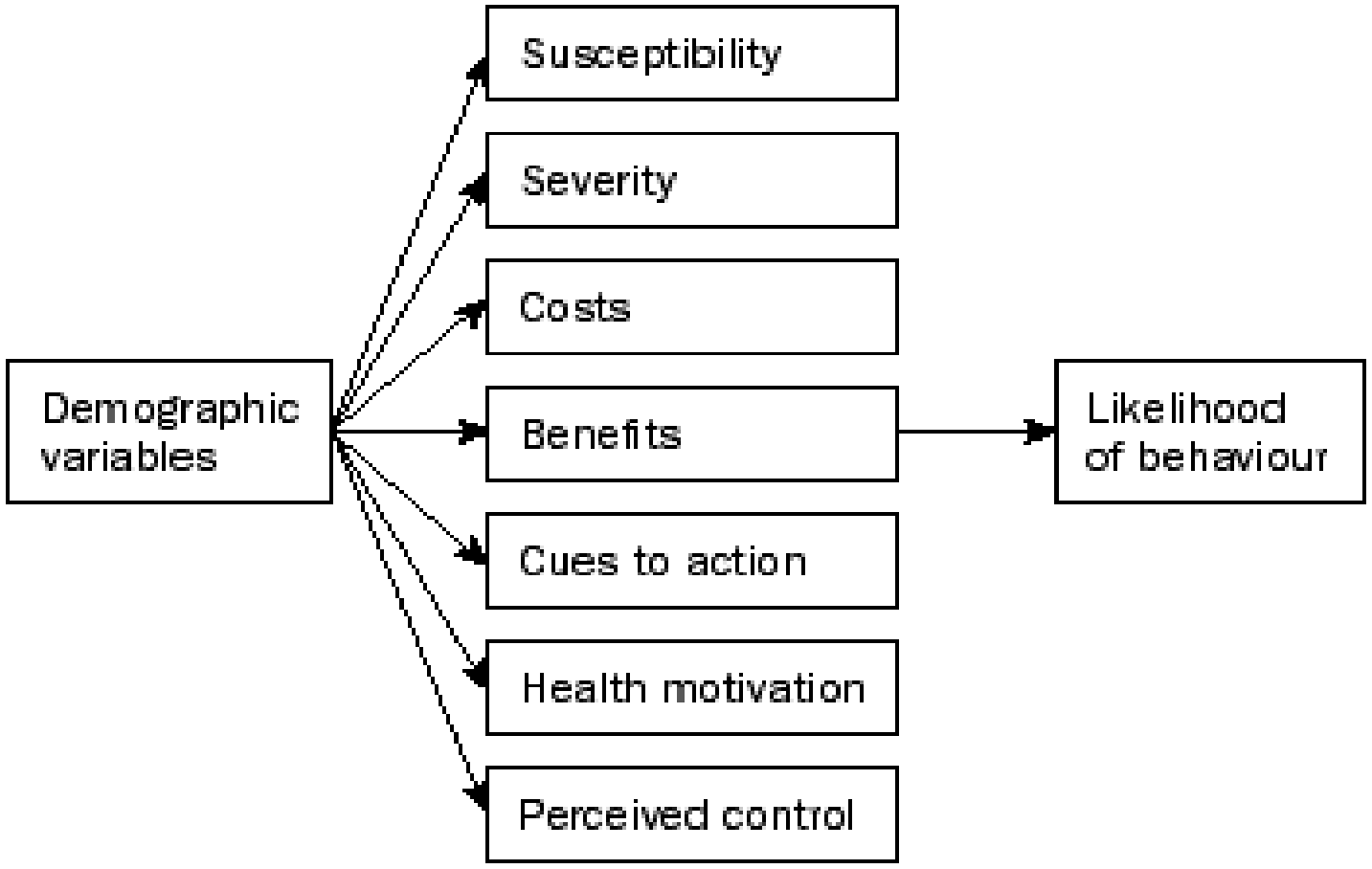
The health belief model

- The health belief model was developed initially by Rosenstock in 1966 and further by Becker and colleagues throughout the 1970s and 1980s (e.g. Becker et al., 1977).

- Their aim was to predict **preventative health behaviours and the behavioural response to treatment in acutely and chronically ill patients.**

- Over recent years, the model has been used to predict many other health-related behaviours.

- The original core beliefs are the individual's perception of:
  - **susceptibility** to illness – 'My chances of getting lung cancer are high';
  - the **severity** of the illness – 'Lung cancer is a serious illness';
  - the **costs** involved in carrying out the behaviour – 'Stopping smoking will make me irritable';
  - the **benefits** involved in carrying out the behaviour – 'Stopping smoking will save me money';
  - **cues to action**, which may be internal (e.g. the symptom of breathlessness) or external (e.g. information in the form of health education leaflets).

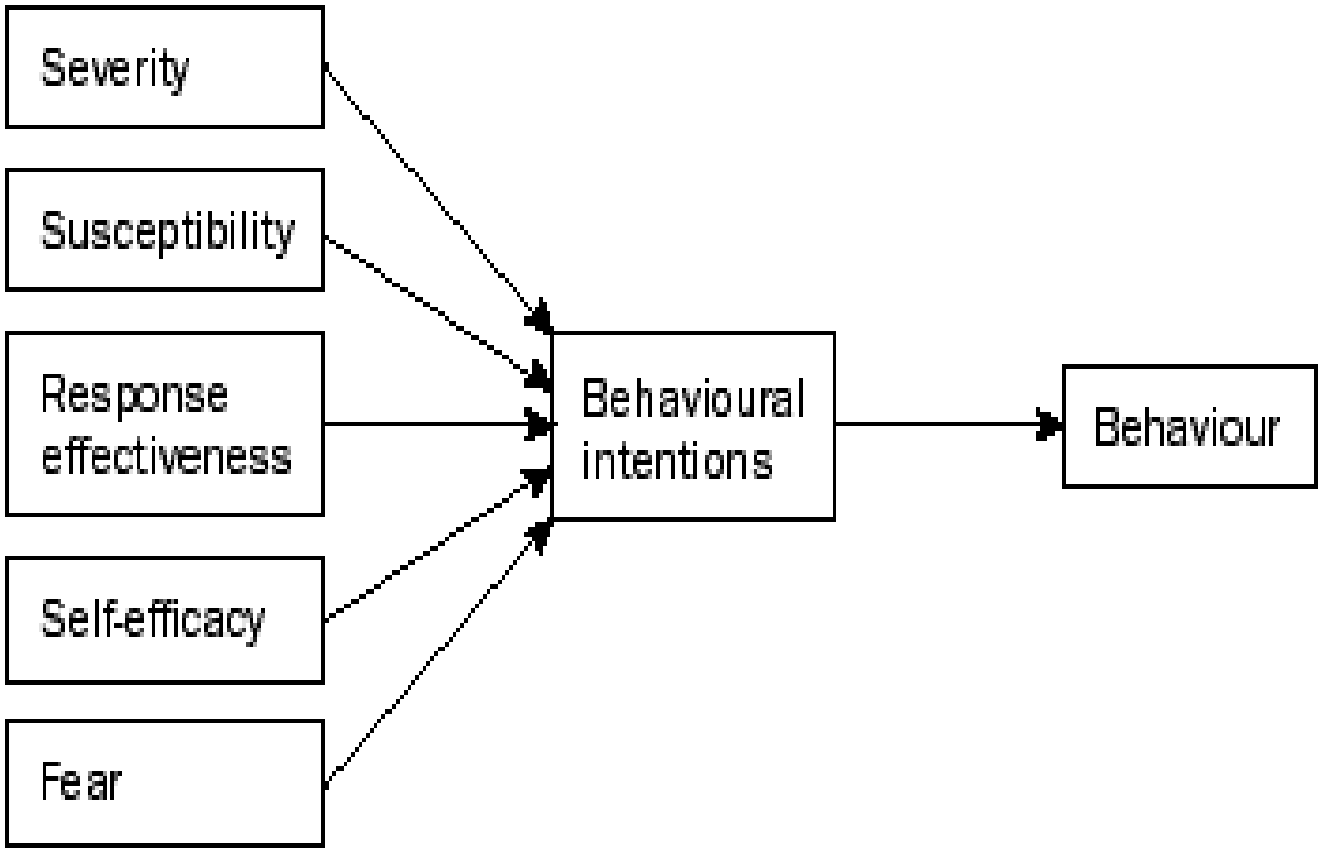


The health belief model. (Fig 19.2)

The protection motivation theory

- Rogers (1975, 1983, 1985) developed the protection motivation theory, which expanded the health belief model to include additional factors.

- The protection motivation theory describes severity, susceptibility and fear as relating to ‘threat appraisal’ (i.e. appraising an outside threat), and response effectiveness and self efficacy as relating to ‘coping appraisal’ (i.e. appraising the individual themselves).



The protection motivation theory. (Fig.19.3)

The theory of planned behaviour

- The theory of planned behaviour was developed by Ajzen and colleagues (Ajzen, 1985; 1988; Ajzen & Madden, 1986).

- It emphasizes behavioural intentions as the outcome of a combination of several beliefs.

- The theory proposes that intentions should be conceptualized as ‘plans of action in pursuit of behavioural goals’ (Ajzen & Madden, 1986), and that these are a result of a set of composite beliefs.

- **Attitude towards a behaviour** – composed of a positive or negative evaluation of a particular behaviour, and beliefs about the outcome of the behaviour.

- **Subjective norm** – this represents the beliefs of important others about the behaviour, and the individual's motivation to comply with such beliefs.

- **Perceived behavioural control** – comprising a belief that the individual can carry out a particular behaviour based on a consideration of internal control factors (e.g. skills, abilities, information) and external control factors (e.g. obstacles, opportunities) – both of which are related to past behaviour.

Illness beliefs

- Leventhal and colleague defined **illness beliefs** as a patient's own implicit, commonsense beliefs about his or her illness.

- They proposed that these beliefs provide a framework, or schema, for coping with and understanding an illness, and for telling us what to look out for if we believe that we are becoming ill.

The dimensions of illness beliefs

- Using interviews with patients suffering from a variety of illnesses, Leventhal et al. identified **five dimensions of illness beliefs:**

1. Identity
2. Perceived cause of the illness
3. Time line
4. Consequences
5. Curability and controllability

Beliefs that influence practice

- Research indicates that the following beliefs influence the development of a health professional's original diagnosis:
  - The nature of clinical problems
  - The probability of the disease
  - The seriousness of the disease
  - The patient
  - Similar patients

The stress–illness link

- The term ‘stress’ means many different things to many people.

- Contemporary definitions of stress regard the external environment as a potential stressor (e.g. problems at work),
- the response to the stressor as stress or distress (e.g. the feeling of tension), and
- the concept of stress as something that involves biochemical, physiological, behavioral and psychological changes.

- Researchers have also differentiated between stress that is harmful and damaging (‘distress’) and stress that is positive and beneficial (‘eustress’).

- The most common definition of stress was developed by Lazarus and Launier (1978), who regarded it as a transaction between people and the environment.

- So a stressful response might be the feeling of stress that results from a **mismatch between:**

a) a situation that is appraised as stressful; and
b) the individual's self-perceived ability to cope and therefore reduce the stress.

Does stress cause illness?

- The relationship between stress and illness is not straightforward, and there is a lot of evidence to suggest that several factors mediate the stress–illness link, including **exercise, coping styles, life events, personality type, social support and actual or perceived control.**

- Stress can affect health through a behavioral pathway (e.g. sleep, food intake and alcohol consumption) and/or through a physiological pathway (e.g. corticosteriods, and changes in activity, such as heart rate).

Stress and behaviour

- Recent research has examined the effect of stress on specific health-related behaviours, such as exercise, smoking, diet and alcohol consumption, in terms of initiation, maintenance and relapse.
- It has also highlighted the impact of stress on general behavioural change.
- For example, research suggests that individuals who experience high levels of stress show a greater tendency to perform behaviours that increase their chances of becoming ill or injured and of having accidents at home, work and in the car.