

person who is profoundly sad after the loss of a loved one is 'clinically depressed' and so on. Over millennia, the health care system has been dominated by medical doctors practising in different specializations. With the exception of nursing, the traditional 'hand-maiden to medicine', other health care professionals (HCPs), including health psychologists, are referred to as 'paramedical'.

Although there are diverse points of view, health psychologists generally hold a holistic perspective on individual well-being, that all aspects of human nature are interconnected. While the primary focus of health psychology is *physical* rather than *mental* health, the latter being the province of clinical psychology, it is acknowledged that mental and physical health are actually 'two sides of one coin'. When a person has a physical illness for a period of time then it is not surprising if they also experience worry (= anxiety) and/or sadness (= depression). If serious enough, 'negative affect' (sadness and/or worry) may become classified as 'mental illness' (severe depression and/or anxiety), and be detrimental to subjective well-being and also to aspects of physical health. Each side of the 'well-being coin' is bound to the other. The distinction between 'health psychology' and 'clinical psychology' is an unfortunate historical accident that is difficult to explain to non-psychologists (or even to psychologists themselves). There is also significant overlap between health and clinical psychology with 'positive psychology' as an integrative new field (Seligman and Csikszentmihalyi, 2000; Seligman et al., 2005) although not without critiques of exaggerated claims (Coyne and Tennen, 2010).

RATIONALE AND ROLE FOR HEALTH PSYCHOLOGY

There is a strong rationale and role for the discipline of **health psychology**. First, the behavioural basis for illness and mortality requires effective methods of behaviour change. Second, a holistic system of health care requires expert knowledge of the psychosocial needs of people.

In relation to point 1, *all* of the leading causes of illness and death are *behavioural*. This means that many deaths are preventable if effective methods of changing behaviour and/or the environment can be found. The mortality rates for different conditions in younger and older people are shown in Table 1.3.

Table 1.3 Leading causes of mortality among adults worldwide, 2002

Rank	Cause	Deaths (000)
Mortality: adults aged 15–59		
1	HIV/AIDS	2,279
2	Ischaemic heart disease	1,332
3	Tuberculosis	1,036
4	Road traffic injuries	814
5	Cerebrovascular disease	783

Rank	Cause	Deaths (000)
6	Self-inflicted injuries	672
7	Violence	473
8	Cirrhosis of the liver	382
9	Lower respiratory infections	352
10	Chronic obstructive pulmonary disease	343
Mortality: adults aged 60 and over		
1	Ischaemic heart disease	5,825
2	Cerebrovascular disease	4,689
3	Chronic obstructive pulmonary disease	2,399
4	Lower respiratory infections	1,396
5	Trachea, bronchus, lung cancers	928
6	Diabetes mellitus	754
7	Hypertensive heart disease	735
8	Stomach cancer	605
9	Tuberculosis	495
10	Colon and rectum cancers	477

Source: www.who.int/whr/2003/en/Facts_and_Figures-en.pdf

BOX 1.4

KEY STUDY: THE GLOBAL BURDEN OF DISEASE STUDY

An important epidemiological perspective comes from measures of 'disability' or 'disablement'. The Global Burden of Disease (GBD) study projected mortality and disablement over 25 years. The trends from the GBD study suggest that disablement is determined mainly by ageing, the spread of HIV, the increase in tobacco-related mortality and disablement, psychiatric and neurological conditions, and the decline in mortality from communicable, maternal, perinatal and nutritional disorders (Murray and Lopez, 1997).

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