

Applied Psychology

Lecture 5: Psychology and Health Promotion

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What is Health Psychology?



The British Psychological Society
Promoting excellence in psychology

The scientific study of psychological processes of health, illness and health care

A branch of psychology that deals with how people cope and manage illness and health behaviour

What is Health Psychology?



The British Psychological Society
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• The main goals of health psychology have been described as:

- The promotion and maintenance of health
- Improving health-care systems and health policy
- The prevention and treatment of illness
- The causes of illness

Topics explored by health psychologists

- Obesity
- Behaviour changes
- Appearance and body image
- Chronic pain
- Stress
- Illness
- The internet and the future of health psychology
- Walking
- Etc, etc, etc

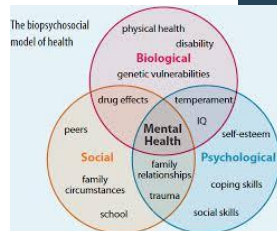
Health Psychology

Health psychology is both an academic discipline and a profession.

- Academic discipline:
 - Research focuses on the causes and processes underpinning health and illness
- Profession:
 - Professional health psychologists work towards improving health care and the delivery of care

A Biopsychosocial Model of Health

- An integrated model of health drawing on many disciplines
- Aims to provide a comprehensive picture of the causes and processes underpinning health and illness
- Supports the integration of biological, psychological, and social factors in the assessment, prevention and treatment of diseases.



What is 'HEALTH'?

Is it simply the
absence of
disease?

How do we
measure health?

WORLD HEALTH ORGANISATION (WHO)

Health needs to be measured on three dimensions:

- Social
- Psychological
- Physical Wellbeing

= QUALITY OF LIFE

Physical functioning

Social support

Depression

Anxiety

*What is Quality
of Life?*

Pain

Occupational functioning

Relationships

Beliefs about illness

Measuring Quality of Life (QoL)

- Reliable
- Valid
- Sensitive to change
- General versus disease-specific measures of QoL

Measuring QoL

WHOQOL Group (1998)

- Individuals perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns
- i.e., the impact of any illness has to be considered across a number of life domains

Individual differences in QoL

What psychological factors predict how well an individual may respond to, or cope with, illness??

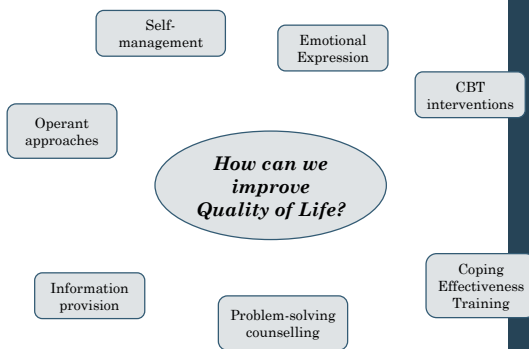
Individual differences in QoL

- Personality type
- Negative affect
- Hardiness
- Optimism
- Hostility

Impact on health indirectly by influencing behaviours in response to health threat

e.g., Type D Personality

- Associated with greater risk of CVD, poorer prognosis and treatment outcomes
- Often described as a 'distressed personality'
- High level of Negative Affective and Social Inhibition
- Denollet et al. (1996) - Type D associated with increased mortality after a cardiac event when controlling for biomedical risk factors
- Likely influence on blood pressure reactivity, heart rate changes and salivary cortisol levels



Health-Related Decision-Making

What is health-related decision-making?



What are some of the key decisions we make in our everyday lives that may have an impact on our physical health?

What factors influence the decisions we may make?

How can Health Psychologists intervene to influence decision-making in order to improve health?

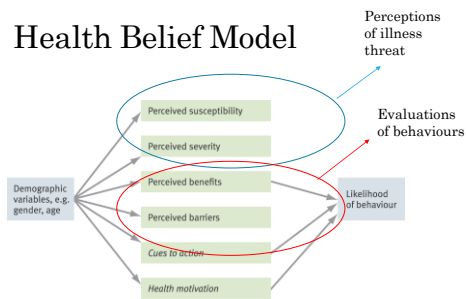
Models and Theories

- Provide an empirically supported framework for understanding how people make decisions
- Identify key factors found to influence decision-making
- Interventions can be targeted at any or all of these factors
- Need to consider generalisability and applicability to specific situations

1. Health Belief Model

(Rosenstock, 1974; Becker, 1974; Becker and Rosenstock, 1984)

Health Belief Model



Health Belief Model

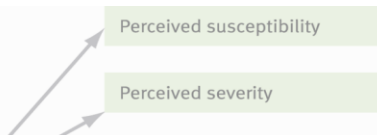
- Proposes that the likelihood that a person will engage in a particular health behaviour depends on demographic factors:
- E.g., Social class, gender, age, and the four beliefs that may arise following a particular internal or external cue to action (namely, perceptions and evaluations, with cues to action and health motivation also added at a later date).

Applying the Health Belief Model

1. How could we apply this model to understanding exercise behaviour?
2. What hypotheses would you identify?
3. How would you research this?



How likely would this person be to change their exercise behaviour?



1. Perception of threat:

I believe that Coronary Heart Disease (CHD) is a serious illness contributed to by being overweight:

perceived severity

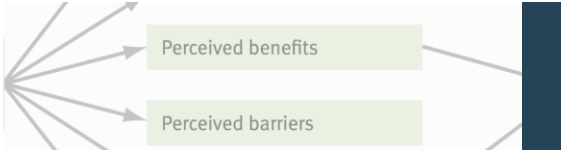
I believe that I am overweight:

perceived susceptibility

2. Behavioural evaluation

If I lose weight, my health will improve

perceived benefits (to change)



Changing my cooking and dietary habits when I also have a family to feed will be difficult, and possibly more expensive

perceived barriers (to change)

3. Cues to action (added in 1975, Becker & Maiman):

That recent television programme on the health risks of obesity worried me

external

I am regularly feeling breathless on exertion, so may I should really think about dieting

Internal



4. Health motivation (added in 1977, Becker, Haifner & Maiman):

It is important to me to maintain my health

How likely is this person to change their exercise behaviour?



Health Belief Model

- May assume or expect that successful behaviour change would occur when the perceived benefits of change outweigh the perceived benefits of continued risk-taking. However, the evidence of this is mixed...
- E.g., Abraham et al. (1996):
 - HBM variables were not significantly predictive of consistent condom use among sexually active adolescents once a measure of previous condom use has been taken into consideration

Limitations of the HBM..

1. Highly salient beliefs (those that hold high importance to use) may enhance the prediction of outcomes beyond a model which employs modal beliefs
2. The HBM may overestimate the role of 'threat'

Limitations of the HBM

3. Takes limited account of social influences on behaviour
4. HBM is a static model – does not allow for staged or dynamic processes

2. The Theory of Planned Behaviour

(Ajzen & Fishbein, 1991)

Attitudinal models

Attitudes: an important influence on Health Behaviour??

What is an attitude?

attitudes are considered as relatively enduring and generalisable and make up of three related parts - thought (cognition), feeling and behaviour

- **Cognitive:** beliefs about the attitude-object, e.g., cigarette smoking is a good way to relieve stress / cigarette smoking is a sign of weakness
- **Emotional:** feelings towards the attitude-object, e.g., smoking is disgusting / pleasurable
- **Behavioural (or intentional):** intended action towards the attitude-object, e.g., I am not going to smoke.

Morrison and Bennett
(2012)

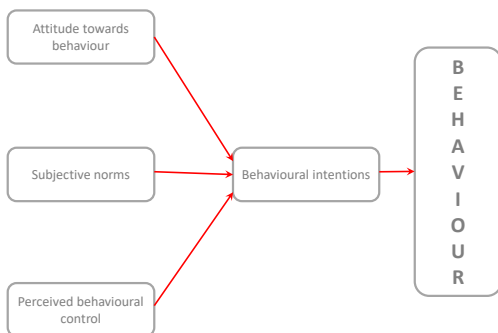
Theory of Planned Behaviour (TPB)

- Social cognition model
 - Social behaviour is determined by beliefs about behaviour in given contexts and not simply by cognitions or attitudes
- Underlying assumption that individuals behave in a goal-directed manner before decisions are made
- Predicts deliberate behaviour, because behaviour can be deliberate and planned

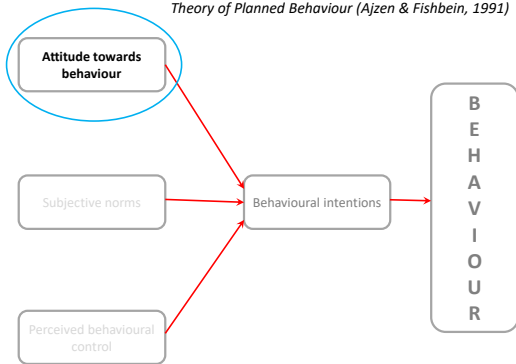
TPB

- Health behaviour is the result of behavioural intentions which are affected by:
 - **Attitudes** towards the behaviour
 - **Subjective norms**
 - **Perceived behavioural control**

Theory of Planned Behaviour (Ajzen & Fishbein, 1991)



Theory of Planned Behaviour (Ajzen & Fishbein, 1991)

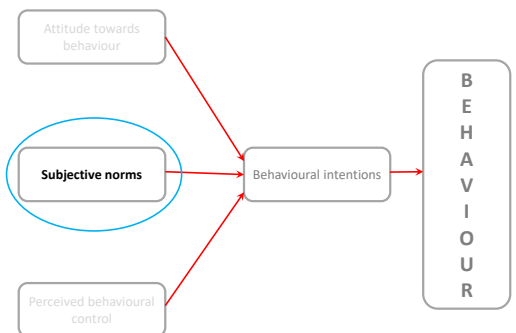


Attitudes towards the object behaviour

Outcome expectancy beliefs X outcome value

- E.g., positive or negative outcome expectancy
 - If I stop smoking, exercise will become easier
 - If I stop smoking I will gain weight
- E.g., outcome value
 - It is important for me to be healthier

Theory of Planned Behaviour (Ajzen & Fishbein, 1991)

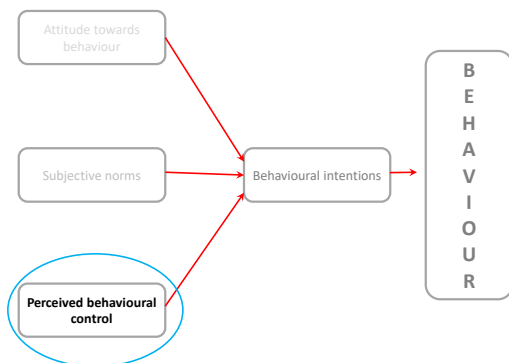


Subjective norms

Normative beliefs X Motivation to comply

- A person's own estimate of the social pressure to perform the target behaviour
- Normative beliefs
 - *How others would like them to behave*
- Motivation to comply
 - *All my friends eat healthier than I do, and I would like to be more like them*

Theory of Planned Behaviour (Ajzen & Fishbein, 1991)



Perceived behavioural control

Perceived internal and external control factors

- Belief that we have control over our own behaviour in certain situations, even when facing particular barriers
 - *E.g., I believe it will be easy for me not to smoke even if I go to the pub in the evening*
- PBC beliefs are influenced by past behaviour and successes or failures in relation to the behaviour in question

Theory of Planned Behaviour

- Person weighs up the pros and cons of quitting smoking and concludes that not smoking can maintain a better state of health

Attitude

- Person feels that his second-hand smoke affects his own and the health of his family and that if he chose to quit, his family would support his decision

Subjective Norm

- Person feels that they could control the amount of cigarettes he has in a day and will slowly wean off them

Perceived Behavioural Control

Evaluation of TPB

- Sutton (2004) - the variables of TPB account for between 35 and 50% of variance in intentions.
- Intention is considered to be the proximal determinant of behaviour, and it reflects both the individual's motivation to behave in a certain manner and how hard they are prepared to try to carry out that behaviour (Ajzen, 1991)
- Compares favourably with the HBM - addition of statement of intent

Evaluation of TPB

- Critiques...?

Intentions do not always predict behaviour...

WHY...?



Critical Evaluation!

- Implementation intentions (Gollwitzer, 1993)
 - People are more likely to engage in an intended behaviour if they identify specific plans to enact that behaviour (where/when/how)
 - e.g., Orbell et al. (1997): Women encouraged to identify a plan to conduct a breast self-examination were more likely to later report having performed a breast self-examination.

Critical Evaluation!

- The model assumes we are always rational decision makers - we are not!
 - Do we always deliberate and consciously weigh up the pros and cons of a given behaviour?
 - Behaviour choices that have become automatic?
 - How easy is it to change attitudes/beliefs underpinning such behaviours?

Critical Evaluation!

- Does 'rational decision-making' actually take place AFTER an event??
 - Is it a rational assessment of potential danger or a way of coping with and rationalising a perceived risk following a behaviour?
 - A 'post-hoc' attempt to reduce the cognitive dissonance between a behaviour and negative attitudes towards that behaviour?
 - e.g., Bennett and Clatworthy (1999): Pregnant women who continued to smoke whilst pregnant were less likely to endorse statements about the harmful effects of smoking on their developing child BUT many still showed attempts to reduce/quit smoking

Some TPB studies..

- Murnaghan et al. (2010): Predictors of physical activity, healthy eating and being smoke-free in teens: A theory of Planned Behaviour approach.
- Rhoades et al. (2011): Understanding overweight adolescents' beliefs using the theory of planned behaviour.

Some TPB studies...

- Martin et al. (2010): Using the theory of planned behaviour to predict gambling behaviour
- Norman and Connor (2006): The theory of planned behaviour and binge drinking: Assessing the moderating role of past behaviour within the theory of planned behaviour

3. Self Regulation Model

(Leventhal et al., 1992)

Leventhal's Self Regulation Model

- People are 'common-sense scientists'
 - We appraise illness situations and health behaviour
- Illness representations

Leventhal's Self Regulation Model

- When faced with a health threat, we form a cognitive and emotional response based upon our beliefs about:

- Identity
- Causes
- Consequences
- Timeline
- Curability/controllability

Leventhal's Self Regulation Model

E.g.,

Sore Throat

Identify the sore throat as the beginning of a cold
(**label**)



Initial cold label determines that it's an acute condition
(**timeline**)



With minor **consequences**, potentially **caused** by a number of factors.



A cold can usually be cured (**control/cure**)

Leventhal's Self Regulation Model



E.g., Outcome?

These attributes of the illness representation making up the 'cold profile' will lead the individual to engage in **common-sense health behaviours!**

e.g., drinking lots of fluid, resting, combating the cold with over-the-counter remedies.

The emotional reactions during these cognitive processes are likely to be muted - possibly ranging from annoyance about the potential impact on work to worrying that the cold is a precursor to something more serious

Genetic risk and the self regulation model

E.g., those who perceive that being at genetic risk is:

- a. *Severe*
- b. *Chronic*
- c. *Uncontrollable*
- d. *and believes that they have an inability to cope emotionally*

Will experience more distress than someone who believes that they can control the same illness and can cope emotionally

e.g., Lancaster, Brain and Phelps (2011)

Negative emotional representation of ovarian cancer risk were moderately associated with greater ovarian cancer specific distress

Cognitive illness representations were weakly related to ovarian cancer-specific distress

Lancaster, D. L., Brain, K., & Phelps, C. (2011). Illness representations and distress in women undergoing screening for familial ovarian cancer. *Psychology and Health*, 26(12), 1659-1677.

Any questions?