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Publisher Routledge

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## Health Psychology Review

Publication details, including instructions for authors and subscription information:

<http://www.informaworld.com/smpp/title~content=t741771149>

### Pick up the pieces and go home - on the demise of health psychology

Ad A. Kaptein<sup>a</sup>

<sup>a</sup> Medical Psychology, Leiden University Medical Centre (LUMC), Leiden, RC, The Netherlands

First published on: 11 February 2011

**To cite this Article** Kaptein, Ad A.(2011) 'Pick up the pieces and go home - on the demise of health psychology', Health Psychology Review, 5: 1, 39 – 47, First published on: 11 February 2011 (iFirst)

**To link to this Article:** DOI: 10.1080/17437199.2010.520114

**URL:** <http://dx.doi.org/10.1080/17437199.2010.520114>

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## **Pick up the pieces and go home – on the demise of health psychology**

Ad A. Kaptein\*

*Medical Psychology, Leiden University Medical Centre (LUMC), PO Box 9600, Post zone J9,  
2300 RC, Leiden, The Netherlands*

*(Received 3 August 2010; final version received 10 August 2010)*

I finally gave up when attending a symposium on social cognition theories at an EHPS Conference: two senior researchers discussed the issue of whether there were intentions that form intentions to use condoms or to use certain types of medications. From the way they approached the topic, I am sure the discussants had never had a detailed discussion with a 19-year-old supermarket cashier worker about her sex life, or listened to an actual patient talk in a real-world setting. Their conference discussion had all the elements of members of a religious sect talking about dogmas in their holy books: humourless, authoritarian, incomprehensibly jargon-filled, with confidence in their absolute wisdom (a North Korean TV-broadcast would pale in comparison). After the conference I continued my research, trying to listen to the stories of lung cancer patients regarding their terminal illness. The ‘unbearable lightness of health psychology’ became very apparent – at least to me.

Am I a grumpy old man? Am I unable to publish potentially exciting stuff myself? Am I embittered? On reflection, I am simply disappointed in where health psychology has gone and where I see it going. I read a substantial range of medical journals, and all health psychology journals. I think I may claim having some publishing and editorial experience in psychology as applied to health and medicine. Yet I am disappointed by the lack of creativity and real-life basis of the majority of research papers in health psychology journals – and I’m worried about the stifling influence of this ‘body of knowledge’ in directing young researchers in an area that, of course, is important – for patients and their relatives, for health care providers and for society at large. I believe Interpretative Phenomenological Analysis (IPA) may help in bringing real life back into psychology as applied to health and medicine.

Earlier papers also discussed some of the issues I’d like to raise here as well (e.g., Coyne, 2010; Marks, 2008; Murray & Campbell, 2003; Ogden, 2003). I’ll discuss: (1) the contribution of health psychology to primary prevention; (2) the value of the theoretical models used in mainstream health psychology for actual human behaviour alongside the apparent arrogance of health psychology researchers; and (3) the value of self-report in health psychology. From this discussion, I will try and

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\*Email: [a.a.kaptein@lumc.nl](mailto:a.a.kaptein@lumc.nl)

assess whether, in my view, (4) IPA is a particularly useful contribution to health psychology research and its applications.

### **Health psychology's contribution to primary prevention**

Textbooks on health psychology claim that health psychology has made a major contribution to 'primary prevention' via behavioural changes in individuals (e.g., Taylor, 2011). Thousands of health psychologists, and especially many a poor Ph.D. student, joined the bandwagon in this quest; under their supervisors' guidance, Ph.D. students undertook studies on smoking tobacco, having sex with or without condoms, drinking alcohol and eating 'enough' vegetables and fruit. Undergraduate psychology students were the favourite samples to study. Yet ever since, there has been an increase in the percentage of smokers, campaigns to stimulate use of condom failed miserably, binge drinking is becoming endemic, alcohol use is up and the '5 a day' campaign encouraging people to eat more fruit and vegetables turned out to be based on flimsy and untenable 'evidence' (Mitka, 2010).

I challenge health psychologists to come up with one example of an effective health psychology primary prevention study in the health psychology domain (Crosby & Noar, 2010). Smoking tobacco? Drinking alcohol? Safer driving behaviour? Safer sexual behaviour? Eating more healthily? As researchers we must be aware that reductions in the number of people smoking tobacco are attributable to public health measures, instigated by societal and political forces (Kaplan, 1990). Earlier, Sackett (2002) made the same assertions regarding the contribution that medicine has made to primary prevention. He describes preventive medicine as 'aggressively assertive, presumptuous, overbearing'. Recently, breast cancer screening was described in a major medical journal (*BMJ*) as having 'limited benefit and some possibility of harm for an individual woman and marginal cost effectiveness for a community' (McPherson, 2010, p. 233). So much for health psychologists who developed theoretical models on intentions of women to participate in breast cancer screening... I maintain that the three elements raised by Sackett (2002) are also clearly and unashamedly visible in papers of health psychology journals. I could pick hundreds of examples, but one will suffice: it is entitled 'sexual risk behaviour among HIV-positive men who have sex with men' and it beautifully illustrates the arrogance of health psychology. After reviewing 53 published studies in the area – a very worthwhile undertaking – the authors conclude that unsafe sex has increased in recent years. Rather than surmising that health psychologists are perhaps quite unsuccessful in influencing behaviour in this context, the authors conclude – of course! – that health psychology 'prevention efforts... need to be intensified' (van Kesteren, Hospers, & Kok, 2007, p. 5).

### **'We need theories!'**

The religious, totalitarian fervour apparent at some large health psychology conferences also reverberates in the 'theories' of many conference delegates. I am amazed at how many professors in health psychology come up with their own 'theory' (or their own 'theoretical model') – something which is not seen in medicine.

A critical analysis of the ‘Transtheoretical (Stages of Change) Model’ has shown that:

- Concepts in the model are artificial and not supported by empirical evidence.
- Individuals do not have coherent and stable plans about their behaviour.
- Concepts in the model are not actually assessed.
- Important underpinnings of human behaviour are not included in the model (West, 2005).

In their paper ‘The OFF theory of research utilization’, Oxman, Fretheim, and Flottorp (2005, p. 115; OFF, as an acronym of the initials of their as names) present a scathing evaluation of what many health psychologists do. These authors conclude that ‘we need less rather than more focus on high-level theories, less rather than more jargon, less dogmatism, more common sense, less theoretical work and more rigorous evaluations that include direct measurement of important concepts’.

Many health psychologists can be heard as maintaining that ‘medicine is unscientific’, ‘medical students are not as intelligent as psychology students’, ‘med school is just a vocational training’. I have had the fortune of working for some 40 years now in medical schools. I also have had the great fortune of collaborating with psychology students and medical students. When one wants to see how physicians use theories about, for example, blood coagulation, breast cancer, or rheumatoid arthritis, I suggest that health psychologists study the journals that focus on basic research in these areas. Papers in those journals bristle with theories and theoretical models. Students in any discipline are bright. It’s their teachers who are able to bring out the best in these young people. The arrogance of health psychologists cannot be stopped, however. Some 10 years ago Ogden (2003, p. 427) already demonstrated how ‘(social cognition) models cannot be tested . . . , they may create and change both cognitions and behavior rather than describe them and as such do not pass the criteria set for a good theory’. Health psychology journals still bristle with papers where social cognition ‘theoretical models’ are being tested. I am not against using theory or theoretical models; I’m not against social cognition theoretical models. I merely suggest being more critical about those models, staying closer to real-life behaviour, studying more interesting research questions, in real-life samples and with more curiosity for the behaviour.

Kaplan (1990, p. 1211) has convincingly and eloquently argued that ‘. . . the only important indicators of health and wellness are behavioral. Thus, outcome measures in health and medicine should be anchored in their relations with behavior . . . biological measures and disease classifications are important precisely because they are predictors or mediators of behavioral outcomes’. His point is that behaviour is the central outcome in health care. Death is, scientifically speaking, a beautiful measure as it is not self-reported and it fits within the line of reasoning: ‘. . . death is a behavioral outcome. It can be defined as the point at which there is no observable behavior’ (Kaplan, 1990, p. 1212).

Kaplan’s point is well-taken by some researchers. Health psychology can be fun. Creative researchers publish papers that make me smile and feel more optimistic regarding the field. For example, Abel and Kruger (2010) recently reported a study on predictors on longevity. Rather than ask people in their twenties about eating habits, sexual behaviour, alcohol consumption and the like, and wait for 50 years to

see who died, they rated degree of smiling on pictures of baseball players in their twenties and found out who of the baseball players still lived or who had died 50 years later, by using year books of baseball players. A genuine smile on a picture of the players in their prime turned out to significantly predict longevity. A creative and elegant approach: important research question, relevant outcome measure that is not self-reported (Figure 1).

### Assessing human (health) behaviour

Self-reports of drinking alcohol, having sex, eating food and using condoms are notoriously unreliable (Schwarz, 1999). This has been highlighted recently in a study on circumcision status in young adults, in which young men were asked to report on the situation of their foreskin. In a sample of 1508 adolescents, mean age 15 years, self reported circumcision status was checked via visual inspection by a (female) nurse (Risser et al., 2004). Results showed that of the fully circumcised subjects, 69% considered themselves circumcised, 7% considered themselves as uncircumcised and 23% did not know. Of the uncircumcised youth, 4% reported being circumcised, and 31% did not know. How much faith can one have in a response to a question in a questionnaire on 'intention to use a condom', one may ask, given these findings on a topic that can safely be defined as sensitive for all involved.

Perhaps the most problematic research designs and studies in health psychology are studies with a 'self-report predicts self-report' format. And those with the next set of elements:

- Undergraduate psychology students as respondents who complete a 30-page questionnaire.
- LISREL analysis is undertaken on the data, with no one knowing what anyone is doing in the analyses.
- Where correlations of 0.07 are significant at a  $p$ -level of 0.0001.
- Where the authors conclude that given the study results in this cross sectional design, intervention studies are indicated in order to prolong longevity.
- The paper is poorly written and does not contain one hint to some sort of fun or humour.



Figure 1. Studying observable behaviour unobtrusively, predicting death (cf. Abel & Kruger, 2010).

In contrast to these kinds of sad ‘studies’, the study of Miller, Tybur, and Jordan (2007) also attempts to explain human behaviour. The dependent variable in this study was the number of US dollars earned by lap dancers in a ‘gentlemen’s club’. Independent variables were NOT intentions to use condoms, attitude towards sexuality, perceived social norms about visiting a gentlemen’s club, etc. It is great fun to read the paper and study how the authors were creative in developing their research question, methodology and data collection. Menstrual status turned out to determine the numbers of dollars earned. The women just before ovulation earned twice as much as compared to when menstruating (of course, there was no way for the visitors of knowing the menstrual status of the women – read the paper to find out more). No self-report predicts self-report, no intentions to give dollars to a topless young attractive woman, no attitudes towards the use of condoms. Count the number of dollars earned by the woman in 4 hours as a reflection of sexual attitudes and behaviour in the human male.

An unwanted finding in health psychology research is when money turns out to be a major determinant of health behaviour. Thousand of papers have been published on social cognition models and compliance (or adherence, or concordance). Still, compliance is an enigma, both in medical and health psychology circles. Health psychologists over the past decades have been unable to predict, increase or change adherence. Giving money to patients to adhere turns out to be the only evidence based way to impact on adherence (Giuffrida & Torgerson, 1997). Recently, a similar finding was reported regarding young women and HIV: payment to girls in poor countries slows spread of HIV (World Bank, in *the Guardian*, 20 July 2010). Financial, economic – and therefore, political – situations are a major determinant of health behaviour, morbidity and mortality, not social cognitive ‘determinants’ (e.g., Marks, 2008).

### Is IPA better?

The paper by Smith (2010) offers a clear view of what IPA has achieved so far. The growth in the number of published papers with an IPA methodology seems to illustrate the perceived attractiveness of the approach, and it may also reflect the growing discontent about the sterile, uncreative and arrogant mainstream quantitative health psychology approach. IPA, almost by definition, is not arrogant, as its research method makes careful listening to patients a *conditio sine qua non*. Superficial listening leads to meaningless findings which, one would hope based on Smith’s quality criteria, would not make it into a publication. Yes, IPA relies, almost by definition, on self-report as well (see Smith’s ‘double hermeneutic’ – p. 2, 2010). Patients lie, patients deny, patients put up a brave face – they do all this in IPA as well. However, talking to a researcher who is sincerely interested in the story of the patient is most likely able to establish a rapport with the respondent that minimises these biases. Telling a story also allows the participant to tell it their way – outlining the things they see as important – rather than forcing that experience into a small number of items with Likert-scale response options, predetermined by a researcher based on questionable theories. And yes, of course, we will never know what the patient really does and feels – unless we sneak around 24 hours a day, recording every sight and sound of our poor respondent. This is all part of psychology (as the study of human behaviour). We are, however, spared respondents’ scores on questionnaires

that are trying to assess a snapshot of health behaviours and people's intentions to perform specific health behaviours.

Smith provides a clear and concise overview of IPA and how it has been used, primarily in health psychology. Yet he does not outline how IPA might relate to the theoretical models that have been developed in mainstream health psychology, nor whether IPA would be useful in shedding any light on such theoretical models. It would be good to know the extent to which Smith thinks IPA might be able to engage with these theoretical models, either now or in the future. Could IPA usefully outline whether aspects of the models employed are apparent in people's experiences of specific behaviours, or experiences of illness?

Additionally, it would be good to know how IPA might be beneficial in terms of modifying, extending or developing health psychology theories. I remain hopeful that results from IPA studies are instrumental in developing new theories or refining existing theoretical models that have some real-life value. As is clear from the tables in Smith's paper, primary prevention is not a highly examined research topic in IPA. This may be understandable given how relatively new this method is, yet it would seem that it does have something to offer here. After all, primary prevention is ultimately about people's experiences; their behaviours, and how they live their daily lives. For example, researchers who undertook a recent study in Finland concluded that 'Rather than trying to motivate and persuade smokers to quit with information translated from epidemiological and medical research, the anti-smoking advocates and health promotion specialists should provide answers to the questions that smokers themselves are pondering and answering, too' (Heikkinen, Patja, & Jallinoja, 2010, p. 877). One is almost tempted to conclude that 'health psychologists can put that in their pipes and smoke it'. These authors used qualitative interviews and highlighted the importance of starting with the respondents themselves, their perspectives and their words. This conclusion, of course, supports the possibility of employing IPA to assist in primary prevention research. It also suggests that it might be time for those wedded to their social cognition models to throw away their questionnaires. Be curious, be brave and spend a couple of hours in a café where smokers are still allowed to smoke, and listen, and think.

But perhaps IPA shares one weakness with all psychology as applied to health and illness: the social and political determinants of behaviour are blatantly ignored. Its focus on the individual and individual experience means that a broader, more structural perspective is not available. Overwhelming evidence exists to demonstrate that health behaviour is determined to a greater extent by sociological and societal determinants than by intrapersonal determinants (Judt, 2010; Marks, 2008; Wilkinson & Pickett, 2008). Predicting longevity, influencing patterns of morbidity and mortality will involve collaborative research with people from public health, social medicine and clinical medicine. Attempting to influence longevity involves collaborating with policy makers and politicians. One may only hope that health psychology can help those groups in providing them with solid knowledge about human health behaviour.

IPA brings the researcher closer to the real world (Smith, 2010) and is likely to be extremely beneficial in medical education. Not surprisingly, medical students tend to adopt a biomedical approach to patients who are ill. In the courses on Literature & Medicine that I teach, I use a combination of perspectives, as outlined in Figure 2. I combine: (1) medical background (top left hand corner of Figure 2);



Figure 2. Teaching health psychology to medical students: the biomedical model (a surgeon holding a tumour in a stomach), listening to a patient with stomach cancer, reading a novel on stomach cancer, writing a paper integrating these three data sources.

(2) the narrative of the patient (top right hand corner); (3) a novel, poem, painting, opera or picture of a patient with the medical condition under study (lower left corner); and (4) the essay on being ill with the condition (lower right corner; see also Kaptein & Lyons, 2009, in press). My objective is to teach medical students about the biopsychosocial model. Students of health psychology tend to adopt a psychological model in their work, ignoring the medical and social background of respondents (see also Camic, 2008). IPA offers both groups the opportunity to adopt an integral approach to the patients they work with. This would be consistent with calls by researchers who emphasise the value of putting real life back into research on ill persons (e.g., Baumeister, Vohs, & Funder, 2007; Pennebaker, 2007; Ring, Gross, & McColl, 2010).

My point in this commentary is not to argue for quantitative measures or theories and theoretical models to be thrown away. It is only that I would like research to be embedded in theories that refer to real-life experiences and behaviours, in all their messy complexity, rather than theories based on concepts thought up behind a desk in some health psychology department, far away from real people. Alongside such theories it would be good to see the use of designs that – if the researcher intends to do so – do allow us to make statements about possible or potential interventions, based on issues that were suggested by respondents, not by health psychology researchers. And designs that emphasise respect for how patients (and we are all patients at some point or another) make sense of their world. It seems perhaps that IPA offers better guarantees to reach these objectives, in my view, than current



mainstream health psychology. It may be time to be less aggressive and presumptuous – and to be more thoughtful and open to listening.

### Acknowledgements

I am very grateful to Willem van der Kloot and Antonia Lyons, who commented on earlier versions. I, of course, am responsible for the paper.

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