PYB 307 Health Psychology – Exam Revision Guide

Week 1: Introduction to health psychology

- Health is more than the absence of disease – it is shaped by biological, psychological, and social factors working together

Defining health

- **WHO Definition** = health is a positive state of complete physical, mental and social wellbeing, not just the absence of disease or infirmity
    - Complete wellbeing would make most people unhealthy most of the time, especially with chronic illness so common – still influences Australian policy
- Health can be judged by **how you feel** (do I feel healthy?), **what you do** (health actions), and **functionality (**what health lets you do) -> definition of health and what it means depends on the individua l
- **Pathogenic approach** (focused on disease and what causes illness) = where the disease comes from? -> traditional biomedical approach
- **Salutogenic approach** (focused on health and what creates or maintains good health) = asks where health comes from -> patient-centred

Salutogenic model – Aaron Antonovsky

- Health sits on a **health-ease/dis-ease continuum**
- Everyone faces stress, our **life experiences shape how well we cope**, which moves us towards ease or dis-ease
- **Sense of coherence (SOC)** = overall confidence you can understand and cope with life's challenges. It consists of 3 dimensions:
    1. **Comprehensibility** – life makes sense; it is structured and predictable
    2. **Manageability** – you have the resources (skills, support) to cope
    3. **Meaningfulness** – the challenge feels worth engaging with
- **A strong SOC = better coping and better health outcomes**
- **The Saultogenic expanded model** has 3 parts: **sense of coherence, stressors, and general resistance resources (GRRs).**
    - Generalised resistance resources push you towards total health, whereas general resistance deficits push you towards death

    - SOC is a dispositional orientation built from life experience -> a stronger SOC predicts salutogenesis

Determinants of health

- Health is partly individual choice, but social factors matter e.g., rural living, housing
- **Environmental** factors – where you live, community safety, geography
- **Socioeconomic** – education, employment, income
- **Health behaviours** – diet, exercise, smoking, sleep
- **Biomedical** – genetic, blood pressure, body weight
- The focus is on how these **combine** to produce health or disease

Biopsychosocial vs biomedical

- **Biomedical model** comes from Cartesian dualism (Rene Descartes) – the idea that the mind and body are separate
- **Health psychology** rejects this – biological, psychological, and social factors all influence health, illness, and healthcare
- Health psychology focuses on the individual, preventing illness and promoting health
- Core topics – health behaviours, stress, coping with chronic illness, treatment adherence, health promotion, patient-provider communication
- A key aim is **persuading people to make healthy decisions**
- AIHW (2012) determinants model – broad features of society, environment, socioeconomic characteristics, knowledge/attitudes, health behaviours, psychological factors, safety factors, biomedical factors all feed into health and wellbeing over time, on top of genetic makeup

Australian health statistics

- **Rising life expectancy** = a sign of good population health
- **There is a persistent male-female life expectancy gap** (females more likely to live longer), and **less life-expectancy for ABTSI**
- **Epidemiological transition** = in colonial Australia most deaths were from **infectious disease and dietary illness**, now **chronic illness** is the leading cause of death, especially in older people
- Leading cause of death for ages **75-84 = coronary heart disease**
- Highest rates of mental and behavioural conditions = ages **15-24 and 25-34** (life transitions)

- Causes of death vary by **age, culture, and biological sex**
- Nearly **1 in 4 Australians are migrants**; migrants tend to have **better health**
- Main goals of health psychology = promote and maintain health, improve healthcare systems and policy, prevent and treat illness, understand causes of illness, vulnerability and risk factors
- Health promotion role = promote positive and reduce harmful behaviours, reduce chronic-disease risk factors, advise other professionals, design public health programs, identify modifiable determinants
- Almost half of Australians have at least 1 of 10 common chronic conditions
- Health of Australians isn't consistent or equitable
- Health psychology aims to improve health from the micro (individual) to the macro (societal) level

Primary, secondary and tertiary prevention

- Primary (before) = STOP it/prevent it from happening before it develops e.g., vaccinations, healthy diet and exercise, sun protection
- Secondary (early) = FIND it early, so it can be treated before it comes worse e.g., cancer screening, blood pressure checks, diabetes screening
- Tertiary prevention (after) = MANAGE it. It occurs after someone already has a disease, aiming to reduce complications, disability, and further deterioration e.g., rehabilitation, managing chronic disease, physiotherapy after a stroke

Factors

1. Macro = factors affecting whole population and society
2. Meso = community/organisations/workplaces/schools
3. Micro = individual e.g., your own knowledge, beliefs, and attitudes

Week 2: Theories of health behaviour and behaviour change

- Social cognition models explain why people do or don't perform health behaviours, so interventions can target the right beliefs.
    - Need to know each model's author/year, components, best use and limitations

Health behaviours

- **Health behaviours (Conner & Norman, 2017)** are overt patterns, actions and habits relating to health maintenance, restoration, and improvement e.g., smoking, alcohol, diet, physical activity
- **The Alameda 7 (1965-1971)** are 7 lifestyle features linked to lower illness and longer survival:
    1. Sleeping 7-8 hours a night
    2. Not smoking
    3. 1-2 alcoholic drinks or fewer per day
    4. Regular exercise
    5. Not eating between meals
    6. Eating breakfast regularly
    7. Being no more than 10% overweight
- **Individual barriers to healthy behaviours** = enjoyment of the risky behaviour, no immediate harm, effort to change, fear/denial, false consensus ("everyone does it"), unrealistic optimism, fatalism ("nothing I can do")
- **Why use theory:** explains psychological/social determinants, predicts who will act, identifies barriers and mechanisms to change, and guides intervention planning

Health belief model (HBM) – Becker, 1974; Rosenstock, 1974

- Behaviour depends on two assessments:

1. **Threat perception: perceived susceptibility** (will I get it?) **+ perceived severity** (how bad will it be?)
2. **Behaviour evaluation: perceived benefits** vs **perceived barriers** of acting

- Plus, **cues to action** (internal/external triggers, e.g., symptoms, family prompting) and **health motivation** (general readiness to care about health)
- **Demographic variables** (gender, age) feed into all of these
- **best for =** risk perception, preventative behaviours and chronic-condition management
- **evidence =** benefits, barriers, and health motivation are the strongest predictors

- **example – testicular self-examination (McClenahan et al., 2007) =** susceptibility ("my chances are great"), severity ("serious disease"), health motivation, benefits ("find lumps"), barriers ("can be painful"), cues (symptoms, family/friends)
- **limitations**
    - strong emphasis on individual agency, ignores social/structural constraints
    - assumes people consciously weigh benefits vs barriers
    - little detail on how constructs relate or which matters most
    - may overestimate the role of threat
    - missing factors = outcome expectancy, past behaviour, emotion
    - Better for initiation than maintenance

Theory of reasoned action (TRA) and the theory of planned behaviour (TPB) – Ajzen, 1991

- **TRA** = beliefs -> attitudes + subjective norms -> **intention** -> behaviour
- **TPB** = TRA **+ perceived behavioural control (PBC)**
- **Intention** is the best predictor of behaviour. Intention comes from:
    - **Attitude** – good/bad evaluation
        - **Behavioural** beliefs
    - **Subjective norms** – do important others think I should do it?
        - **Normative** beliefs
    - **PBC – perceived control** ("it's up to me") **+ perceived self-efficacy** ("I'm confident I could")
        - **Control** beliefs = barriers/facilitators
- **PBC can also directly influence behaviour**
- Example **– undergraduate binge drinking (Norman, 2011)** – intention to drink predicted by attitude and self-efficacy. Behaviour was predicted by intention. Interventions: challenge positive attitudes, make the environment harder for binge drinking
- Example – **nurses' hand hygiene (White et al., 2015) –** key behavioural beliefs = protecting co-workers, key control beliefs = lack of time, forgetfulness
- **Best for** = behaviours shaped by social influence
- **Limitations** = assumes conscious thoughts fully drive behaviour, intention-behaviour gap
    - **Implementation intentions =** work by identifying barriers and using situational cues

Prototype/willingness model (PWM) – Gibbons et al., 2003

- Explains **unplanned, spontaneous** behaviour**. Dual-process** model:

    - **Reasoned action path** = attitudes + subjective norms -> **behavioural intention** -> behaviour (deliberate)
    - **Social reaction path: prototypes -> behavioural willingness** -> behaviour (heuristic, quick)
- **Prototypes** = images of the typical person who does the behaviour. Judged by **favourability** (how positively seen) and **similarity** (how like me)
- Previous behaviour feeds into attitudes, norms and prototypes
- **Willingness scenarios** remove barriers to ask "if this happened, would you?"
- **Example – adolescent pregnancy prevention (Gibbons et al., 1995):** prototype favourability and similarity predicted willingness to have unprotected sex
- **Best for –** adolescents and spontaneous risk behaviour
- **Limitations –** no control/self-efficacy element

Health Action Process Approach (HAPA) – Schwarzer, 1992

- Focuses on the **intention-behaviour gap**

1. **Motivation phase (pre-intenders):** task/action self-efficacy, outcome expectancies and risk perceptions -> intention
2. **Volition phase (intenders -> actors)**
    a. **Action planning** – when, where, how and with whom
    b. **Coping planning** – anticipating barriers and how to overcome them
    c. **Maintenance self-efficacy** – coping with barriers
    d. **Recovery self-efficacy** – getting back on track after setbacks
    e. **Action control** – self-monitoring behaviour against a standard

- **Barriers and resources** affect every stage
- **Example – hand washing study in Costa Rican undergraduates (Fernandez et al., 2016) ->** action and coping planning linked intention to behaviour via action control
- **Best for:** the intention-behaviour link
- **Limitations:** assumes conscious processing, many factors to measure at different times, fits some populations better

Transtheoretical Model/Stages of Change – Prochaska & DiClemente

- People differ in **readiness** to change
- Five stages of change:

1. **Precontemplation** – not thinking about change, unaware of the issue
2. **Contemplation** – aware, considering change, not committed
3. **Precontemplation** – ready, planning a goal
4. **Action** – actively changing
5. **Maintenance** – keeping the change, resisting relapse

- Movement is not linear – people spiral back and forth

- Mass media campaigns work best at contemplation
- **Limitations –** stages may not be discrete, little evidence people go through all stages, a continuum may fit better, ignores social aspects
- **Implementations should be targeted to the person's stage**

Other theories

Social cognitive theory (SCT) – Bandura

- Focus on self-efficacy. There are 3 expectancies: situation-outcome, outcome expectancies (action-outcome), self-efficacy
- The 2 expectancy beliefs: action-outcome and self-efficacy both directly influence behaviour
- Reciprocal determinism: person, behaviour, and environment influence each other

Implementation intentions – if-then plans for when, where, and how to turn a goal into an action

Self-determination theory (SDT) – intrinsic vs extrinsic motivation. People have 3 needs – autonomy, competence, relatedness. Autonomous motivation predicts long-term maintenance

Social learning theory – vicarious learning (learning by watching others).

Limitations of social cognition models

- Reliance on self-report
- Emphasises individual agency, downplays the influence of social/structural and impulse factors
- Inconsistent measurement
- Poor predictive power

Common General Limitations

- Assume conscious info processing (being aware of what you are processing) and focus on individual agencies
    - they assume rationality = people act in a certain way, process A leads to process B

Choosing a theory

Theory	**Best for**

Health beliefs model - HBM	Risk perception
Theory of planned behaviour - TPB	Social influences
Prototype willingness model - PWM	Adolescents, spontaneous, unplanned behaviour
Health action process approach - HAPA	Intention-behaviour gap
Transtheoretical model = TTM	Readiness to change, matching interventions to change
Self-determination theory	Long-term maintenance

Behaviour change, persuasion and fear appeals

- Models identify targets for interventions
- Persuasion: social influence, elaboration likelihood model (how deeply information is processed). Central route = careful thought, peripheral route = cues such as source attractiveness
- Protection motivation theory – Rogers, 1983 developed to understand fear appeals. Motivation to protect oneself depends on 2 appraisals:
    - Threat appraisal: severity + probability (vulnerability) of the event
    - Coping appraisal: response efficacy (will it work?) + self-efficacy (can I do it?)

Primary, secondary and tertiary prevention

- Primary = changing **risk factors** before disease develops e.g., vaccination
- Secondary = **identifying and treating illness early** e.g., screening
- Tertiary = **containing damage, preventing disability, rehabilitation**

Prescribed reading – Conner & Norman 2017: Health behaviour, current issues

- Looked at four health behaviours – smoking, binge drinking, healthy diet, physical activity
- Most research uses self-report = validity concerns
- Shared determinants = motivation and self-efficacy, social influence/attitudes, SES and gender, environment, impulsivity

Week 3: Gender, age, SES, culture and individual differences

- Sociodemographic factors (sex, gender, age, SES, location, culture) and individual differences (locus of control, personality, motivation) all shape health beliefs and behaviours, so interventions must account for them
- Health literacy = a person's ability to find, understand, evaluate and use health info to make appropriate health decisions

Sex, gender and health

- Sex = biological characteristics. Gender = socially constructed roles and identities
- Policy should integrate sex and gender
- Females live longer but with higher levels of morbidity (more illness)
    - Oestrogen = positive effect on why females live longer
- Females live longer due to biological differences amplified by psychosocial factors
- Biological: sex hormones modulate the immune response
- Social/behavioural: men take more risks and seek healthcare less. Women report lower scores on self-report health measures
- Biopsychosocial: gender roles (caregiver vs masculinity), women are more often the targets of health campaigns
- Gender diversity: understudied and political – mental health is more studied: gender diverse people have poorer mental health and higher suicide rates
- Caveats: differences are group-level (individuals vary), factors intersect e.g., first nations women, however these are understudied
- Sociodemographic factors fit in – TPB, COM-B model/behaviour change wheel

The COM-B model

- A model for understanding what needs to happen for someone to change a behaviour
- 3 things needed for behaviour to occur
- C = capability: does the person have the knowledge or skills to do the behaviour?
- O = opportunity: does the environment allow/support them to do it?
    - E.g., a farmers market opening in a neighbourhood makes healthy options easier to get (a physical opportunity)
- M = motivation: do they want or feel driven to do it?

Age and health

- Health risks are highest in infancy and older adulthood
    - Infants – high rates of accidental poisoning, hospitalisation, death
- Avoidable conditions shift with age – injuries in childhood, lifestyle-related chronic disease in adulthood
- Adolescents can reason logically about health but are prone to risk-taking -> their thinking can be shaped by confirmatory bias (seeking info that supports existing beliefs), social influence and optimism bias
- About ¾ of older adults rate their health as good/excellent

SES, location and culture

- SES = education, employment, income. Affects health and access to healthcare
    - Differs across countries and intersects with other variables
- SES influence on health is mediated by health literacy-(a person's ability to find, understand, evaluate and use health info)
- Geographic conditions – rural areas have higher rates of some conditions
- Culture – often overlooked
    - Aboriginal health beliefs – health linked to land, kinship, obligations, and spirituality. Social / spiritual dysfunction causes illness
- Culturally informed health promotion involves family and community and acknowledges diversity e.g., Deadly Choices
- Culturally safe care improves outcomes. It operates on a continuum: cultural awareness -> sensitivity -> competence/safety/responsiveness

Children's understanding of illness

- There are 6 stages

1. phenomenism = pre-logical, illness = single symptom, remote cause
2. contagion = pre-logical, illness = single symptom, cause = proximity to a person/object
3. contamination = concrete logic (7-10) = multiple symptoms, germs and behaviours cause illness
4. internalisation = concrete logic (7-10) = contaminants enter the body, illness can be prevented by proper care
5. physiological = formal logic (11+), illness in specific body organs, multiple physical causes

6. psychophysiological = formal logic (11+), both physical and psychological causes e.g., germs and stress

Individual differences: locus of control

- Internal LOC – I control my heath outcomes
- External LOC – outcomes are controlled by external forces. Dimensions that predict health behaviour:
    - Chance – luck, fate
    - Powerful others – doctor, family
    - God – religion
- Multidimensional health locus of control (MHLC) in healthcare:
    - Internal LOC – active participant, prefers shared decision-making
    - Low powerful-others scores – prefer active collaboration
    - High powerful-others – others decide, follow instructions
    - Chance LOC – least engaged, fatalism (the belief events are predetermined or outside your control)
- Self-efficacy mediates LOC, so interventions target self-efficacy

Individual differences: personality

- Conscientiousness (organised, self-disciplined, impulse control, plans ahead) has the strongest, most consistent link with positive health
- Neuroticism = tendency to negative emotions and instability
- Challenges for personality research = direction of causality (correlational), unmeasured background variables, self-report bias

Social Cognitive Theory

- Developed by Albert Bandura
- Reciprocal determinism – personal factors, behaviour and environment consciously influence each other
- Self-efficacy = belief in your ability to perform a behaviour, the strongest predictor of change
- Bandura's 4 sources of self-efficacy

1. Mastery experience – past success
2. Vicarious experience – seeing similar others succeed
3. Verbal persuasion
4. Psychological/emotional states

- In SCT, both outcome expectancies and self-efficacy directly influence behaviour
- SCT vs SDT – SCT = can I do this? (self-efficacy). SDT = do I want to and why? (autonomous motivation)

Self-Determination Theory and Motivation

- SDT is highly relevant to long-term maintenance of behaviour change
- Health behaviours are driven by motivations along a continuum of autonomy

Type	Meaning
Amotivation	No intention, no reward
External regulation (controlled)	Rewards/punishment
Introjected regulation (controlled)	Avoid guilt/shame, boost ego
Identified regulation (autonomous)	Personally value the outcome
Integrated regulation (autonomous)	Part of identity
Intrinsic motivation (autonomous)	Inherent enjoyment

- Extrinsic motivation often gets people started, but the behaviour drops off when the pressure is removed
- Intrinsic motivation is the gold standard, but rare as may health behaviours aren't enjoyable
- You want to support autonomy as a psychologist

Reading

- Meta-analysis of 74 self-determination theory based heath intervention studies. They looked at techniques used to create a need-supportive environment (autonomy, competence, relatedness support)
- Autonomy showed the greatest affect on creating a need-supportive environment
- Need support comes from combined techniques delivered in an autonomy-supportive style