

Antonia C. Lyons and Kerry Chamberlain

Health Psychology

A Critical Introduction



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ANTONIA C. LYONS

and

KERRY CHAMBERLAIN



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Setting out: using this book

There are many reasons why we feel that a book like this is overdue. We have both been teaching health psychology and searching for a text that takes a more critical approach to notions of health and illness, without success. Although there are many health psychology texts available, and more keep appearing, none seems to us to be suitable for the ways in which we want to approach health psychology, either as researchers or as teachers. Existing health psychology texts do not reflect the changes in this field, where increasingly a variety of methods and approaches, qualitative and critical, are being employed to examine health and illness issues from a psychological perspective. For some years we have felt dissatisfied with the ways in which health psychology conducts its research and promulgates its findings. We are critical of the way it unreflectively continues the traditions of mainstream psychology, assuming that psychological factors have a real existence, that they can be meaningfully and accurately measured, that statistical findings have meaning by virtue of their significance levels and that findings (almost) have the status of general laws. We are critical of the lack of consideration in health psychology of the social context within which health and illness are experienced and understood. We are critical of the way in which health psychology all too readily adopts the premises and assumptions of biomedicine, and the ways in which its findings promote biomedical understandings, albeit in the guise of a 'biopsychosocial' approach, a vague rhetorical entity with many meanings. We are critical of the way in which health psychology fails to engage with any serious theorisation of health issues, and the way it confuses and conflates theories and models.

The absence of texts that take a more critical approach, of any sort, to health psychology is a major concern to us as teachers of health psychology. Although one or two critically oriented texts have appeared, the bulk of health psychology texts seem to us to be virtually interchangeable in their approach to the field, and we find them problematic in a number of ways. First and foremost, existing texts overwhelmingly present ideas drawn from mainstream psychology about health and illness, and use only traditional, positivist research as their literature base. This is problematic because it means that health and illness are located at the individual level, and social, structural and cultural perspectives are not taken into account. These texts atomise the individual into physical and cognitive 'parts' and focus on the individual in isolation, dislocating people from their lived social worlds. This concern plagues psychology in general, but is

fundamentally more difficult when matters of health and illness are the focus of study. Second, although existing texts cover most areas of health psychology, they commonly present information in a fragmented and disjointed manner. For example, many of these texts present separate chapters on stress, coping and social support, and detach these from other chapters on specific chronic illnesses such as heart disease, diabetes, cancer and so on. Third, existing texts fail to include any critical notions about health psychology work. The values of positivist 'science' and the 'detached' researcher are taken for granted, and there is no attempt to examine the assumptions and values which underlie the research presented in the texts. There is little reflection on the part of authors about the field of health psychology *per se*, and how it operates as a discipline. This works to exclude issues of power and advantage, and marginalises the meanings of health and illness for specific groupings of people, mainly women, children, ethnic minorities, people in lower socioeconomic positions and minority groups such as those with disabilities and older adults. We are also tired of having to go beyond the current boundaries of health psychology, into medical sociology and anthropology and health sciences, to locate other sorts of findings, other ways of working, and for informative learning resources to bring to our students. We believe it is time that health psychology managed this within its own discipline. We thus feel that there is a strong need for a health psychology textbook which takes a very different orientation to health psychology material, integrating mainstream work with more critical and qualitative research (from outside psychology where necessary), providing a broader and more considered approach to the field.

We have several major aims for this book. First, it sets out to present an original and exciting perspective on the health psychology field. Second, it aims to comprehensively cover the major topics of health psychology, but in doing so to provide an alternative look at traditional material. Third, it aims to locate psychological work concerning health and illness among work from other social science disciplines, such as sociology and social anthropology, while retaining a focus on implications for the individual throughout. Fourth, it aims to present material that will challenge readers to think more broadly, and more critically, about notions of health, illness, sickness and disease. Fifth, it aims to highlight the role that health psychology plays in creating our everyday understandings of health and illness.

What, then, is the approach of this book? We do not have all the answers to the best alternatives for working in health psychology. We are not dismissive of mainstream approaches, but we do try to be critical about how we work, how we might work and the potential benefits of changing the ways in which we work. In this text we adopt a critical approach, outlined more fully in ch. 1, which entails being critical about what we do at a number of levels. First, it means being thoughtful and critical, in both negative and positive senses, about the endeavour we are engaged in – the questions we ask, the methods we use, the understandings we bring and so on. Second, it means taking on

notions of criticality, and starting to become more informed about the nature and limits of our approaches, methods and findings, who they include and who they exclude, who they might benefit and who they might oppress. Third, and interlinked with these, it means being reflexive about ourselves, our approaches and our field, questioning our own values and assumptions. We try, throughout the book, to include comment which will make readers reflect on these issues, and we take up the issue of what a critical health psychology might be more fully in the final chapter of the book. At that point, we anticipate that readers will have developed a more informed critical perspective on health and illness from the discussions and commentaries within each chapter.

How have we organised the book in order to promote all this? We bracket the body of the book with introductory and closing chapters focused directly on the field of health psychology. In the opening chapter we locate the field, both of health and of health psychology, and discuss a number of potentialities for the latter. We also argue the case for a critical approach to health and illness. In the closing chapter we relocate the field in the light of the material covered and the arguments made within the text, setting out a version of what a critical health psychology could be. In the body of the book we deal specifically with issues of health and illness. We have used a 'journey' or 'passage' metaphor to sequence this material. This begins with a consideration of ideas about health, illness and the body, goes on to discuss staying healthy by choosing lifestyles and controlling the body, and then continues the journey through becoming ill, comprehending bodily experience, interacting with health professionals, treating illness, experiencing and recovering from illness, and closes with dying. This organisation is quite deliberately radically different from other health psychology texts for two reasons. First, it disrupts the common textual arrangement that structures health and illness around bodily systems and specific diseases, so dominant in the field. Second, it facilitates a more general and integrative discussion of issues ranging across bodily systems and diseases, and enhances the viability of our objective to present a more critical and integrative perspective on matters of health and illness. In taking this approach, we retain the sociocultural location of individuals in view by threading and integrating sociocultural issues – gender, ethnicity, socioeconomic status (SES), minority status, disability and sexual orientation – into the topics of each chapter. This avoids social factors being separated from the person and partitioned off into separate chapters.

We have also incorporated several features within the book to promote learning. Each chapter opens with specific learning objectives that can be accomplished from a study of the chapter. Each chapter then provides an overview of content and an orientation to the specific topics under consideration. There are frequent section summaries throughout, and all chapters end with clear (and opinionated) conclusions that identify implications for the field. Readers are left in no doubt of our position in relation to the concerns discussed within the chapters. Each chapter includes topic-relevant research in focus boxes, which

provide an overview of a specific research study together with a commentary and critical reflection on the study and issues arising from it. These are used to provoke critical engagement with the field. Chapters also include a range of relevant figures, tables and sidebars to illustrate specific issues in depth and to enhance interest in the topics under discussion. An extensive glossary of key terms is also provided, and a definition for each term is located alongside the relevant text. Finally, the chapters initially address their material from a traditional perspective and then engage with the implications of this as part of a broader critique, leading to consideration of critical alternatives and interpretations of the material. This is also intended to provoke readers to consider the value and limitations of alternative, and more critical, perspectives.

In short, we hope that working through this text changes the way you think about health psychology.

1 Locating the field: introducing health psychology

I hope I have convinced you of some simple but far-reaching truths. That our mental state and physical health are inexorably intertwined. That stress, depression and other psychological factors can alter our vulnerability to many diseases, including bacterial and viral infections, heart disease and cancer. That the relationship between mind and health is mediated both by our behaviour and by biological connections between the brain and immune system. That these connections work in both directions, so our physical health can influence our mental state. That all illnesses have psychological and emotional consequences as well as causes. That there is nothing shameful or weak about the intrusion of thoughts and emotions into illness. That our social relationships with other people are central to health. That our dualist habit of contrasting mind and body, as though they were two fundamentally different entities, is deeply misleading. (Martin, 1997, p. 314)

The psychology of health, illness and health care needs to be considered in economic, political, ecological, social and cultural context. (Marks *et al.*, 2000, p. 1)

Learning objectives

This chapter will provide an introduction to health psychology and locate studies of health and illness within their sociohistorical context. By the end of this chapter, you should be able to:

- provide a brief historical overview of dominant Western views on health and disease;
- outline the historical development of psychological approaches to health and illness, and health psychology in particular;
- define and explain the biomedical and biopsychosocial models of health and illness;
- describe what health psychology covers as a field of study;
- outline how health psychology relates to subfields of psychology, and other health-related fields;
- describe variations in health across social categories such as social class, age, gender and ethnicity;
- critically evaluate the assumptions and values that underlie health psychology research and practices.

Health psychology is a diverse and wide-ranging field. It covers questions about what health is through to how people cope with chronic illness (both their own and others'). For example, think about some of the following questions:

- Do you think psychology has anything to do with health? What do you think health actually is? Is it simply the opposite of illness?
- Has psychology got anything to do with staying healthy? Think about whether or not you do anything to stay healthy. Do you get regular exercise to keep healthy? Or do you get regular exercise for fun, not for health? Or can't you be bothered with regular exercise?
- Is behaving in ways to stay healthy the same as behaving in ways to prevent getting ill? Did you give up smoking cigarettes for health reasons? If you do smoke cigarettes, you probably know you 'should' give them up for health reasons.
- Do you think psychological factors influence getting ill? Does stress really make us ill? Think about your own experiences – when you feel stressed, do you also feel as though you are likely to become ill? If so, how do you know you're getting sick?
- Is psychology relevant to how we interpret sensations in our bodies? How do you know when that strange feeling in your throat is actually a 'symptom' that might require you to go to the doctor? Do things like your gender, your personality, what you're doing, what others tell you, what your beliefs about illness are, influence whether or not you notice physical symptoms?
- Do you like going to the doctor? Why? Is the interaction you have with your doctor relevant to your health? Do you take your medications? Why or why not? Do you do what your doctor says? Why or why not? Do you see alternative health practitioners?
- What if your illness is ongoing and affects your life more than you thought it would? How do you cope with this? What effect might it have on you and others? Do you think about dying? What happens when people close to you die? How do people die?

All of these questions fall within the domain of health psychology, and all of them will be covered in this text at some point. They highlight how diverse health psychology is, and the range of issues it covers (and this is not a comprehensive list by any means). In this chapter we describe the field of health psychology, what it is, how it developed and how it fits into other health-related fields. To do this, we locate these fields both historically and academically, stepping back and considering how the study of health and disease has developed over the centuries. We examine how health psychology differs from other approaches to the study of health and illness such as medical sociology, medical anthropology and medicine. We examine traditional models of health and illness based on the biomedical model, and compare this model to the biopsychosocial model put forward as the basis of health psychology.

We also describe how health varies not just across individuals, but across social groupings, such as social class or socioeconomic status (SES), age, gender and ethnicity. Finally, we describe what we mean by taking 'a critical approach' to topics within health psychology.

First, in order to provide a framework for the study of health and disease, we begin with a very brief account of the major views on health and causes of disease throughout Western history. This description highlights how our dominant Western ideas about health and disease are historically specific. Other cultures have developed different conceptions of health and illness over the centuries; an example is shown in sidebar 1.1.

1.1 Māori beliefs about health

Traditional Māori beliefs about health view it as stemming from well-being across four domains: family/community, physical, spiritual and emotional. For example, illness is seen as due to *mate atua* (the spiritual realm) or to *mate tangata* (the people's realm – wounds, injuries, etc.). Breaches of *tapu* (the sacred or divine) are seen to lead to misery, including physical illness. *Tohunga* are expert healers, who treat not just the physical but also the spiritual, emotional and family/community aspects of health. With the colonisation of New Zealand/Aotearoa by Europeans from the late 1700s onwards, these beliefs about health and illness were suppressed. Indeed, in 1907 the government passed the Tohunga Suppression Act, making it illegal for traditional Māori healers to practise (the Act was repealed in the 1960s). As Durie (1998) has argued, 'early Māori approaches to health and to health care do provide a cultural and social framework . . . that has a continuing relevance to modern times' (p. 23).

A historical view of health and disease

During Western history three different medical models have prevailed, and these coincided with the periods from c. 300 BC to c. AD 400 (the ancient Greeks), from c. AD 400 to c. 1300 (the Middle Ages), and from 1300 onwards.

The ancient Greek civilisation was one of the first to consider health and illness in terms of bodily functioning rather than seeing illness a result of evil spirits invading the body. The mind and body were seen as part of the same thing, a unit working together. This conceptualisation of mind and body is known as **monism**. Subsequent Greek philosophers, most notably Plato, broke with this view, and proposed that the mind (or soul) and the body were actually separate entities. From this perspective, the body was seen as a physical being, and the mind as something else, something more abstract. Viewing the mind and body as separate substances is a position known as **dualism**.

Hippocrates (c. 460–377 BC) was a firm believer in the dualistic nature of mind and body. He made the radical suggestion that disease occurred in the body and that this process was independent of the mind. Hippocrates proposed that the body contained four specific fluids, called humours: blood, black bile, yellow bile and phlegm. According to this 'humoral' theory of health and

The philosophical view that the body and the mind (or soul, or mental processes) are essentially one substance, and are part of one underlying reality.

The philosophical view that the body and the mind (or soul, or mental processes) are fundamentally different substances.

1.2 The mind–body problem

Philosophers have been grappling with the mind–body problem for centuries. Although dualism has been a dominant perspective for many hundreds of years, problems still remain. How can the non-material mind have an influence on the material body? Are the two things connected? The relationship between the mind and the body is fundamental to health psychology.

disease, when these humours were balanced, a person experienced health. However, when the fluids were out of balance, disease occurred. Treatment therefore involved an attempt to restore balance to the four fluids. This conceptualisation of health and disease was radical for its time because previously disease had been thought to

occur as a result of demons or spirits possessing bodies. Hippocrates challenged the dominant view and situated health and disease within the individual body. For this work he is often described as the ‘father of medicine’. The humoral theory became dominant throughout Greece and Rome, and was developed further by Galen during the second century AD. A prominent physician, Galen demonstrated that disease can occur in a specific part of the body, and that different diseases can have different effects on the body.

Following the collapse of the Roman empire in the fifth century, the advancement of knowledge slowed considerably. Views on health and disease shifted, and illness was again seen as the result of evil spirits, demons or punishment by God. Ideas about the causes of illness were heavily religious, as were forms of treatment, such as torturing the body to drive away evil. Priests replaced physicians as healers and medical knowledge became the domain of the church. As people and animals were seen as possessing souls, they were sacrosanct and therefore dissection was forbidden. Here we also see a return to a monistic view of the mind and body: physical bodies and minds were seen as one, as the soul (or mind) was inherent in all parts of the physical body.

These dominant religious views on health and disease (and the mind–body relationship) remained until the Renaissance (which began around the fourteenth century). During the Renaissance a ‘re-birth’ of inquiry in Europe led to the scientific revolution during the 1600s. René Descartes, a French philosopher and mathematician, proposed novel views on the body. He put forward the notion that the mind and body are completely separate entities, but that they communicate with one another (through the pineal gland). This was a dualistic account of the mind and body, but Descartes went further by specifying that although mind (or soul) and the body were separate substances, they interacted with one another. Such an idea was extremely radical for the time and led to major consequences for the study of health and disease. Essentially, the body could be conceptualised as a physical machine. Descartes proposed that the human soul left the body at death and that animals have no soul – which enabled dissection of bodies to occur. From here knowledge of the body grew quickly, and Van Leeuwenhoek’s work on microscopy in the seventeenth century, along with Morgagni’s work on autopsy (seventeenth to eighteenth centuries) led to the rejection of the humoral theory of disease.

Over the next three hundred years medical knowledge and knowledge about bodily processes and functions grew tremendously. Physicians reclaimed the realm of medical knowledge and focused on bodily factors, primarily at the cellular level. Diagnosis and treatment of disease was based solely on physical evidence. These views developed into what is called the biomedical model of health and disease, which is the fundamental basis of traditional Western medicine today. Thus, modern Western medicine also employs a dualistic view of mind and body: the body is our physical being and the mind is made up of abstract processes of thoughts, feelings and so on, which are independent of physical disease processes.

Biomedicine and the biomedical model

The biomedical model of health and disease has dominated the field of medicine for over two hundred years, and continues to do so. According to the biomedical model:

- the body is separate from psychological and social processes of the mind;
- all diseases and physical disorders can be explained by disturbances in physiological processes, resulting from injury, biochemical imbalances, bacterial or viral infection and so on;
- health is seen as biochemical or physical in nature.

The biomedical model stimulated an enormous amount of research into identifying the pathogens that cause particular diseases. It also enabled the development of physical treatments for disease, such as medications, vaccines and surgical procedures (Bernard & Krupat, 1994). Medical technology continues to develop at an astounding rate, and more and more technologies are available to diagnose disease (such as computerised axial tomography, ultrasound and magnetic resonance imaging), conduct surgical procedures (such as heart bypass, organ transplantation, fetal surgery, microscopic surgery) and test for the risk of disease (such as some forms of genetic testing – see ch. 4) (Joralemon, 1999).

Despite these technological advances, however, the biomedical model has been heavily criticised. It has been described as (Hardey, 1998a):

- reductionist, and therefore ignoring the complexity of factors involved in health (Bernard & Krupat, 1994);
- mechanistic, and therefore assuming that every disease has a primary biological cause;
- dualistic, and therefore neglecting the social and psychological aspects of the individual (Engel, 1977);
- empirical, and therefore assuming that we can objectively identify biological causes of disease;

- disease oriented, and therefore emphasising illness over health;
- interventionist, and therefore overly intrusive.

If we assume that every disease has a primary biological cause that we can objectively identify, then behavioural, social and psychological factors will not be considered as potential contributors to disease, because these will not be assessed as part of the process of diagnosis (Stroebe, 2000). Thus, from the perspective of the biomedical model it is difficult to value lifestyle and psychosocial factors as affecting health and illness (Engel, 1977). From a more sociological perspective, many of the criticisms levelled at biomedicine throughout the 1970s were premised on an awareness that the values and activities of the medical profession were congruent with a patriarchal and capitalist society (Nettleton, 1995). Medicine was male dominated and sexist in its teaching, research and practice, and also functioned to sustain the capitalist status quo.

Two major changes occurred during the twentieth century in Western societies that led to serious questioning of the value of the biomedical model. First, there were enormous changes in the illnesses and diseases which affected people and caused death. Second, the concept of health became more prominent and reduced the emphasis placed on illness by biomedicine. Health became conceptualised in a much broader way than previously. These changes are outlined briefly below.

Changes in health and disease

Over the twentieth century rates of infectious disease declined dramatically in Western societies. In the early 1900s, people became ill and died primarily from **acute illness** (such as tuberculosis, pneumonia, influenza). However, over the course of the twentieth century life expectancy increased dramatically, and people became ill and died from chronic rather than acute illnesses (such as heart disease, cancer, diabetes) (Donaldson, 2000). A **chronic illness** is a degenerative illness which is slow in developing, and which people live with for a long time. Chronic illnesses are not so much cured as 'managed' (Taylor, 1999).

Although it is commonly thought that the increase in life expectancy and decline in infectious illness was the result of advances in medicine, in many cases the decline occurred many years before effective vaccines and medications were available. This was true for tuberculosis, diphtheria, measles, scarlet fever, typhoid, pneumonia and influenza (McKinlay & McKinlay, 1981). The primary reasons for the decline were better hygiene, better nutrition and reduced poverty (McKeown, 1979). For example, public health innovations and engineering allowed the building of sewage treatment and water purification facilities, which had a major impact on health.

Thus, although the biomedical model was a useful framework for infectious disease, it is not sufficient for the diseases of today. Chronic illnesses such as heart disease, cancer, stroke and diabetes are multiply determined disorders and psychological, behavioural and social factors play roles in their development. They are known as **lifestyle diseases**, as everyday behaviour such as diet, exercise and smoking puts people at risk of developing these chronic illnesses. The inadequacy of the biomedical model for diseases of today has been noted by Carroll (1992), who writes: 'to isolate disease and treatment as topics only for the attention of medicine and biology is to misunderstand the nature of most contemporary illness' (p. 2).

Diseases in which a person's everyday behaviours (e.g. diet, exercise, smoking) play roles in their development, such as coronary heart disease, lung cancer, Type II diabetes.

The broadening perspective on health

In 1948 the World Health Organisation (WHO) defined health as 'a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity'. This definition broke ground for three reasons:

- it is a positive definition, rather than a negative one – health is not merely the absence of illness;
- it recognised various dimensions of health status, including mental, physical and social aspects;
- it included political and social considerations, and was therefore inspirational. For example, well-being might require the elimination of poverty and freedom, enabling people to live in a society with social justice.

However, under this definition it is difficult for very many people to be categorised as healthy. Furthermore, it has been criticised because it is idealistic and utopian (Seedhouse, 1986). In summary, disenchantment with the biomedical model, and an increasing focus on social and psychological influences on health, led to the development of the biopsychosocial model (Engel, 1977).

The biopsychosocial model

Essentially the biopsychosocial model states that health and illness arise from the interplay of biological, psychological and social factors (Engel, 1977). For example, biological factors such as genetic predisposition, behavioural factors such as smoking and stress and social conditions such as social support and peer relationships may all contribute to the development of a particular disease (such as cancer). In terms of the mind–body debate, the biopsychosocial model has a holistic approach and sees that the mind and body are both involved in health and illness. Initially proposed by psychiatrist George Engel (1977), this model developed out of a need for medicine to take the patient into account, including her social context and how society deals

with her illness. The biopsychosocial model is certainly in accord with the definition of health provided by WHO in 1948.

While the biopsychosocial model has been a major influence in the development of health psychology (Marks *et al.*, 2000) it has received considerable criticism. Researchers have argued that the biopsychosocial model is still essentially biomedical and needs further theoretical work (e.g. Armstrong, 1987; Ogden, 1997). In psychiatry McLaren (1998) has strongly argued that the biopsychosocial model is seriously flawed and should be abandoned. McLaren argues that this model should be seen in its historical context, as a reaction against psychoanalysis (which is woolly and cannot be pinned down for empirical study) and behaviourism (which strips context from the person). Psychologists have put forward similar arguments. Stam (2000) has argued that authors do not discuss the biopsychosocial model as an explicit theory or formal model. He states (p. 276):

I think it is sufficient to say that it is a clever neologism masquerading as a model and its naïve distribution to undergraduates ought to lead us to urge publishers to place a warning label on textbooks indicating that they are a danger to the health of one's theoretical education.

On the other hand, Spicer and Chamberlain (1996) have argued that the basic perspective of the biopsychosocial model is right, but that the ways in which it is being implemented are inappropriate. According to these authors, the 'social' part of the model is not being captured in health psychology research, and the integration of the social and psychological has yet to be achieved. In a similar vein, Marks (2002) argues that the biopsychosocial model is not a model in the formal sense, but is better understood as a way of thinking about health and illness which functions heuristically to justify and legitimate research. Suls and Rothman (2004) also argue that 'as a guiding framework, the biopsychosocial model has proven remarkably successful as it has enabled health psychologists to be at the forefront of efforts to forge a multilevel, multisystems approach to human functioning' (p. 119). However, they also state that it is best viewed as a 'work in progress', and that for it to be effective five specific issues need to be addressed:

- transforming the biopsychosocial model from a conceptual framework into a formal model which specifies linkages between subsystems;
- recognising and emphasising that relevant constructs can serve multiple roles within a theoretical model (e.g. culture influences all levels of analysis);
- designing and collecting rich data sets which assess people at all relevant levels and across time, to enable an exploration of complex interacting systems;
- focusing on discovery and exploration rather than prematurely on hypothesis testing and explanation;
- ensuring that research findings translate into practice and policy (and vice versa).