

# INTRODUCTION: CRITICAL ISSUES IN CLINICAL AND HEALTH PSYCHOLOGY

# 1

Why do women live longer than men? Why are ethnic minority groups in the UK and USA more often diagnosed with schizophrenia? Why is HIV concentrated in sub-Saharan Africa? Why is it that the poorer you are the more ill-health you experience? Epidemiological studies have observed such disparities and more in the prevalence and experience of health, illness and disease. We also have different beliefs about what causes health, illness and disability. Consider HIV/AIDS for example. Medical scientific research has established that the conditions collectively known as AIDS is caused by the Human Immunodeficiency Virus (HIV). Yet so many people understand HIV/AIDS as a divine punishment for deviancy and sin. Some illnesses, diseases and disorders are responded to with relative neutrality, while others (such as cancer or schizophrenia) are responded to with fear. We may hold different assumptions about a man diagnosed with depression than we might do about a woman diagnosed with depression. Such differences and disparities challenge our assumptions that ill-health can be explained only in terms of things like viruses, bacteria and brain abnormalities.

This book provides an introductory exploration to some of these issues, by looking at various social aspects that are associated with differences in physical and mental health and disability. Although primarily a book for psychology, it draws on a variety of related disciplines, such as sociology, public health and medical anthropology, to explore how social processes impact on individual

health. In focusing on both mental and physical health as well as disability, this book covers the sub-disciplines of clinical psychology and health psychology. Books generally deal with one sub-discipline or the other, so let's first consider the differences and overlaps of these different disciplines.

# 1.1 LOCATING THE FIELD

## 1.1.1 WHAT IS CLINICAL PSYCHOLOGY?

Clinical psychology is a scientific and clinical profession that is concerned with the understanding, treatment and prevention of psychological distress, the relieving of symptoms of distress and promotion of well-being. In most countries, clinical psychology is a regulated health profession. Clinical psychologists typically work as part of a mental health care team, which includes psychiatrists, nurses, social workers, and occupational therapists. Such a team is usually led by a psychiatrist, who would take on the medical responsibility for service users, diagnosing mental health problems and prescribing medication for its treatment. Clinical psychologists take responsibility for providing therapy for service users, and may take part in the process of assessment and diagnosis of mental health problems. This system of care is organized around the assessment and diagnosis of mental health *disorders*, and its treatment, and is rooted in a medical model of mental health, which assumes that mental health problems are understood as being the result of underlying physiological abnormalities, particularly abnormalities in brain functioning. Treatment typically involves drug therapy, which modifies the underlying physical abnormality, in combination with psychological therapy. Psychiatry, and as a consequence clinical psychology, draws on the classification system of mental disorders of the World Health Organization's (WHO) *International Classification of Diseases* (WHO, 1992), now in its tenth edition, and perhaps more so from the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders*, now in its fourth (revised) edition, the DSM-IV-TR (APA, 2000). A fifth edition of the DSM is currently being developed, with a much anticipated release date for 2013 (see [www.dsm5.org](http://www.dsm5.org)).

The DSM is a multi-axial system, which allows for an individual's state of mental health to be evaluated along five different axes:

*Axis 1* includes the presence of most acute (and chronic) mental health syndromes, usually as the primary diagnosis. This would include, for example, mood disorders, anxiety disorders, eating disorders and psychotic disorders.

*Axis 2* includes the presence of long-term stable conditions, which include learning disabilities and the various personality disorders. A learning disability on its own is not considered a mental health problem requiring treatment. Only if a dual diagnosis of an axis 1 disorder is present, is this then a matter for a



mental health care team. In some cases a diagnosis of a personality disorder may be the primary diagnosis.

*Axis 3* includes any relevant information about the physical health of the individual.

*Axis 4* includes any psychosocial and environmental problems that may exacerbate the mental health problem (for example, inadequate housing, unemployment and relationship difficulties).

*Axis 5* includes a rating on a scale of 1–100 of an individual's global level of functioning, with 1 being most problematic to 100 being symptom free.

Although psychosocial and environmental problems are included in axis 4, the primary focus of treatment is usually an axis 1 diagnosis.

### 1.1.2 WHAT IS HEALTH PSYCHOLOGY?

Health psychology is a broad field that is concerned with applying psychological theory and practice to issues of health, illness and health care (Marks, Murray, Evans, & Estacio, 2011). It is concerned primarily with physical health, focusing on key topics such as pain, health behaviours such as smoking, drinking and exercise, stress and coping, as well as issues related to health care such as the doctor–patient interaction, health literacy and health promotion. Health psychology emerged as a sub-discipline of psychology in the 1970s (Marks, 2002a), when increased attention was given to the role of individual psychological factors in health, and how individual lifestyle and behaviour affect health (see Chapter 2).

Marks (2002a) outlines four different approaches in health psychology, which focus on different values and beliefs regarding important considerations for health. These are:

- 1 Clinical health psychology, which is the dominant approach in health psychology. Clinical health psychology is highly research based, and is located within the clinical health care system. Clinical health psychology has many overlaps with clinical psychology, and is concerned with applying psychological theories to promoting health and well-being, preventing illness, and identifying causal factors to the development and maintenance of illness. It is also concerned with treatment of illness and with improving health care systems. Clinical health psychology draws predominantly on the biopsychosocial model of health (see Chapter 2), investigating the biological, psychological and social causal factors of illness. This is the approach of health psychology which is represented in most textbooks of health psychology. As a sub-discipline, clinical health psychology has aligned itself with the medical profession, and much of the work of health psychologists take place in clinical health settings, with clinical populations.



- 2 Public health psychology, like clinical health psychology, is focused on the clinical health care system, but is more concerned with the improvement of the health of the population. Its focus is on health promotion, rather than treatment of illness. This is a multi-disciplinary approach, concerned with not only health promotion, but also health policy, health communication, and epidemiological studies of illness prevalence.
- 3 Community health psychology is based on community-level research and action. Community health psychology is concerned with working in partnership with members of vulnerable communities with the aim of empowering the community and facilitating social change to address the social and structural obstacles to health (such as poverty). Community health psychology is concerned with promoting both physical and mental well-being. This approach shall be discussed further in Chapter 3.
- 4 Critical health psychology is concerned with structural factors, analysing how issues of power, politics, economics, and social processes influence or shape health. The context of this approach is the broader social and political system, and is concerned with “the political nature of all human existence” (Marks, 2002a: 15). We shall return to this in more detail in Chapter 2 with reference to critical psychology more broadly.

The more dominant approaches in health psychology are clinical health psychology and public health psychology, which, as the above definitions suggest, are aligned quite closely to the medical sector.

### 1.1.3 THE OVERLAPS BETWEEN PHYSICAL AND MENTAL HEALTH

Clinical psychology and health psychology are two separate and distinct sub-disciplines within psychology, each with its own specialization of training. The body of knowledge is contained in different volumes of work, with separate textbooks devoted to clinical psychology and to health psychology. Typically, textbooks do not consider both, understandably given the different areas of specialism. However, there are many overlaps between clinical and health psychology.

First, many conditions that are considered mental health problems are also concerns of health psychology. Most notable here are substance use disorders and eating disorders. While health psychology is more concerned with the health risk aspects of drinking alcohol and drug use, clinical psychology is more concerned with problems of dependence and regular abuse as behavioural mental health problems. The issues here exist on a continuum from little or no use to regular abuse and dependence. The consequences for physical health are well established. Similarly, with eating practices, health psychology is concerned



with the health consequences of unhealthy eating, while clinical psychology is concerned with disordered eating considered as a behavioural mental health problem. As with substance use disorders, eating disorders are associated with significant physical health consequences.

Secondly, some conditions which are diagnosed as mental health problems, involve physical symptoms. Obvious examples here include the somatoform disorders, which are disorders characterized by physical symptoms and complaints for which there are no medically diagnosable physical cause. Perhaps the most commonly known of these is hypochondriasis, which is characterized by a fear of getting or having a serious disease, as a result of misinterpretations of physical symptoms (APA, 2000). Thus, a headache will be interpreted as a possible sign of a brain tumour. People suffering from hypochondriasis are frequent visitors to the health care system as they seek confirmation or reassurance of their symptoms. Many people experience somatic complaints as part of the expression of emotional distress, most notably depression. This shall be looked at more closely in Chapter 4 with regards cultural variations in how emotional distress is expressed.

Thirdly, research evidence suggests a strong association between mental health and physical health outcomes. For example, Moussavi and colleagues (2007) analysed data from the WHO World Health Survey, which collected data from a total of 60 countries across the world. Moussavi and colleagues investigated the role of depression in overall health status, and found that a co-morbid depression with any of four chronic illnesses (angina, asthma, arthritis or diabetes) made the biggest contribution to worsening health status than having a chronic illness without depression or having a combination of chronic illnesses. The data also shows that people with chronic illnesses are more likely to suffer with depression than people without a chronic illness. Physical illness may also affect mental health. Research has indicated that having a chronic illness or surviving a critical illness is associated with the development of psychological disorders, such as depression and anxiety (Cooke, Newman, Sacker, DeVellis, Bebbington, & Meltzer, 2007; Sukantarat, Greer, Brett, & Williamson, 2007).

Finally, a number of physical illnesses can induce symptoms of mental disorders. For example, Malaria can cause cognitive impairments; Lupus may cause fatigue, mood and anxiety symptoms, as well as cognitive impairments; and hypoglycaemia may cause low mood (see Williams & Shepherd, 2000).

#### 1.1.4 INCLUDING DISABILITY STUDIES

Many chronic diseases and mental health problems have serious disabling effects, and are classified as a disability. When considering the term 'disability' most of us would think of persons who have physical impairments and require the use of wheelchairs, or people who may be blind or deaf. However, mental health problems, particularly those that can be severe and chronic (for example, schizophrenia) are classified as a disability. Cognitive and neurological



problems such as dementia and epilepsy are disabilities. Likewise many physical illnesses, such as AIDS, osteoarthritis and diabetes, are classified as disabilities. It seems pertinent then to consider disability issues in a book referring to health and clinical psychology. However, disability issues are often neglected in textbooks of health and clinical psychology. Disability studies is a growing, interdisciplinary academic field concerned with the experience of disability and the role of persons with disabilities in all aspects of society. Much of the discussion in this book is about disability, particularly discussions about mental health problems, but at times the book also takes a look at disability as a general concept in relation to the specific topics discussed.

## UNDERSTANDING HEALTH, ILLNESS AND DISABILITY

**1.2** This book takes a critical approach to our understanding of physical and mental health and ill-health, and disability. The field of health is dominated by the science of medicine and the medical model, which understands illness, diseases and health conditions in terms of biological factors, requiring biological treatment and interventions. It is of course important to pay attention to such biological factors. However, the medical model neglects the roles that psychological, social and structural factors may play in who becomes ill, or how such ill-health is experienced and understood. The medical model has not always been the way that we have understood health and ill-health. It is actually a relatively recent approach to understanding health. At this point it is worth taking a more detailed look at the medical model, within a historical context.

### 1.2.1 EARLY CONCEPTUALIZATION OF THE BODY AND DISEASE

How we, in the western world, have sought to explain and understand health and illness has changed over the centuries. I use the term the 'western world' to refer to countries in Europe and North America (see Chapter 4 for further discussion about the concept of the 'western world'). Alternative understandings exist in other parts of the world, although there has been an influence of dominant 'western' views. There is also a diversity of understandings within societies, influenced by religious and cultural beliefs.

In early cultures in Europe and in other regions of the world, people believed that the spiritual world was responsible for health and illness. Diseases or illnesses were understood to be caused by evil spirits, while health and good fortune were caused by positive spirits. In ancient Greece, such spiritual explanations for health and illness were less prominent, as the early Greek philosophers advocated the process of rationalism and naturalism (Lawson, Graham, & Baker, 2007).

Rationalism refers to the view that phenomena can be explained and understood by means of systematic observation. Naturalism refers to the idea that the physical world and our experience of it can be explained and understood by physical principles and laws, rather than through supernatural causes. Hippocrates, who is often referred to as the 'father of medicine', proposed a theory that linked disease with physiology. He argued that the body contained four liquids called *humors*, which are: blood, phlegm, black bile, and yellow bile. When the body's humors were out of balance, disease occurred. Hippocrates thought that an excess of black bile was the cause of mental health problems (Cockerham, 2011). When the humors were in balance, the body was in a state of health. Similar notions of balance of energies in the body and health are found in other cultures, such as in Ayurvedic medicine traditional to India. Hippocrates argued that diseases were located in the body, and had nothing to do with the mind, and furthermore had nothing to do with supernatural or spiritual forces. This was a radical new idea for the time. Among such ancient Greek philosophers, the mind was considered as a separate entity to the body (a position referred to as dualism). This remained the dominant view in Greece and in the Roman Empire, and debates about the mind/body split still remains today. The ideas of Hippocrates were developed further by Galen, a physician who, from dissecting the bodies of animals, was able to discover that diseases can be localized in specific parts of the body, and that different diseases had different physical effects.

During the Middle Ages (the fifth to the fifteenth centuries) in Europe, after the fall of the Roman Empire, advancement in medical and scientific knowledge slowed down with the influence of the Catholic Church. A spiritual influence to understanding health and illness re-emerged with people's understanding about the cause of illness having a strong Christian influence. Illness was understood to be God's punishment for sins, or possession by demonic spirits. Priests became involved in treating illnesses, with practices such as exorcising the evil spirits from a sick individual's body. Beliefs about the soul rendered the body sacrosanct, and dissection of bodies was forbidden. The soul was understood as inhabiting all parts of the body and thus there was a return to viewing the mind (in the form of the soul) and the body as a single entity (a position referred to as monism).

The Middle Ages came to an end with a period of growth in scientific and intellectual enquiry, a period known as the Renaissance. The French philosopher and mathematician, René Descartes, was an important figure in the development of scientific and medical knowledge. He had a renewed interest in the mind and body, which he continued to conceptualize as separate entities. However, he proposed that the mind and the body could communicate via the pineal gland, and thus they were linked. Furthermore, he conceptualized the body as a machine, the mechanics of which can be observed and studied. He proposed that an individual's soul left the body once the person died, and thus it was acceptable to dissect and investigate the body after death. The church conceded to this, and as a result of dissection and investigation, there was a



rapid growth in scientific and medical knowledge about the body. With these investigations, scientists were able to establish that diseases were caused by micro-organisms, rather than humors or spirits. Physicians were the holders of medical knowledge, replacing the role of priests. With these advances, a new model for understanding health and illness began to emerge – the biomedical model, which proposes that all physical disease and illness “can be explained by disturbances in physiological processes, which result from injury, biochemical imbalances, bacterial or viral infection, and the like” (Sarafino, 2006: 7). The explanation of disease and its treatment was based solely on physical explanations.

### 1.2.2 THE BIOMEDICAL MODEL

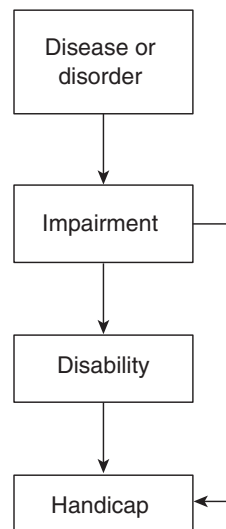
The biomedical model became the dominant, accepted model for understanding health and illness during the nineteenth and twentieth centuries, and remains dominant in medicine today, including psychiatry. The biomedical model proposes that illness and disease are afflictions of the body, caused by biological factors. Psychological and social factors are separate and have little direct bearing on the understanding and treatment of illness. Thus the biomedical model has a dualistic view of the body and mind as separate entities. All diseases can be explained by abnormalities in the physiological processes, caused by infections, injuries, biochemical imbalances and other types of biological factors. Health is seen as the natural state, and the body is healthy when there is an absence of biological disease. Thus health is restored when the pathogen is removed. Treatments act upon the disease or pathogen and not on the person. The person’s subjective experience is not generally considered by the biomedical model.

The biomedical model can be well illustrated with reference to understanding and explaining disability. Disability has traditionally been understood in terms of the biomedical model, or what has been referred to as the medical model of disability, which emphasizes physical impairment as the cause of disability.

#### *The medical model of disability*

The medical model of disability views disability as resulting from physical or psychological impairments caused by an underlying physical disease or disorder (Johnston, 1996). In earlier years the World Health Organization (WHO) used this medical model to conceptualize disability as: “any restriction or inability (resulting from an impairment) to perform an activity in the manner or within the range considered normal for a human being” (WHO, 1980: 1). The WHO differentiated between ‘disability’ and ‘handicap’, which they conceptualized as the disadvantage experienced by the individual as a result of their impairment or disability that limits the extent to which the individual can lead a ‘normal’ life. Figure 1.1 provides a conceptual diagram of the WHO medical model.





**FIGURE 1.1** The WHO model of disability (WHO, 1980)

In this model, a person's disability may cause them to be socially handicapped. However, a person may be handicapped because of an impairment, but not necessarily be disabled. For example, a person who has a facial disfigurement, such as a birthmark or scar, may be socially handicapped as a result, but not necessarily disabled by it. The impairment is seen as central to the person's experience of disability or handicap. The social handicap or social struggles faced by the person is attributed to the person's physical impairment, rather than to any social barriers that the individual may face (see discussion of the social model of disability in Chapter 2). Edwards (1997) highlights three characteristics of 'disability' within this medical model. That is:

- 1 that 'disability' result from an individual's impairment;
- 2 that 'disability' is "context-neutral" (p. 591) and not determined by the individual's particular social context; and
- 3 that 'disability' is intrinsic to the individual.

Disability in this model is a form of medical anomaly (Arney & Bergen, 1983), and solutions to such defects are found through medical interventions. The assumption is made that it is the individual who is alterable, while the individual's physical environment is fixed and unalterable (Barnes & Oliver, 1993). This model has been critiqued by social scientists, who emphasize the social, political and environmental barriers as central to the experience of disability (see Chapter 2).

### *Some critiques of the biomedical model in health*

The biomedical model has influenced considerable advances in health and the prevention and treatment of illness. Research within the biomedical approach

has resulted in the development of vaccines to prevent many infectious diseases (for example, polio and measles). It has allowed for the development of antibiotics to treat bacterial infections. Surgical procedures have been advanced, and there has been a rapid development in medical technology for use in testing, diagnosis and treatment. In more recent years biomedical research has sought to identify the genes that may cause various physical and mental disorders. Although the biomedical model has been important in the advancement of medicine, it has received considerable criticisms. Hardey (1998) summarizes key elements of the medical model against which criticisms are raised:

- The biomedical model is reductionist, seeking only biological explanations for disease. In so doing, it ignores the complexity of factors involved in health and illness, which may include psychological and social factors.
- The model has a dualistic view of the body and mind as separate, thus ignoring psychological influences on the body.
- The model is mechanistic, assuming that every disease and illness has a biological cause; a view that something has gone wrong biologically and can be fixed.
- The model assumes that the biological causes of diseases can always be objectively observed, and that the objects of observation are “only subject to natural forces” (p. 9).
- The model advocates interventionist treatment, which may be overly intrusive on the body.

The problem with this model is that it is also clear that individual behaviour, lifestyle and personality have an important role in affecting health and illness. With its emphasis on the physical body, the person as a unique entity is not included (Engel, 1977). The criticisms against the biomedical model were influenced by two important changes that took place during the twentieth century in western societies: the changing pattern of the types of disease and illness affecting the majority of the population, and the increased prominence of considering *health* over illness (Lyons & Chamberlain, 2006). First, during the twentieth century, we have witnessed a dramatic decline in the prevalence of acute illnesses (such as tuberculosis and pneumonia) and an increase in chronic illnesses (such as cancer and heart disease). While the decrease in acute diseases were thought to be as a result of the development of vaccines and medical treatment, it is evident that this change began to occur prior to the availability of vaccines as a result of improvements in hygiene, reduction in poverty and improved nutrition (McKeown, 1979). McKeown concludes that “the contribution of clinical medicine to the prevention of death and increase in expectation of life in the past three centuries was smaller than that of other influences” (p. 91). Chronic diseases are related to issues of lifestyle, with behaviours like smoking, diet, alcohol consumption, and exercise associated



with incidence of disease such as cancer and heart disease (Mokdad, Marks, Stroup, & Gerberding, 2004). These changes in disease prevalence point to the importance of social and lifestyle factors in disease, for which the biomedical model does not account (we shall return to discuss the role of lifestyle and behaviour in Chapter 2).

Secondly, there has been an increased emphasis on health, which in 1948 the World Health Organization defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2006a: 1). With this definition, health was not understood as only the absence of disease (which the biomedical model would suggest), but also includes the social and the personal (mind).

These observations of the importance of psychological and social factors in health and ill-health influenced the development of the biopsychosocial model, which considers psychological and social factors as well as biological factors in health and ill-health. These developments in understanding health and ill-health also influenced the development of health psychology as a sub-discipline of psychology, concerned with the psychological aspects of physical health. These developments will be discussed further in Chapter 2.

### ***The biomedical model, psychiatry and clinical psychology***

Psychiatry has tended to be influenced by a biomedical model to mental ill-health, which, as we have seen above, is based on a positivist, scientific epistemology. The main assumptions of such an approach is that mental health problems are a result of underlying biological factors which can be measured, observed, and treated biologically. The emphasis is on biological, physical factors, such as genetic abnormalities, the role of neurotransmitters and brain abnormalities. Such an approach assumes that mental health problems (or ‘mental disorders’) are diseases which are found universally. In this approach, mental disorders, like physical diseases, should be treated medically, typically with the use of drug therapy. Other more controversial treatments include electroconvulsive therapy (ECT) and psychosurgery (brain surgery). However, it became clear that it was difficult to attribute most mental health problems to biological causes. Spitzer and Wilson (1975, cited in Cockerham, 2011) point out how most mental disorders do not meet the four criteria for a physiological disease: (1) having a definite etiology, such as a virus; (2) that there is an observable physical change; (3) the mental disorder is qualitatively distinct from normal functioning; (4) and that there is an internal process that once initiated, proceeds independently of the external environment. Yet the biomedical model in psychiatry still dominates. As discussed above, psychiatry has a system of classification of mental disorders in the DSM-IV-TR (APA, 2000), and the ICD-10 (WHO, 1992). Both systems of classification are primarily medical diagnostic tools, and assume that abnormal mental states are distinguishable from normal mental states, and that mental disorders can be identified through presentation of discrete symptoms.



Cockerham (2011) argues that the persistence of the biomedical model in psychiatry may be explained by the medical training of psychiatrists, where psychiatrists are trained as medical doctors, and thus trained within the biomedical model. Furthermore, mental health problems are not regarded as 'diseases', but rather as 'disorders', which are treatable through medical intervention. This extends the definition to include human suffering and functional impairment that cannot be considered a 'disease', but that nevertheless can be treated medically, and responds to medical treatment. Cockerham also points out how psychiatrists may wish to align themselves fully with a prestigious medical profession, and eagerly promote the treatment efficacy of psychoactive drugs.

Clinical psychology in the UK (and in the USA) emerged in an era of mental health care, concerned with post-war treatment of war trauma, which was dominated by the biomedical model (Cheshire & Pilgrim, 2004). Hans Eysenck, one of the profession's leaders at the time, advocated for clinical psychology to be a scientific discipline concerned primarily with psychometric testing and diagnosis and research. Eysenck did not consider therapy to be the domain of clinical psychology, and distanced the profession from psychoanalysis in particular, which he felt was unscientific and ineffective (Cheshire & Pilgrim, 2004). Only later did he include behavioural therapy as part of the work of clinical psychologists. The aim was to establish clinical psychology within the medical profession.

Clinical psychology is now less concerned with diagnosis, but rather on the assessment and formulation of mental health problems. It has as its influence psychoanalysis, and more predominantly, behavioural and cognitive models of abnormal behaviour. These will be discussed in Chapter 2. Mental health problems are assessed and formulated according to the different factors that contribute to its development: predisposing factors (that may include biological factors or biological vulnerability), precipitating factors and maintaining factors. In this way, mental health problems are understood in terms of the biological, psychological and social factors that contribute to their development (this follows the ideas of the biopsychosocial model, discussed in Chapter 2). However, clinical psychology still relies on the DSM as its diagnostic tool, and is increasingly influenced by cognitive neuroscience, which perpetuates the influence of the biomedical model.

Cockerham (2011) outlines a number of criticisms of the biomedical model of mental disorders. First, Cockerham points out how the defining condition of mental health problems as biological is that they can be treated by medication, rather than on whether they necessarily have a medical cause. In this way, the symptoms are treated, without always understanding their cause. This relates to a second criticism that the biomedical model of mental health problems "focuses almost exclusively on controlling symptoms rather than on cures" (Cockerham, 2011: 57). Thirdly, Cockerham argues that the biomedical model has formulated medical treatments for mental health problems, but has not been able to provide explanations for the exact cause of them. A large number



of research studies find support for genetic, neurological and other biological causes for mental disorders, but equally a large number of research studies find support for environmental and social causal factors. The result is that we do not have a clear, definitive understanding of what causes mental disorders, in the same way that we know that malaria is caused by Plasmodium parasites, for example.

## CRITICAL ISSUES IN CLINICAL AND HEALTH PSYCHOLOGY

**1.3** I have briefly introduced some of the key criticisms made of the biomedical model in relation to physical health, mental health and disability. The remainder of the book will proceed from this starting point to explore aspects of health, illness and disability that provides a critique of the assumptions of a biomedical understanding. The book is partly structured around four key ‘issues’: socio-economic status (SES), culture, gender and sexuality. These are by no means all, but are four of the primary social aspects that shape the development, understanding and experience of health and ill-health. These are areas that are typically only given brief mention in mainstream health psychology and clinical psychology textbooks, and thus are areas that often remain neglected in the health and clinical psychology curriculum. There are books that focus specifically on each of these various issues, for example books on culture and health or gender and health. The relationships between SES, culture, gender, sexuality and health are complex, and these are vast subjects. This book can only provide an introduction to these issues for students of health psychology and clinical psychology and related disciplines.

The remainder of the book is divided into seven chapters:

Chapter 2 explores the various critiques made of the biomedical model and alternative models that have been developed that take into account the psychological, social and structural factors associated with physical and mental health and disability. The chapter first explores some of the dominant models used in health psychology, namely the biopsychosocial model, and in clinical psychology, the cognitive-behavioural model and the psychoanalytic model. These models still have as their primary focus factors within the individual as the most important areas of consideration with regards understanding health and ill-health. More recent critiques have focused more centrally on social and broader structural factors in relation to our understanding of health, illness and disability, and these are explored in the second half of the chapter.

Chapter 3 explores models developed to understand health behaviour, which has been influential in considering how to change people’s health behaviours. This chapter is primarily focusing on models used in health psychology, although also used sometimes in mental health research. The chapter introduces



a few of the most influential models of understanding health behaviour used in mainstream health psychology. These models have been critiqued for focusing almost exclusively on factors within the individual that influence health behaviours, such as attitudes, perceptions and motivation. These models fit within a biopsychosocial paradigm, which although they take into account psychological and social factors as well as biological, they have been critiqued for their remaining focus on the individual, and for remaining, to a certain extent, aligned to a biomedical model for understanding health. Critical approaches emphasize the importance of social and structural factors for facilitating and even shaping individual health behaviours, which are explored in the later parts of the chapter.

These two chapters (and this introduction) provide a conceptual basis for the next four chapters. In Chapter 4, the universalist assumptions of the biomedical model is challenged with an exploration of cultural differences in the understanding and experience of physical and mental health. This chapter explores cultural relativism in relation to understanding health and ill-health, highlighting how many of our assumptions, which do not exist universally, are influenced by a 'western' culture. The chapter explores cultural differences in the understanding and experience of cancer and pain (relevant for the discipline of health psychology), and explores cultural differences in understanding mental health problems, particularly depression. The chapter also looks at disordered eating, which overlaps both health psychology and clinical psychology, and highlights the influence that western notions of the ideal body have on the development of eating disorders. Such cultural differences in understanding and experiencing health and illness are important for working in multicultural contexts, where cultural clashes may occur between professionals and their clients who have different perspectives on the issues involved. The chapter ends by exploring different systems of health care that people may draw on, and also looks at cultural competence in health care.

Chapter 5 explores the important influence of socio-economic status on health. There is a well-observed health gradient that shows how health improves as one moves up the SES hierarchy. Globally, differences exist between poorer countries and wealthier countries with regards the prevalence of different diseases and mortality rates, which can be attributed to issues of poverty and inadequate resources that facilitate good health. But differences are also found *within* countries, with health disparities existing alongside income inequality. A consistent pattern found is that the poor live shorter lives than the rich, and experience more illness during that shorter life. This is explored in relation to physical and mental health and disability. The chapter presents some theoretical models for understanding these SES health inequalities.

Chapter 6 explores the issue of gender differences in health. As with other topics, this is a vast subject area, and the chapter can only introduce some areas for consideration. The chapter explores both issues of femininities and masculinities in relation to health, illness and disability. Epidemiological studies have



shown clear gender differences in health between men and women, with women living longer than men, but experiencing more illness during their lives than men. Gender differences also exist with regard to different mental health diagnoses, with more women than men being diagnosed with mental health problems such as depression and borderline personality disorder. Gendered aspects of diagnosis are also explored in relation to sexual disorders, and the medicalization of sexual problems for both women and men. The chapter includes a focus on notions of masculinities in particular, and how this influences men's health behaviours, such as smoking and drinking. Masculinities and health has been generally neglected until recently, with more attention given to women's social roles and health. Masculinity will also be explored in relation to body image and eating disorders, again an area of overlap for health psychology and clinical psychology.

Chapter 7 explores issues of sexuality and health, and focuses predominantly on three issues of sexuality. First, the concept of a mental disorder is critiqued with reference to the history of the pathologizing of homosexuality in psychiatry. Up until 1973, homosexuality was included in the DSM as a mental disorder, which could be treated by psychiatric means. The historical account of the removal of homosexuality as a diagnosis in the DSM provides an interesting account of how 'medical' concepts can rest on biased, subjective assumptions. The chapter progresses from this to the continuing demonizing of sexuality in relation to HIV/AIDS, at first with regards to homosexuality and HIV and, in more recent years, Africa and 'African sexuality' in relation to HIV. This discussion also provides an example of how a disease is not just about biological factors, with HIV providing a good example of how illnesses carry specific meanings and representations that have more to do with social identity than with biology. The chapter then explores sexuality in relation to people with disabilities, which has been an area of oppression for many years, and continues to be in some cases. People with disabilities, particularly learning disabilities, are often wrongly assumed to be asexual, and are thus excluded from leading full sexual lives. The chapter explores the issues in relation to HIV, and how people with disabilities have been generally excluded from HIV prevention work, despite evidence suggesting that they may be at equal risk for HIV infection.

Finally, Chapter 8 describes some of the different research methods that are used for a more critical approach in clinical and health psychology. Qualitative methods in particular have been argued as being valuable in exploring the different subjective meanings and experiences of health, illness and disability. Different qualitative methods lend themselves to exploring different kinds of questions, and are useful for different types of research project. Although many of the studies drawn on in the chapters of this book come from epidemiological studies that reveal disparities in health and illness prevalence and incidence (see Box 8.1), the chapters also draw on qualitative research that has been useful in providing some understanding of the complexity of different issues. Interspersed across the chapters are text boxes containing examples of



qualitative studies exploring different aspects on the issues covered, providing examples of some of the methods described in the last chapter.

As stated earlier, each of these topics is a vast field, and not all aspects of each topic can be covered in a book of this scope. This book thus provides an introduction to the issues for students. The issues explored are complex, and require a multi-disciplinary lens. Thus the book draws on literature from a variety of disciplines, including sociology, anthropology, public health, disability studies, and psychiatry as well as psychology. At the end of each chapter I have listed some recommended further reading (not all of them from psychology) for a more detailed exploration of some of these issues and more.