A photograph of three soccer players sitting on a blue bench. They are wearing blue jerseys with yellow stripes on the sleeves and blue socks with yellow stripes. The player in the center is looking to his right and has a cigarette in his mouth. The background shows a blurred crowd in a stadium.

Edited by
**DAVID FRENCH, KAVITA VEDHARA,
AD A. KAPTEIN and JOHN WEINMAN**

Health Psychology

Second Edition



BPS BLACKWELL

Health Psychology

SECOND EDITION

Edited by David French, Kavita Vedhara,
Ad A. Kaptein and John Weinman



BPS BLACKWELL

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Praise for the first edition

"Health psychology has developed rapidly as a discipline over the past 25 years and this book gives a very valuable contemporary view of the area. The editors and authors are world experts in their fields and they offer a well-organised overview of the empirical evidence, theoretical approaches and opportunities for intervention in behaviour relevant to health, illness and healthcare."

—**Professor Marie Johnston**, School of Psychology,
University of Aberdeen

"*Health Psychology* offers a well-structured, state-of-the-art overview of the major theoretical, empirical and practical issues, written by leading international experts. It is an indispensable companion for students, researchers and practitioners. *Health Psychology* is an essential volume that moves the field another step ahead."

—**Wilmar Schaufeli**, PhD, Director of the Research Institute
Psychology & Health, Utrecht University

"Written by a team of internationally known writers and researchers in the field, this book stands out from other textbooks of health psychology. The opening chapter alone ought to be mandatory reading for anyone contemplating health psychology as a career and those in related professions, while the ensuing chapters give new interest to the major issues in current mainstream health psychology. This is a timely and welcome contribution to the discipline."

—**Sandra Horn**, School of Psychology,
University of Southampton

"This volume constitutes a major step forward in the development of health psychology as a science and as a professional discipline by giving an up-to-date and thorough overview of the field, often with a refreshing European flavour. It offers a number of useful features like mentioning key studies for a certain area and proposing 'discussion points'."

—**Professor Dr Jan Vinck**, Limburgs
Universitair Centrum, Belgium

"This comprehensive collection provides an authoritative overview of current thinking in health psychology research. A team of leading and predominantly European researchers map out the state of the science in an accessible and informative style."

—**Professor Charles Abraham**, Department of Psychology,
University of Sussex

"*Health Psychology* is another very good textbook that has much to offer those with an interest in health psychology ... The content is densely packed, but the 'Chapter Outline' and 'Key Concepts' at the beginning of each chapter ensure that finding particular information is quick and easy ... The book has a contemporary feel to it, referring to up-to-date studies and ideas. Many of the chapters are thoughtful and critical, and often acknowledge current difficulties and shortcomings."

—**Emma Dures**, University of the West of England, *Psychology, Health and Medicine*, February 2005, 10(1): 122–124

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Health Psychology

Introduction to Second Edition

David P. French, Kavita Vedhara,
Ad A. Kaptein and John Weinman

Health psychology is concerned with the study of psychological processes in health, illness and health care, and this book has been structured to provide an authoritative overview of the field. Later in this introduction we will outline some of the key issues and areas within health psychology but, before that, we would like to summarise the changes to the book since the first edition.

The first edition of this book was published in 2004 and was very well received by the health psychology community. In 2008, we obtained very constructive feedback on the first edition and this has been used as the basis for planning the second edition. The most important feedback concerned the generally high quality of the chapters, all of which were written by subject experts. However, our attention was also drawn to the fact that some key topics were either missing or only partially covered. In particular it was recommended that the book needed to provide a good quality coverage of all the key areas and topics listed in syllabus recommendations for masters degree-level health psychology programmes, such as those provided by the British Psychological Society (Division of Health Psychology Training Committee, 2008). Thus, in this edition, we have not only continued to ensure that all the chapters are written by subject experts but we have also substantially extended the scope of the book by adding many new chapters, which has resulted in a very comprehensive coverage of the key areas. In particular, there is greater coverage of specific health behaviours, health-behaviour models and processes, individual and contextual factors, and underlying psychobiological processes. Since the

book has now grown considerably in size and breadth of coverage, the original editors were really pleased to be joined by David French and Kavita Vedhara as co-editors for this edition in order to extend the scope and expertise of the editorial team.

In order to achieve all this, we have added 20 entirely new chapters as well as changing a number of existing chapters. In addition to providing a general overview of the role of behaviour in health (Stephens *et al.*, Chapter 2), we now have included specific chapters focusing on the key behaviours which have significant influences on health and well-being. Thus we now include separate chapters on smoking (Shahab & West, Chapter 3), physical activity (Biddle, Chapter 4), eating behaviour (Odgen, Chapter 5), alcohol and drug use (Hammersley, Chapter 6) and sexual health and behaviour (Parsons & Wells, Chapter 7), all of which now ensures that the book has a really comprehensive coverage of those health-related behaviours that make a major contribution to public health.

The first edition had a single, general chapter which covered the social-cognition models used to explain variation in health-related behaviours. We have now split this material into three chapters, to reflect the advances in knowledge brought about largely by the rapid increase in quality and quantity of intervention studies using these models. We have included a chapter on risk perception (Wright, Chapter 9), which also covers research on the effectiveness of different approaches to risk communication in changing health-related behaviour, in addition to chapters on changing health-related behaviours using both stage models (Snieder & Anger, Chapter 11), and non-stage or

'continuum' models such as the theory of planned behaviour (Sutton, Chapter 10). Extending this theme of applying theory to intervention, another of the new chapters deals with general issues in health behaviour interventions (Abraham, Chapter 8). The inclusion of this topic reflects the increasing concern of health psychology with the development of theory-based interventions, which aim to ensure not only that behaviour-change interventions are based on a sound theoretical understanding of the determinants of the behaviour but also make it possible to understand how and why such interventions succeed or fail.

A similar logic also applies to another new chapter, namely the one on health care professional behaviour (Francis & Johnston, Chapter 15), which describes the ways in which health psychologists are using psychological theories to both understand and influence key clinical behaviours. This new chapter has effectively replaced the one on communication in health care in the first edition, partly because the editorial team felt that no substantive recent developments had taken place in medical communication research but mainly because we felt that the contribution of health psychology to understanding and improving the clinical behaviour of health-care professionals represents an exciting and new extension of the discipline. Just as it is recognised that many patients do not follow medical advice or treatment, we now realise that health-care professionals often fail to adopt recommended evidence-based new clinical practices. The widespread patterns of treatment non-adherence has generated considerable research not only into understanding the reasons for this but also into testing the efficacy of interventions to remedy non-adherence, and this work is included in yet another new chapter (Horne & Clatworthy, Chapter 14). Another area of developing medical practice, where there are important psychological issues to consider, is that of screening and prevention. Thus we have included a new chapter which describes some of the emotional, cognitive and behavioural consequences associated with undergoing screening (Brain, Chapter 17).

Whereas the first edition had a single chapter on pain and symptom perception, we have now divided these topics in order to do justice to each. Thus, while the new chapter on symptom perception and help seeking (Scott, Chapter 13) focuses on the important

links between the processes involved in detecting symptoms and the decision to seek help, the revised pain chapter covers the key conceptual and clinical issues in pain, perception, cognition and behaviour (Daniel & Williams, Chapter 24).

As well as recognising the importance of stress, stress-related emotions and associated physiological processes in health outcome (Thayer & Brosschot, Chapter 19) and in hospitalisation and medical procedures (Smolderen & Vingerhoets, Chapter 18), we also thought that it was important to introduce a new chapter giving an overview of psychoneuroimmunology (Broadbent & Loft, Chapter 20) since this field provides insights into some of the key pathways and mechanisms through which psychological states can influence physiological processes and disease outcomes. Following this, we now have new authors and a new approach to the chapter on coping with stress (Smyth & Filipkowski, Chapter 21) and an updated chapter, which overviews the influence of social support on health and illness (Schwarzer & Knoll, Chapter 22). The chapters on illness cognition and behaviour (Cameron & Moss-Morris, Chapter 12) and quality of life (McGee & Ring, Chapter 26) have also been updated to reflect new developments in these areas. Also updated and considerably revised because of the inclusion of new authors and new research in the field is the chapter on psychological interventions in chronic illness (Wearden & Bundy, Chapter 16).

The final way in which this edition has been influenced by the British Psychological Society's recommended curriculum for health psychology is reflected in the inclusion of a number of new chapters focusing on both individual and contextual factors which can influence psychological processes in health and illness. Thus we now include an overview of the ways in which personality factors can influence health and illness-related behaviour (Wiebe *et al.*, Chapter 23). We have also recognised the importance of a life-span perspective in health psychology by the introduction of new separate chapters on developmental and family influences (Arden-Close & Eiser, Chapter 29) and ageing and health (Penedo *et al.*, Chapter 30). In addition, new chapters on social-cultural perspectives (Uskul, Chapter 27) and gender influences on health (Hunter & Rosairo, Chapter 28) provide coverage of the considerable influence of these two major

social/contextual factors in health and illness behaviour. Moreover, we have included new chapters that recognise the actual and potential input which health psychologists can contribute to understanding of the nature of disability (Dixon & Johnston, Chapter 25) and to the needs of patients at the end of life (Hall & Payne, Chapter 31).

The addition of so many high-quality new chapters together with the updating and development of existing chapters has ensured that this volume, quite uniquely, now provides an expert-based coverage of the breadth of content recommended for masters level degree courses in health psychology (e.g. Division of Health Psychology Training Committee, 2008). The only areas of such courses we do not attempt to cover relate to generic issues of methodology and research, which already have numerous excellent books devoted to them (e.g. Field, 2009; Smith, 2003), as well as book chapters which focus on these same issues in a health psychology context (French *et al.*, 2004; Johnston *et al.*, 2004; Sutton & French, 2004). The remainder of this introductory chapter includes an overview of the context and nature of health psychology research and practice.

Health Psychology in Context

Health and illness have long been the object of scientific and clinical interest for psychologists. Health psychology was first used in a book title in 1979 (Stone, Cohen & Adler). Over 30 years on, one would need a large bookcase to hold all the books that have 'health psychology' in their titles or that belong to the category of health psychology. The year 1979 was important for the formal establishment of the subdiscipline. The book by Stone *et al.* (1979) was published, and in September 1979, Matarazzo presented his presidential address to the Division of Health Psychology at an APA meeting. The title of his address was 'Behavioral Health and Behavioral Medicine – Frontiers for a New Health Psychology' (Matarazzo, 1980). He defined health psychology as 'the aggregate of the specific educational, scientific, and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, and the identification of

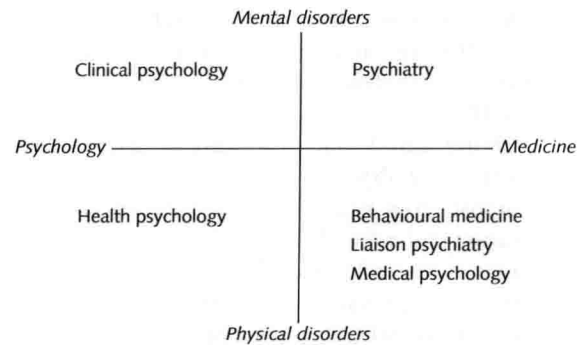


Figure 1.1 Health psychology and related disciplines

etiologic and diagnostic correlates of health, illness, and related dysfunction' (p. 815). In the 1982 definition, the following text was added: '... and to the analysis and improvement of the health care system and health policy formation' (Matarazzo, 1982, p. 4).

Health psychology is sometimes confused with a number of related disciplines (Weinman & Petrie, 2009). Figure 1.1 summarises the position of health psychology and those disciplines in a grid with 'psychology–medicine' on the *x*-axis, and 'mental disorders–physical disorders' on the *y*-axis (Kaptein & Weinman, 2004, pp. 4–6). Of course, separating 'mental problems' from 'physical disorders' is artificial, and the allocation of the different disciplines into their positions in the four quadrants may be somewhat forced. The quadrant with 'psychology' and 'physical disorders' constitutes health psychology. As we will discuss in detail in the next section, in health psychology, psychological theories and methods are applied in order to examine how to ensure that people stay healthy or achieve better adaptation to or recovery from illness.

Clinical psychology focuses on patients, or clients, with mental health problems (e.g. phobias, anxiety disorders, depression, substance abuse). The theoretical models and interventions that clinical psychologists apply to clients with these problems have been shown to be applicable to patients with chronic physical health problems (White, 2001). This has encouraged clinicians and researchers to apply these models to individuals with physical health problems as well. In this sense, health psychology and behavioural medicine were influenced and shaped by clinical psychology,

and there are now many clinical psychologists who work in the area of clinical health psychology (e.g. Bennett Johnson *et al.*, 2002; Kennedy, 2007; Newman *et al.*, 2009).

Psychiatry also focuses on patients with mental health problems. Psychiatrists mainly adopt a biomedical approach to patients with such disorders, applying medication and medical treatment. Currently, psychiatry appears to be dominated by biomedical, genetic and molecular approaches but, within psychiatry, there are practitioners who make use of psychological treatments, either on their own or more commonly in conjunction with medical approaches.

Behavioural medicine, liaison psychiatry and medical psychology are in the quadrant 'physical disorders' and 'medicine'. These three fields all focus on physical disorders and diseases, although there are differences in their emphasis and theoretical background. Behavioural medicine is defined as 'the interdisciplinary field concerned with the development and integration of behavioural, psychosocial, and biomedical science, knowledge and techniques, relevant to the understanding of health and illness, and the application of this knowledge and these techniques to prevention, diagnosis, treatment and rehabilitation' (Outlook SBM, 1995, p. 1). Central to behavioural medicine is its interdisciplinary nature, and the emphasis on integration of behavioural and biomedical knowledge. In addition, although behavioural medicine also incorporates (primary) prevention, just like health psychology, behavioural medicine's emphasis is more on treatment and rehabilitation. A comparison of the content of the major journals in behavioural medicine (*Annals of Behavioral Medicine*, *Behavioral Medicine*, *International Journal of Behavioral Medicine*, *Journal of Behavioral Medicine*) with the major journals in health psychology (*Health Psychology*, *British Journal of Health Psychology*, *Psychology & Health*) easily demonstrates this point.

Liaison psychiatry is a subspecialty within psychiatry, focusing on patients in a medical setting whose responses to illness – for medical or psychological reasons – lead to problems for the patient and/or the medical staff. Although liaison psychiatry and health psychology have developed over a similar period of time with a number of overlapping interests and concerns, there are some important differences between

the two fields. Whereas liaison psychiatry has its major focus on patients with physical health problems and who are experiencing psychological difficulties, health psychology has a much broader remit since it is concerned with all behaviours which influence health and illness in all individuals. Thus, while health psychology has focused on the development of theoretically based explanations and interventions for health-related and illness-related behaviours, liaison psychiatry has been concerned primarily with the diagnosis and treatment of people with either unexplained symptoms or with psychiatric disorders occurring in the context of a physical health problem.

Medical psychology is an older term which was used for describing the disciplinary area for psychologists who worked in medical settings (medical schools and hospitals), and who diagnosed and managed patients with physical health problems and were often involved with teaching and training of medical students and staff about psychology as applied to health and illness. However, this term is used much less frequently now, as most psychologists working in these contexts tend to be called health or clinical health psychologists.

Health Psychology and its Four Fields

We now move on from defining and demarcating scientific disciplines to illustrations of the four core elements of health psychology. The *first* element of health psychology, given Matarazzo's definition, is the promotion and maintenance of health. Studies in this area are aimed at healthy individuals and identifying where health psychology is instrumental in achieving this aim. Wardle (2000) has labelled this 'public health psychology', and has outlined various areas where health psychology can play a role.

Kaplan (2000) pointed out how 'promotion and maintenance of health' have very different connotations in medicine and (health) psychology. Prevention in the medical context pertains to 'identifying an existing disease at an early stage and eliminating the problem before it gets out of control', while prevention in behavioural models pertains to 'maneuvers that reduce the chances that a health problem will ever develop' (p. 382). Physicians and others working with a medical model of health and illness often define

activities that scientists and clinicians who work in a behavioural model would call 'secondary prevention' as 'primary prevention'. This is a matter that is not only limited to a semantic issue, or to confusion in medical students and behavioural-science teachers when they teach about prevention. As Kaplan (2000) emphasises, 'Secondary prevention is typically based on a traditional biomedical model that requires the diagnosis and treatment of an existing condition and that usually involves one or more of the following: medical diagnosis, surgery, or use of medications. Primary prevention is usually based on a behavioral rather than a disease model. Diagnosis plays a lesser role because there is no disease to diagnose. Intervention is typically behavioral and might include exercise, dietary change, or the avoidance or reduction of alcohol use. Interventions might also include public policy changes' (p. 383). However, in the context of secondary prevention, reduction of disease risk or progression may be achieved by behaviour changes, either to promote increased physical activity or improved dietary choice or to reduce the risks associated with smoking, alcohol and drug use, and certain sexual behaviours.

The *second* element, prevention and treatment of illness, has some overlap with the first area, but more obviously focuses on people who have been identified to be at risk for disease (e.g. those who have been screened to be at risk for coronary heart disease or stroke from blood pressure screening, or for colorectal, cervical or breast cancer as the result of screening programmes involving testing for faecal occult blood, the cervical smear test and mammography, respectively). Here the aim is to detect risk or early signs of disease at an early enough stage in order to eliminate or slow down its development. Although this approach is often thought of as primarily biomedical, it may also involve key behavioural factors. Thus there is now considerable evidence of the importance of psychological factors in the uptake (Cooke & French, 2008; Jepson *et al.*, 2000) and impact of screening (Brain, Chapter 17). Moreover, if risks are identified then subsequent prevention is often achieved through behavioural changes and/or medical options, such as anti-hypertensive or lipid lowering medication, which also involve a major behavioural component (i.e. adherence to the treatment).

Health psychologists have an excellent track record when it comes to psychological interventions in people who are ill. There are now many studies, as well as systematic reviews (including Cochrane reviews), and meta-analyses of psychological interventions aimed at improving either disease or disease-related outcomes, such as depression or quality of life, across a wide range of physical health problems (see Kennedy, 2007; Newman *et al.*, 2009).

If we consider three of the major physical illnesses and some of the best intervention studies from a (clinical) health psychology point of view, a number of important papers illustrate what the field has to offer. Linden *et al.* (1996), in a meta-analysis of behavioural interventions in cardiovascular disease, conclude, 'The addition of psychosocial treatments to standard cardiac rehabilitation regimens reduces mortality and morbidity, psychological distress, and some biological risk factors' (p. 745). In the area of cancer, Rehse and Pukrop (2003) and Meyer and Mark (1995) present two meta-analyses on the effects of psychosocial interventions on 'quality of life' and other major outcome measures. The conclusions by Meyer and Mark are of the utmost importance: 'it would be an inefficient use of research resources to conduct more studies ... to ask the simple question: Is there an effect of behavioural, educational, social support, and non-behavioural counselling and therapy interventions on the emotional adjustment, Functional adjustment, and treatment-and disease-related symptoms of cancer patients? These interventions have a consistent beneficial effect on all three areas' (p. 106). In the area of the third leading cause of death in developed societies, chronic obstructive pulmonary disease (COPD), Lacasse *et al.* (2003) in a Cochrane review conclude that psychosocial interventions 'relieve dyspnea and fatigue, and enhance patients' sense of control over their condition. These improvements are moderately large and clinically significant' (p. 1; see also Kaptein & Creer, 2002). However, not all such reviews are so positive in their conclusions and there are a number of areas where there is not yet consistent evidence of positive outcomes from psychological intervention (e.g. Yorke *et al.*, 2006).

Two further issues deserve discussion. The first has to do with the kind of outcome measures which health psychologists choose as dependent variables in

the intervention studies examining effects of psychological or psychosocial treatment on various conditions. As outlined by Kaplan (1990) in his important paper 'Behavior as the Central Outcome in Health Care', choosing observable outcome measures which make sense in the real world is his preferred type of dependent variable. It is important to consider Kaplan's views when planning a study, or when studying the research literature in health psychology. All too often, health psychologists fall victim to the trap of examining associations between two self-report measures, and so it is no surprise to find high correlations between self-reports of, for example, life events and physical symptoms. Self-reports are susceptible to a variety of biases and it is equally important to try and predict more 'objective' indicators, such as survival, resumption of work and social activities (Petrie *et al.*, 2002). Secondly, various authors, health psychologists themselves, increasingly publish critical papers on a number of major issues in health psychology. For example, Ogden (2003) has critically reviewed the social cognition theories developed in the health psychology domain, and concluded that 'If social cognition models are to be given the status of theories, then it is recommended that the critical eye that psychologists place on other areas of research also be cast on this one' (p. 427). Similarly, Salmon and Hall (2003) have critically reviewed one of the pet concepts of health psychologists ('patient empowerment and control'). These papers illustrate the coming of age of health psychology: the area is being criticised by scientists who contribute to the further development of health psychology.

The *third* element of health psychology in Matarazzo's definition is 'etiologic and diagnostic correlates of health and illness'. Illustrations of these two topics can be found in almost any recent issue of a health psychology journal. Appels' work on 'vital exhaustion' as a contributor to the incidence of myocardial infarction is a good example of the role of a psychological factor in the aetiology of a major illness (van Diest *et al.*, 2002). With this type of research, the use of appropriate designs and well-chosen samples is crucial. Thus health psychology research has needed to make use of longitudinal, case-control and quasi-experimental designs in order to establish the role of psychological factors in the aetiological process.

The *fourth* and final element is 'health care system and health policy'. Health psychology research aiming at examining or changing the health-care system and/or health policy is rather scarce. However, there are interesting studies which have examined the impact of different types of health-care environment on patient well-being and recovery (e.g. Devlin & Arnell, 2003), and there is growing interest in examining the role of psychological factors in explaining variation in health-care professional behaviour, particularly in the adoption of evidence-based approaches to investigation and treatment (see Chapter 15, this volume).

Types of Health Psychology Research

As in every other area of psychology, there are very different types of research conducted within health psychology. A broad distinction can be made between three broad categories of study, namely those which are descriptive, predictive or intervention-based.

At the most basic level are the descriptive studies, which represent a very useful first step in research since they provide accounts of the nature and range of key behaviours or other psychological processes. For example, descriptions of the levels of engagement in different health behaviours such as daily physical activity or dietary intake (see Chapter 2, this volume), or of the ways in which people cope with stressors, including major health problems (see Chapter 21, this volume) provide an important database for the discipline.

Typically, *predictive studies* will involve either the development or application of psychological theories. A large number of theories have been developed for explaining variations in health- and illness-related behaviour, and these continue to be refined in order to improve their predictive power. Some have been borrowed from other areas of psychology, particularly from social psychology, and applied to the explanation of different health behaviours whereas others have been developed specifically within the context of health psychology research and both have been shown to be valuable. In a discussion of general and health-specific models of self regulation, Cameron and Leventhal (2003) point to the important interchange between general and health-specific models, and the potential that this can offer for enhancing the flow of

information between the fields of social cognition and personality and health psychologies. In this way health psychology research can effectively inform the development of theory in these other fields; and so the fields can develop in synchrony.

Despite the importance of descriptive and predictive studies for establishing the empirical and theoretical basis of health psychology, a more definitive test of theory needs to involve experimental or quasi-experimental methodologies. Increasing levels of confidence in explaining health and illness behaviour can be gained from studies in which independent variables (e.g. arousal, emotion, knowledge, beliefs, etc.) are experimentally manipulated in order to see whether this results in predicted/hypothesised changes in behaviour or other outcomes, including health. This can be achieved using laboratory-type experimental methods where tight control can be exercised over the manipulation of independent variables and where dependent variables can be observed and/or measured with precision. For example, psycho-physiological studies have been conducted to establish relations between such factors as stressors and both physiological (e.g. blood pressure, salivary control, immune function) and psychological outcomes (e.g. mood, information processing). Similarly there is increasing use of analogue or vignette studies, which not only allow the researcher to investigate how individuals respond to imagined scenarios (e.g. being provided with a genetic test result – Wright *et al.*, 2006) but also to see how responses are affected by the manipulation of specific variables, such as the type of information presented or the way in which it is framed.

In the longer term, the most valuable types of experimental or quasi-experimental study in health psychology will be those involving interventions based on the findings from earlier predictive studies, which were based in turn on relevant theory. For example, building on the evidence that illness and treatment beliefs predict differences in illness-related behaviour, there are now a small but growing number of intervention studies designed to modify beliefs as a basis for changing behaviour and related outcomes (see Broadbent *et al.*, 2009; French *et al.*, 2008; Karamanidou *et al.*, 2008; Petrie *et al.*, 2002;). These not only provide a test of the intervention but can also allow the researcher to develop and refine the underlying theory.

Another important distinction in health psychology research is between the use of qualitative and quantitative research methods, which can differ considerably in their approach and function. Quantitative approaches typically involve the use of methods for measuring and/or manipulating variables, and for defining relationships between them in order to describe processes, test hypotheses or examine the impact of an intervention. In contrast, qualitative research is often more concerned with understanding the meaning of experience or situations as they are interpreted by the individuals participating in a study.

Traditionally, psychology research, and health psychology research in particular, have relied more on theory-based quantitative methods, but there is increasing use of qualitative methods for guiding research and developing theory (e.g. Yardley, 2000). There is not space here to discuss the assumptions underlying qualitative research or to map out the range of approaches that can be used for data collection or analysis. Nevertheless it is important to note that many methods exist, including interview, focus groups and observational methods, and these typically but not exclusively involve the use of audio or video recording for the collection of data. Most commonly, qualitative research involves the use of in-depth interviews or focus group discussions to generate data, which then can be analysed in a range of ways, and vary in their level of imposed structure and their underlying assumptions.

The qualitative/quantitative distinction is sometimes presented or perceived as a competitive, either-or issue, and this is both absurd and pointless. Both qualitative and quantitative research encompasses several variations in terms of intent and underlying assumptions, and researchers need to be clear about the overall aims of their research in order to select the appropriate method (see French *et al.*, 2004).

Journals in Health Psychology

A growing number of journals focusing on health psychology have been established in the past 10 to 20 years, helping the field to develop. *Health Psychology* is the subdiscipline-linked journal with the highest impact factor score of journals in the specific health psychology area. The other key journals include