PART ONE

OVERVIEW
CHAPTER 1

Health Psychology: Overview and Professional Issues

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The importance of psychological processes in the experience of health and illness is being increasingly recognized. More and more evidence is accumulating for the role of behavior in current trends of morbidity and mortality: Certain health behaviors reduce morbidity and mortality (Breslow & Enstrom, 1980; Broome & Llewellyn, 1995; Marks, Murray, Evans, & Willig, 2000; Matarazzo, Weiss, Herd, Miller, & Weiss, 1984; Taylor, 1986). Maes and von Veldhoven (1989), reviewing all the English language handbooks on health psychology known at that time, counted 15 published during the period 1979 to 1989. Recent developments, especially in clinical practice, have been even more encompassing, and health psychologists are in increasing demand in clinical health care and medical settings. In the United States, the single largest area of placement of psychologists in recent years has been in medical centers. Psychologists have become vital members of multidisciplinary clinical and research teams in rehabilitation, cardiology, pediatrics, oncology, anesthesiology, family practice, dentistry, and other medical fields (American Psychological Association [APA], 1996). With this increasing participation of psychologists in health services, guidelines for professional training programs and ethical practice have been developed in the United States, Europe, and elsewhere. This chapter reviews some of the professional and ethical issues that have been identified and discussed in these regions. The emphasis is on education and training.

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recognizes the field of health psychology in the United States occurred less than 20 years ago. It is no longer correct to speak of health psychology as an ‘emerging’ specialty within American psychology; for the last two or three decades, health psychology has flourished as one of the most vibrant specialties within the larger discipline of psychology. Not only is it recognized as a specialty in its own right, health psychology has had a profound impact on clinical psychology, and has played a major role in developing and vitalizing the interdisciplinary field called “behavioral medicine.” The overlap with behavioral medicine in both theory and practice has been strong and, like behavioral medicine, health psychology is really an interdisciplinary field (Marks, 1996). Because the leading causes of mortality have substantial behavioral components, behavioral risk factors (e.g., drug and alcohol use, unsafe sexual behavior, smoking, diet, a sedentary lifestyle) are the main focus of efforts in the area of health promotion and disease prevention. Behavioral methods are also playing an increasing role in treatment and rehabilitation. Beyond the clinical domain, the relevance of psychology to public health, health education and health promotion has been discussed by health psychologists (Bennett & Murphy, 1997; Winett, King, & Altman, 1989) and health promotion specialists (Macdonald, 2000).

Given its emphasis on behavior and behavioral change, psychology has a unique contribution to make to health care and public health. Health psychologists are currently conducting research on the development of healthy habits as well as the prevention or reduction of unhealthy behaviors. Both the impact of behavior on health as well as the influence of health and disease states on psychological factors are being explored. Psychosocial linkages in areas such as psychological immunology, pain, cardiovascular disorders, cancer, AIDS/HIV, and other chronic diseases are being defined. Psychosocial mediators of effective public health promotion are being identified.

The United States has produced the most influential theoretical and ideological frameworks and a large proportion of the empirical work. The Health Psychology Division of the APA (Division 38) is one of the largest and fastest growing in the association. Its journal, Health Psychology, has one of the largest circulations among psychology journals. However, in the 1990s, a considerable amount of research was initiated in Europe. Health psychology was no longer totally dominated by developments in the United States. The European Health Psychology Society (EHPS) has organized scientific meetings since 1986. Undoubtedly these have had an influential role in the proliferation of the European health psychology scene. Linked to the EHPS, the journal Psychology and Health is a respected review of health psychology and since 1985 has been the leading European journal. The establishment of the Journal of Health Psychology in 1996 has encouraged an interdisciplinary and international orientation to the field and created a forum for new methods and theories, discussions, and debate, including critical approaches. Another journal, Psychology, Health & Medicine has focused on psychological care for medical problems. Other journals that publish papers in this field are the International Journal of Behavioral Medicine and Social Science & Medicine. Several other academic journals focus on health psychology at a national level (e.g., British Journal of Health Psychology, Gedrag & Gezondheid: Tijdschrift voor Psychologie en Gezondheid, Revista de Psicologia de la Salud, Zeitschrift für Gesundheitspsychologie). As in the United States and Europe, psychological associations in Canada, Australia, New Zealand, and elsewhere have boards, divisions, or branches specializing in health psychology and research and professional work in the field are expanding rapidly.

In the light of these developments, it can be seen that health psychology is one of the most vibrant and dynamic fields in Western psychology. As health psychology progresses from a research field to health service delivery, it is inevitable that professional and ethical issues are at the forefront of discussion within the major psychological associations. This chapter reflects the principle focus of this discussion that is on education and training.

THE DEFINITION AND SCOPE OF HEALTH PSYCHOLOGY

The currently accepted definition of health psychology was originally proposed by Matarazzo (1982) 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, the identification of etiologic and diagnostic correlates of health and illness and related dysfunctions, and the analysis and improvement of the health care system and health policy.

Virtually every health psychology organization and textbook has adopted Matarazzo’s (1982) definition without criticism, debate, or discussion. For researchers in health psychology, this definition is a very fine and appropriate one. Researchers invariably specialize and the fact that a definition of their field is a very broad one is not a problem. For practitioners, however, the breadth of the Matarazzo
definition can pose some serious difficulties. In fact, at face value, the definition is quite grandiose, encompassing all of clinical psychology, counseling psychology, rehabilitation psychology, occupational psychology, and much else as well. No single health care professional can reasonably be expected to possess and practice with genuine competence in all of the areas mentioned in Matarazzo’s definition and yet that is what the American, British, and most other psychological associations have agreed to.

The “official” definition of health psychology needs to be narrowed, or at least specialties within it, need to be defined (e.g., clinical health psychologist, rehabilitation health psychologist, occupational health psychologist, health promotion psychologist). Otherwise there is a risk of becoming Jacks-and-Jills-of-all-trades, and master-of-none. McDermott (2001) recently argued that the Matarazzo definition is over-inclusive, encompassing any topic connected with health, including primary, secondary, and tertiary care in their entirety. McDermott states, “The over-inclusivity is likely to prove detrimental to the long-term well-being of health psychology since such a broad definition does not allow for the subject area to distinguish itself clearly from other subdisciplines, in particular from clinical psychology and behavioral medicine” (p. 7). McDermott’s solution to this problem is to replace the first Matarazzo definition with another, his definition of behavioral health:

. . . new, interdisciplinary subspecialty . . . specifically concerned with the maintenance of health and the prevention of illness and dysfunction in currently healthy persons. (Matarazzo, 1982, p. 807, cited by McDermott, 2001)

This proposal is an elegant one. Secondary and tertiary care would thus remain the province of clinical psychology, leaving health psychology to become a true psychology of health. Correspondence suggests that Matarazzo (2001) essentially agrees with this proposal (Marks, 2002).

Another critique questions the focus on the rejection of the biomedical model and argues for a more social orientation, drawing on the knowledge base of the social sciences. The first author has argued elsewhere for a new agenda in which “health psychology should accept its interdisciplinary nature, venture more often out of the clinical arena, drop white-coated scientism, and relocate in the richer cultural, sociopolitical and community contexts of society” (Marks, 1996, p. 19). Ogden (1998) has suggested that the challenge of the biomedical model in the form of the “biopsychosocial” model is a rhetorical strategy lacking any solid theoretical foundation. A more societal emphasis in health psychology, and psychology as a whole, will encourage psychologists to make a more significant contribution in a world threatened by the sequelae of its industrial, scientific, and medical attainments but also by war, crime, and poverty.

This step broadens the agenda rather than narrows it. It is a broadening of awareness about the social context of health experience and behavior and of the social and economic determinants of health. In no way does it dilute the psychologist’s ability to deliver effective approaches to health issues. Economic and political changes have considerable, long-lasting influence on human well-being. Warfare remains an intermittent threat to human security. The gap between the “haves” and the “have-nots” widens, the Western population is aging, and the impacts of learned helplessness, poverty, and social isolation are becoming increasingly salient features of society. Global warming and energy addiction remain unabated. The health and psychological impacts of these phenomena present many challenges that lead us to repeat what Taylor already wrote over 10 years ago, “The only aspect of health psychology that is more exciting than its distinguished past and its impressive present, is its promising future” (Taylor, 1986, p. 17).

As currently defined, health psychology is the application of psychological theory, methods, and research to health, physical illness, and health care. Human well-being is a complex product of genetic, developmental, and environmental influences. In accordance with the World Health Organization (WHO) definition, health is seen as well-being in its broadest sense, not simply the absence of illness. Expanding the WHO definition, well-being is the product of a complex interplay of biological, sociocultural, psychological, economic, and spiritual factors. The promotion and maintenance of health involves psychosocial processes at the interface between the individual, the health care system, and society (Marks et al., 2000).

Health psychology is concerned with the psychological aspects of the promotion, improvement, and maintenance of health. The ecological context of these psychological aspects of health includes the many influential social systems within which human beings exist: families, workplaces, organizations, communities, societies, and cultures (Marks, 1996; Marks et al., 2000; Whitehead, 1995). Any psychological activity, process, or intervention that enhances well-being is of interest to health psychology. Equally, any activity, process, or circumstance which has psychological components and which threatens well-being is of concern to health psychology. Interventions need to be considered in the light of the prevailing environmental conditions that contain the contextual cues for health-related behaviors. A behavioral change resulting from an intervention delivered in one specific environment (e.g., a classroom, hospital, or prison) will not necessarily transfer to other environments.
The mission of professional health psychology is to promote and maintain well-being through the application of psychological theory, methods, and research, taking into account the economic, political, social, and cultural context. The primary purpose or “vision” of professional health psychology is the employment of psychological knowledge, methods, and skills toward the promotion and maintenance of well-being. The latter extends beyond hospitals and clinics—it includes health education and promotion among the healthy population as well as among those who are already sick.

The application of psychological knowledge, methods, and skills in the promotion and maintenance of well-being is a multifaceted activity; it is not possible to define the field narrowly because of the many different settings and situations in which psychologists may have a role in promoting and maintaining human health. It also must be acknowledged that the psychologist often will be working with laypeople, many of whom are patients’ relatives, acting as informal caregivers: “People are not just consumers of health care, they are the true primary care providers in the health care system. Increasing the confidence and skills of these primary care providers can make health and economic sense” (Sobell, 1995, p. 238).

Relationships with Other Professions

Health psychology is an interdisciplinary field with theoretical and practical links with many other professions (e.g., medicine, nursing, health promotion, and social work among many others). Health psychology overlaps with many other subfields or professional activities of psychology. Particular examples include subfields such as clinical psychology and activities such as psychotherapy. These overlapping subfields and activities are concerned with the independent application of psychological principles and methods to health, illness, and health care. However there are similarities and synergy between health psychology, clinical psychology, psychotherapy, and other applied psychological fields that have common foundations and overarching objectives. The primary goals are (a) the promotion and maintenance of good health and quality of life; (b) the prevention and improvement of ill health, disability, and the conditions of impairment and handicap through psychological intervention; and (c) adherence to the ethical guidelines specified by the national societies.

Health psychology is primarily concerned with physical health, illness, and health care although it is recognized that mental and physical health are highly interrelated. Clinical psychology is primarily concerned with assessing, predicting, preventing, and alleviating cognitive, emotional, and behavioral disorders and disabilities. Psychotherapy is primarily concerned with the treatment of psychological and psychologically influenced disorders by psychological means. Although it is recognized that these three fields overlap, they are independent professions of psychologists with university degrees that have their own postgraduate training needs and curricula.

Health and clinical psychologists, and those psychologists who conduct psychotherapy, work with:

1. Individuals, couples, families, groups, and communities;
2. People of all ages;
3. In institutions, organizations, and companies;
4. In the public, private, and voluntary sectors.

They undertake: (a) assessment and diagnosis; (b) intervention and treatment; (c) teaching and training; (d) supervision, counseling, and consultancy; (e) evaluation, research, and development for a range of areas of life, including promotion of well-being; prevention of deterioration of health; intervention in psychological aspects of physical health; intervention in psychological aspects of mental health; and promotion of optimum development and aging. These individuals are responsible for:

1. The delivery of good services with respect to standards of quality and control;
2. Planning of new services;
3. Informing and influencing the health care system and health policy; and
4. Contributing toward multidisciplinary working in the health care system.

Areas of overlap exist between health psychology and many other types of psychology: community psychology, organizational/occupational psychology, work psychology, rehabilitation psychology, educational psychology, and forensic psychology. To the extent that the psychology discipline is concerned with arriving at a better understanding of behavior and experience and in the improvement of well-being, all aspects of psychology have relevance to the psychology of health in its broadest sense.

The Clinical and Community Approaches to Health Psychology

There are two different approaches to health psychology. The first is based on the biopsychosocial model and working within the health care system. It is founded on Matarazzo’s (1980) definition of health psychology. It
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locates professional health psychology within the clinical domain, in hospitals, and outpatient settings. The environment in which the practice occurs is the health care marketplace. Another name for it is “clinical health psychology.” The second approach is community research and action. This forms a significant part of community psychology, working on health promotion and illness prevention among healthy people as members of communities and groups. This approach is consistent with Matarazzo’s (1980) definition of behavioral health, but it locates behavioral health not purely within the individual but within its social, economic, and political context. A summary of the two approaches is presented in Table 1.1.

Each approach has its strengths and weaknesses. There is a need for both and they complement each other. Each requires appropriate training and education. A third hybrid approach would be to attempt to integrate the clinical and community approaches within a single profession or discipline. This is an ambitious target that may be too difficult to achieve. It would be comparable to putting clinical and public health medicine together as a single endeavor. It seems unlikely that this will happen and, sadly, the paths of the community and clinical health psychologist may be forced to diverge. The training pathways are already separate, as we shall discuss next.

Conditions That Promote and Maintain Health

Cohesion, harmony, and meaningfulness are key characteristics of psychosocial well-being; fragmentation, disharmony, and

| TABLE 1.1 Two Approaches to Health Psychology: The Health Service Provider and Community Action Models |
|---------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| Characteristic | Health Service Provider Model | Community Action Model |
| Definition | “[T]he 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, the identification of etiologic and diagnostic correlates of health and illness and related dysfunctions, and the analysis and improvement of the health care system and health policy” Matarazzo (1982). | “Advancing theory, research and social action to promote positive well-being, increase empowerment, and prevent the development of problems of communities, groups, and individuals” Society for Community Research and Action (2001). |
| Theory/philosophy | Biopsychosocial model: Health and illness are: “the product of a combination of factors including biological characteristics (e.g., genetic predisposition), behavioral factors (e.g., lifestyle, stress, health beliefs), and social conditions (e.g., cultural influences, family relationships, social support)” APA Division 48 (2001). | Social and economic model: “Change strategies are needed at both the individual and systems levels for effective competence promotion and problem prevention” Society for Community Research and Action (2001). |
| Context | Patients within the health care system, i.e., hospitals, clinics, health centers. | Families, communities, and populations within their social, cultural, and historical context. |
| Focus | Physical illness and dysfunction. | Physical and mental health promotion. |
| Target groups | Patients in hospital and clinics. | Healthy but vulnerable and/or exploited persons and groups. |
| Objective | Therapeutic intervention. | Empowerment and social change. |
| Orientation | Top-down service delivery. | Bottom-up, working alongside. |
| Skills | Clinical and therapeutic. | Participatory and facilitative. |
| Research methodology | Effectiveness trials, typically using quantitative or quasi-experimental methods. | Action research: Active collaboration between researchers, practitioners, and community members utilizing multiple methodologies. |
meaningless are key characteristics of illness. Having the resources to deal effectively with life events and changing social and economic circumstances is a necessary condition for health. Resources can be classified into five main categories: biological, sociocultural, psychological, economic, and spiritual. The availability and appropriate combination of these resources creates the conditions for well-being. Their absolute or relative nonavailability, creates the conditions for ill health. A primary goal of health psychology is to establish and improve the conditions that promote and maintain the quality of life of individuals, communities, and groups.

Inalienable Right to Health and Health Care for All

All people have an inalienable right to health and health care without prejudice or discrimination with regard to gender, age, religion, ethnic grouping, social class, material circumstances, political affiliation, or sexual orientation. The Health-For-All 2000 strategy of the WHO (1985), originally formulated in Alma Ata in 1978, served as an aspirational goal for all countries. As the year 2000 approached, it was apparent that the ambitious goals of Alma Ata would not be achieved, at least, by the year 2000. In 1995, the forty-eighth World Health Assembly renewed the Health-For-All global strategy as a “timeless aspirational goal” and urged member states to “adapt the global health policy . . . into national or subnational context for implementation, selecting approaches specific to their social and economic situation and culture” (WHO, 1995). Professional psychological organizations across the globe can lend their support to the WHO’s renewed strategy.

Centrality of the Scientist-Practitioner Model

The scientist-practitioner model provides the ideal model for professional training in health psychology. It is a common principle across programs in all Western countries. This accords with the position statements on health psychology training provided by an expert group working in the United States (Sheridan et al., 1988) and in Europe (Marks et al., 1998). Professional health psychologists normally require some form of practitioner skills training in health care settings in addition to research and evaluation skills. Only by demonstrating competency both in the provision of health care and in evaluation and research will professional health psychologists be able to meet the future challenges and demands of health care systems and society more generally. In the next section, we review the professional status of health psychology in the United States.

EDUCATION AND TRAINING IN THE UNITED STATES

At present, health psychologists in the United States are divided fairly evenly between academia and the health care system, some having a foot in both camps. Health psychology in the United States is being taught, researched, and practiced in two different traditions. The first tradition, which can fairly be described as the mainstream, focuses on the clinical issues of patients in the health care system. Responsibility for accrediting professional health psychology programs in the United States lies with the American Psychological Association (APA) Division 38. Division 38 employs the biopsychosocial model that defines health and illness as: “the product of a combination of factors including biological characteristics (e.g., genetic predisposition), behavioral factors (e.g., lifestyle, stress, health beliefs), and social conditions (e.g., cultural influences, family relationships, social support).” We will return to this model later, but the model is an extension, rather than a replacement, of the biomedical model (Marks, 2002).

The second approach is that of community health psychology as represented by Division 27 of the APA, the Society for Community Research and Action (SCRA). The mission of the SCRA is described as follows:

The Society is devoted to advancing theory, research, and social action to promote positive well-being, increase empowerment, and prevent the development of problems of communities, groups, and individuals. The action and research agenda of the field is guided by three broad principles. Community research and action is an active collaboration between researchers, practitioners, and community members and utilizes multiple methodologies. Human competencies and problems are best understood by viewing people within their social, cultural, and historical context. Change strategies are needed at both the individual and systems levels for effective competence promotion and problem prevention.

Membership of the SCRA includes psychologists and people from related disciplines such as psychiatry, social work, sociology, anthropology, public health, and political science, including teachers, researchers, and activists. Community psychology is concerned with healthy psychosocial development within an ecological perspective. It focuses on health promotion and disease prevention, rather than waiting for illness to develop and to diagnose and treat the symptoms. Education and training for health psychologists in the United States is offered using both models that will be described in turn. Among clinical service providers, education
and training in health psychology was first discussed in the early 1980s. A National Working Conference on Education and Training in Health Psychology at Arden House recommended that two years of postdoctoral training be mandated for licensed practitioners in health psychology. The conference proposed a three-stage continuum of education from predoctoral studies leading to the PhD through a predoctoral internship year followed by a mandatory two-year postdoctoral residency.

The predoctoral content of education is the traditional coverage of biological and social bases of behavior, individual differences, history and systems, ethics, and professional responsibility. Within this generic general psychology education, there should be a health psychology track including specific instruction in the theory and science of human physiology, pathophysiology, neuropsychology, social systems theory, psychopharmacology, human development across the life cycle, and psychopathology. Students are expected to acquire special skills during this predoctoral phase including:

- Assessment, intervention techniques, broad consultation skills, short-term psychotherapy, family interventions, group dynamics, sensitization to group and ethnic norms, and prospective epidemiologic research training (Sheridan et al., 1988).

Matarazzo’s (1980) definition of health psychology was the foundation stone. The model is based on the programs that exist for medicine and dentistry and as such should be no less rigorous and quality controlled. The committee proposed a “model” of postdoctoral training with the following points:

- Candidates should possess a PhD or PsyD from an APA-approved program with a track or specialty in health psychology and have completed a formal one-year predoctoral residency.
- General hospitals and outpatient clinics are likely to be the principal setting for health psychology training and at least 50% of any postdoctoral trainee’s time should be spent in such settings.
- Two years of integrated, specialty training.
- Postdoctoral faculty should be predominantly psychologists, yet interdisciplinary, with doctoral degrees, licensed, and have established expertise in the areas advertised by the programs.
- At least one supervisor per rotation.
- A resident will have a minimum of two rotations in the first year and, normally, two in the second year.
- At least six of the following techniques and skills:
  1. Relaxation therapies.
  2. Short-term individual psychotherapy.
  3. Group therapy.
  4. Family therapy.
  5. Consultation skills.
  6. Liaison skills.
  7. Assessment of specific patient populations (e.g., pain patients, spinal cord injury patients).
  11. Hypnosis.
  12. Health promotion and public education skills.
  13. Major treatment programs (e.g., chemical dependence, eating disorders).

Sheridan and coworkers (1988) conclude their report with a brief review of the key issue of funding: Who pays for health psychology training? In the late 1980s, federal funding of training posts through the NIH and Alcohol, Drug Abuse, and Mental Health Administration was under threat and it seemed likely that Medicare and Medicaid would not pick up the tab. The removal of public and private training funds meant that training providers would be forced to pass the
training costs on to the trainees themselves in tuition fees. However, in spite of this changing climate, a large proportion of training places in doctoral programs have remained fully or partly funded.

The very impressive range of expertise listed by the post-doctoral implementation committee surely requires an educational program extending into a minimum of two years, and arguably, much longer. It cannot be doubted that to carry out any six of the 14 areas of competence would certainly require a minimum of two years.

Approximately 50 clinical and counseling doctoral programs in North America offer a concentration in health psychology. Another few are concerned exclusively with health psychology. Almost all of these programs require candidates to complete a one-year internship/residency before obtaining their doctorates. The Guide to Internships in Health Psychology developed by Division 38’s Committee on Education and Training lists APA-accredited psychology internship programs at about 70 establishments in the United States and five in Canada. These internships devote a minimum of half of the intern’s time to training in health psychology. Another dozen institutions offer minor rotations with less than half-time spent in health psychology. Stipends for predoctoral internships are generally in the range of $15 to $20 thousand. At postdoctoral level, there are around 30 training programs in the United States. Weiss and Buchanan (1996) published a list of international training opportunities, some of which may be substituted for an internship in the United States. Once a postdoctoral qualification has been obtained, a health psychologist in the United States can apply for a state license and be listed in the National Register of Health Service Providers.

The second training model for health psychologists exists within graduate programs in community psychology. A survey on behalf of the Council of Program Directors in Community Action and Research (CPDCRA) by Lounsbury, Skourtes, and Cantillon (1999). The survey revealed 43 programs offering graduate training in community psychology, 21 of which have a primary emphasis on community psychology. Twelve of the programs are community/clinical programs that typically have grown out of preexisting clinical psychology programs and offer doctorates. These programs accepted approximately 80 students in 1998 from a total of 1,700 applications. Health promotion, in the sense of positive well-being, is a prominent theme in these programs and the graduates. Field placements occur in a variety of settings including mental health settings. Graduates most often take clinical or community work positions. With a growing awareness of the community psychology, such programs are likely to expand.

It can be seen from this brief description that both of the approaches to health psychology described previously (see Table 1.1) are being developed in the United States.

EDUCATION AND TRAINING IN EUROPE

Professionalization of health psychology in European countries is on average 10 to 20 years behind the United States but follows a similar philosophy and rationale. In some countries (e.g., France, Portugal), it is 50 years behind, in others (e.g., Austria, Netherlands), it is not behind at all. Responsibility for policy regarding professional psychology in Europe lies with an umbrella organization called the European Federation of Professional Psychologists’ Associations (EFPPA). Under the umbrella of EFPPA, national member associations operate with a mixture of national and transnational agendas and policies. Member associations balance the desirability of subscribing to pan-European principles with national priorities and interests.

A Task Force on Health Psychology was established by EFPPA in 1992 with the following objectives:

1. To define the nature and scope of health psychology and its possible future development to the year 2000.
2. To specify training needs and objectives for professional health psychologists consistent with the agreed definition.
3. To examine different models and options for the training of health psychologists and to select from among them suitable models for EFPPA countries.

The Task Force disseminated its working papers in a series of newsletter reports, conference symposia, and workshops (Donker, 1994, 1997; Marks, 1993, 1994a, 1994b, 1994c, 1994d, 1997a, 1997b; Marks, Donker, Jepsen, & Rodriguez-Marin, 1994; Marks et al., 1995a; Marks & Rodriguez-Marin, 1995; Rodriguez-Marin, 1994; Sidot, 1994; Wallin, 1994). An interim progress report was accepted by the EFPPA General Assembly in 1995 (Marks et al., 1995b). The Final Report was adopted by the General Assembly of EFPPA in Dublin in 1997 and published by Marks et al. (1998). The EFPPA approach followed the health service provider model of Table 1.1 although it addressed some issues that are amenable to the community action approach.

Rationale for Training

The rationale for developing training of health psychologists in Europe is the rapid growth of new developments in research
and practice flowing out of this interdisciplinary field. At the same time, changes in health policy in many countries are generating new roles for psychologists. With a growing awareness of the importance of psychosocial factors in the promotion and maintenance of well-being, the demands for professional health psychology services within European health care systems are expected to increase. As García-Barbero (1994) stated, “Health professionals clearly need more appropriate training to meet the challenges of the health for all policy, to meet the health needs of the population, to reduce health costs, to assure quality, and to permit the free movement of sufficiently qualified health professionals.”

Under the national ethical codes of the psychology profession, there is an absolute responsibility to ensure that psychologists only practice in areas of competence. This principle requires that health psychologists be trained and assessed for their competence before they enter into unsupervised practice. Psychologists wishing to practice in new areas therefore have a responsibility to become appropriately trained and experienced.

Complementing Other Fields of Applied Psychology

As noted earlier, there are overlapping competencies between health psychologists and other applied psychologists working in health fields and it is likely that there will be shared, generic components of training. All psychologists working in health fields have a common foundation of basic education in psychology. Psychologists with experience and/or training in fields of applied psychology wishing to have a professional qualification in health psychology should be permitted to receive accreditation of their prior experience and/or training. The proposed training should be specifically designed to fulfill this objective of complementarity.

Professional Autonomy and Complementary Independence

The ultimate objective of training should be professional autonomy and complementary independence. The latter requires mutual respect of experience and training, without intrusions, infringements, or subordination across health care professions.

Stages of Competency

It is recognized that practitioner-training passes through stages in which a person will, at first, practice under supervision of another fully experienced practitioner. Following an appropriate level of supervised, placement experience with a range of settings and client groups, the psychologist will be competent to practice in his or her own right. However, training is never final and practitioners require continuous professional development through the acquisition of new skills and with the development of new technologies and the updating of knowledge following the advancement of research.

Training Guidelines for Professional Health Psychologists

Different educational systems and traditions affect the structure of curricula for training professional psychologists in different European countries. In several meetings, the Task Force deliberated on the idea of formulating a fixed set of minimal standards for the whole of Europe. Three case studies of training at different levels of development were analyzed in depth (training in Denmark, Germany, and Holland). Symposia and workshops were held at international conferences at which training models for different countries were compared and contrasted (Donker, 1994; Marks et al., 1995a; Rodriguez-Marin, 1994; Rumsey et al., 1994a; Sidot, 1994; Wallin, 1994). Large, possibly irreconcilable, variations are evident in the models and methods of training and in the amount of experience deemed necessary for nationally accredited recognition as professional psychologists across different countries. One country (Austria) has a law specifying the tasks to be performed by professional health psychologists. In the remainder, the tasks and responsibilities of professional health psychologists (and, for most countries, other applied psychologists as well) are dependent on a complex array of national, regional, and local agreements. Training practices are equally diverse. In a few countries, training programs are well advanced and have been implemented by national associations (e.g., Berufsverband Österreichischer Psychologen, 1995; Dansk Psykologforening, 1996). Other associations are making progress in formulating and implementing training guidelines (e.g., British Psychological Society: Edelmann et al., 1996; Rumsey et al., 1994b; Berufsverband Deutscher Psychologen: Rielander, 1995). However, many European countries still do not yet train health psychologists in any specific and specialized manner.

If health psychology is to achieve its full potential in European health care systems, training will need to be implemented much more widely than is presently the case. This will only be possible within the particular legal and professional conditions that determine the organization of psychology and health care in different countries. A principle of subsidiarity must therefore operate. However, it will be necessary to at least have a framework for training in each country and these guidelines provide that framework.
The EFPPA task force placed the training requirements of professional health psychologists into eight categories:

1. *Academic Knowledge Base (Psychology).* Professional health psychologists require an in-depth understanding of:
   - Lifespan perspectives and developmental processes.
   - Health-related cognitions.
   - Social factors and ethnicity.
   - Psychoneuroimmunology.
   - Psychophysiological processes.
   - Primary, secondary, and tertiary prevention in the context of health-related behavior.
   - Risk factors.
   - The health and safety of individuals in the workplace.
   - Personality, health, and disease.
   - Stress, illness, and coping.
   - Health care professional-patient communication.
   - Psychological aspects of medical procedures.
   - Coping with life events.

2. *Academic Knowledge Base (Other).* Professional health psychologists require understanding of relevant aspects only of:
   - Epidemiology.
   - Ethics.
   - Genetics.
   - Health policy.
   - Health sociology.
   - Health economics.
   - Human biology.
   - Immunology.
   - Medical anthropology.
   - Medicine.
   - Physiology.
   - Pharmacology.
   - Neuroendocrinology.
   - Cultural and religious studies.

3. *Application of Psychological Skills to Health Care.* Professional health psychologists require a working knowledge of:
   - Communication skills.
   - Consultancy skills.
   - Counseling skills.
   - Assessment and evaluation.
   - Psychological interventions aimed at change in individuals and systems (e.g., families, groups, worksites, communities).

4. *Research Skills.* Professional health psychologists require a working knowledge of research skills in specific application to health and health care.

5. *Teaching and Training Skills.* Professional health psychologists require skills for teaching and training students and other health and social care professionals including supervisory skills.


7. *Professional Issues.* Professional health psychologists require a working understanding of:
   - The place and status of health psychology in society.
   - Professional identity and autonomy.
   - Legal and statutory obligations and restrictions.
   - Transcultural issues.
   - International perspectives on professional health psychology.

8. *Ethical Issues.* Professional health psychologists are required to follow the ethical code of their national associations.

**Implementation of Training**

The future development of health psychology as a profession depends on putting theory and policy into practice through the implementation of high-quality training. Currently, there are relatively few European countries where this has yet happened. Training programs need to be introduced in all European countries within the framework of each member-country’s national laws, regulations, and practices.

Section three specifies five skill areas that were seen, not as optional, but as mandatory. The assumptions of the Matarazzo definition, the biopsychosocial model, and working in clinical settings are held in Europe as strongly as in the United States. The Education and Training Committee of the EHPS has published a reference guide of graduate programs in health psychology in Europe (McIntyre, Maes, Weinman, Wzresniewski, & Marks, 2000). There are many masters and PhD level programs but few DPsych or PsyD programs have yet been developed. The traditional PhD is an academic qualification providing little or no training in practitioner skills. With some exceptions (e.g., the Netherlands), European programs have a long way to go before they match most U.S. programs for the depth and breadth of coverage.

**EDUCATION AND TRAINING IN THE UNITED KINGDOM**

Responsibility for the accreditation of education and training in psychology in the United Kingdom lies with the British Psychological Society (BPS). The Society approved regulations for a full professional qualification in health psychology
in 2001. This qualification is essential to all those wishing to work professionally in the health psychology field. On completion, candidates are eligible for full membership of the Division of Health Psychology permitting the member to use the title “Chartered Health Psychologist” and to have his or her name listed in the Society’s Register. The training system is based on the health service provider model of Table 1.1. No programs using the community action model have yet been accredited by the BPS Health Psychology Division. In the United Kingdom, community action programs are more likely to be located in departments of geography or in health promotion units than in departments of psychology (e.g., Cave & Curtis, 2001; Lethbridge, 2001). To date, with one or two notable exceptions (e.g., Bennett & Murphy, 1997), there has been relatively little interest in the community approach within British health psychology.

Education and training of health psychologists in the United Kingdom is in three stages: (a) undergraduate, (b) postgraduate stage 1 (MSc), (c) postgraduate stage 2 (MPhil, PhD, PsychD, or DPsych). To enroll as a candidate for the stage 1 postgraduate qualification in Health Psychology, the applicant must:

1. Be a graduate member of the British Psychological Society and hold the Graduate Basis for Registration; and
2. Either hold, or be enrolled in, a postgraduate research degree relevant to health psychology and include an empirical research project, or
3. Be a chartered psychologist seeking lateral transfer from another area of psychology.

The postgraduate stage 1 is often completed as a BPS-accredited MSc degree in health psychology in any one of about 20 institutions. Otherwise candidates may take an examination set by the Board of Examiners in Health Psychology (BEHP). This examination comprises four written papers, a research project, and an oral examination on the research project. The topics covered in the written examination papers are:

- Health-related behavior: Cognitions and individual differences.
- Psychosocial processes in illness and health care delivery.
- Research and development in health psychology.
- Context and related areas.

The research dissertation must be a piece of supervised, self-selected original health-related research in accordance with the BPS ethical guidelines, and should not exceed 14,000 words.

Following successful completion of the stage 1 qualification, candidates may proceed to stage 2. To enroll as a candidate for the stage 2 qualification, the applicant must:

1. Be a graduate member of the BPS and hold Graduate Basis for Registration.
2. Hold either the stage 1 qualification in health psychology, or a postgraduate BPS accredited qualification in health psychology, or have a statement of permission to proceed to the stage 2 Qualification from the BEHP.
3. The stage 1 qualification involves the attainment of a health psychology knowledge base and postgraduate research skills. The stage 2 qualification builds on stage 1 by assessing professional level capability in research, consultancy, teaching, and training and also generic professional competence in relation to psychological practice. From September 2004, applicants for Chartered Health Psychology status who began their training after September 1, 2001, will have to demonstrate competence in 21 units—19 core units and two optional units. The 19 required units are divided into 73 specific components in four domains.

**Professional Competence**

Health psychologists should be able to maintain personal and professional standards in their practice and act ethically. Core competencies include:

1. Implement and maintain systems for legal, ethical, and professional standards in applied psychology—security and control of information; compliance with legal, ethical, and professional practices; procedures to ensure competence in psychological practice and research.
2. Contribute to the continuing development of self as a professional applied psychologist—process of self-development; knowledge and feedback to inform practice; access to competent consultation and advice; professional development; best practice as standard.
3. Provide psychological advice and guidance to others—assess opportunity, need, and context for giving psychological advice; provide psychological advice; evaluate advice given.
4. Provide feedback to clients—evaluate feedback requirements; preparation and structure; methods of communication; presentation of feedback.
Research Competence

Health psychologists must be capable of being independent researchers. Core competencies include:

1. Conduct systematic reviews—define topic and search parameters; employ appropriate databases and sources; summarize findings.

2. Design psychological research—identify relevant research findings; generate testable hypotheses; define resources and constraints; methodology; validation of measures; prepare, present, and revise research designs.

3. Conduct psychological research—obtain required resources and access to data and/or participants; research protocol; pilot existing methods; conduct research.

4. Analyze and evaluate psychological research data—analyze and interpret data; evaluate research findings; written account of research project; review research process; review and evaluate relationships between current issues in psychological theory and practice.

5. Initiate and develop psychological research—conduct research; monitor and evaluate research in accordance to protocols; explain and critique implications of research for practice; evaluate potential impact of research developments on health care.

Consultancy Competence

Health psychologists must be capable to apply psychological knowledge to health care and health promotion practice. Core competencies include:

1. Assessment of requests for consultancy—determine, prioritize, and confirm expectations and requisites of clients; review literature for relevant information; assess feasibility of proposal.

2. Plan consultancy—aims, objectives, and criteria; implementation plan.

3. Establish, develop, and maintain working relationships with clients—establish contact with client; contract; develop and maintain, and monitor and evaluate, working relationships with clients.


5. Monitor the implementation of consultancy—review consultancy; implement necessary changes; review client expectations and requisites; implement quality assurance.

6. Evaluate the implementation of consultancy—design and implement evaluation; assess evaluation outcomes.

Teaching and Training Competence

Health psychologists must be capable to train others to understand and apply psychological knowledge skills, practices and procedures. Core competencies include:

1. Plan and design training programs that enable students to learn about psychological knowledge, skills, and practices—assess training needs; identify training program; select methods; produce materials; employ appropriate media.

2. Deliver training programs—implement training methods; facilitate learning.

3. Plan and implement assessment of such training programs—identify assessment methods and select regime; determine availability of resources for assessment procedures; produce assessment materials; ensure fair appreciation of assessment methods; keep record of progress and outcomes.

4. Evaluate such training programs—evaluate outcomes; identify contributing factors of outcomes; identify improvements.

Optional Competences

Two of the following eight optional units of competence must also be attained:

1. Implement interventions to change health-related behavior.

2. Direct the implementation of interventions.

3. Communicate the processes and outcomes of interventions and consultancies.

4. Provide psychological advice to aid policy decision making for the implementation of psychological services.

5. Promote psychological principles, practices, services, and benefits.

6. Provide expert opinion and advice, including the preparation and presentation of evidence in formal settings.

7. Contribute to the evolution of legal, ethical, and professional standards in health and applied psychology.

8. Disseminate psychological knowledge to address current issues in society.

The trainee health psychologist undergoes a period of supervised practice equivalent to two years of full-time work (a five-day week for 46 weeks a year). This provides direct experience of professional life and facilitates the development of skills and abilities relevant to health psychology. Candidates’ total work experience should encompass at least two different categories of clients and be health-related work of a psychological nature. Health-related work may
include paid employment, academic work, training and development activities, and voluntary work.

Candidates must arrange supervision from an approved Chartered Health Psychologist. A contract of supervision, indicating payment, is drawn up. Candidates devise a formal supervision plan that includes a work plan outlining core competencies addressed with target dates, details of evidence that will demonstrate satisfactory completion of competencies, name of supervisor, expected date of completion of stage 2, and any additional training and development activities needed. To achieve the stage 2 qualification, candidates must demonstrate competencies in all 19 areas. No exemptions are permitted. All candidates are bound by the BPS Code of Conduct.

The role of the supervisor is to:

• Oversee the preparation and review of the supervision plan.
• Countersign the supervision plan, supervision log, and supporting evidence, and fill in the required sections of the completion forms.
• Provide information.
• Listen to the views and concerns of the candidates concerning their work in progress and advise as appropriate.
• Encourage reflection, creativity, problem solving, and the integration of theory into practice.

The examination consists of an oral examination and the submission of a portfolio of evidence of competencies. The portfolio should include a practice diary, supervision log, records of completion, supporting evidence, and any additional clarification. Candidates are enrolled for a minimum of two years, and a maximum of five years. When full membership of the Division of Health Psychology has been gained, members become Chartered Health Psychologists and they are listed in the British Psychological Society’s Register.

SIMILARITIES AND DIFFERENCES BETWEEN THE U.S., EUROPEAN, AND U.K. MODELS

It is informative to compare the three health service models developed in the United States, Europe, and United Kingdom. A summary of the competencies included in the three models are presented in Table 1.2.

A Common Core

It can be seen that there is a solid core of three competencies that all three models include in one form or another: teaching/training, consultancy, and research. All practicing health psychologists need to acquire these skills for their professional work whether they are working in the United States or Europe. In the United States, health psychologists are trained to carry out therapies and interventions alongside their clinical colleagues. Perhaps more than in some other areas of applied psychology, the core competencies of the health psychology practitioner in the United Kingdom show considerable overlap with those of the academic psychologist. However, this is likely to change as the profession becomes more confident about what it has to offer.

Differences between Regions or Countries and Gaps in Training

Some skills that are seen as essential in one region or country are seen as optional in others, for example, interventions aimed at change in individuals and systems, counseling, management, liaison, and health promotion skills. There are some significant omissions in training requirements that warrant further discussion by the relevant committees. For example, the BPS curriculum omits training in assessment and evaluation, communication, counseling, and management skills. The APA curriculum also omits communication, counseling, and management. Can health psychologists really practice to their maximum potential without competence in these areas? Merely having access to research information about these subjects is insufficient: Knowing about is not the same as knowing how.

Table 1.2 reveals a number of gaps in training in the United States and United Kingdom medical textbooks invariably have chapters about doctor-patient communication, comment on its deficiencies, and recommend special training on communication skills for medical doctors. Why should health psychologists be any better at communication, without special training, than physicians? Without mandatory training, these competencies are left to individual practitioners to pick up when, where, and however they can. The quality of services and health improvements may be less than optimum as a consequence. Another surprising gap is the lack of assessment and evaluation training in the U.K. training curriculum. These are basic competencies that are used everyday within clinical psychology. Assessment is a necessary stage in the choosing and tailoring interventions for individual clients. Evaluation of effectiveness is paramount to the assessment of efficacy and effectiveness.

Perhaps these differences and gaps reflect the histories and cultures of professional psychology in different regions and countries. Perhaps they reflect a desire not to encroach on other established psychological professions such as clinical,
counseling, and occupational psychology. Perhaps they also reflect the lack of consensus about the definition of health psychology. Should it strive to become the overarching health care profession of Matarazzo’s (1980) definition, or a more specialized profession focusing on the maintenance of health and prevention of illness in currently healthy persons in line with Matarazzo’s (1980) definition of behavioral health, as recommended by McDermott (2001)? Only the future will tell which of these models wins the day.

CRITIQUE OF PROFESSIONALIZATION

The development of an outline of a set of core competencies for health psychologists has led to a great deal of discussion and debate. One of the main issues of concern has been whether health psychology is ready yet to become a profession, and if so, how this change in status is to be accomplished. Developing the profession too early may result in a profession with too little to deliver, a “naked emperor” (Michie, 2001). Worse, a naked emperor, or empress, might cause offense and do harm to, rather than improve, the health of his or her subjects!

The construction of a core set of competencies took the APA and EFPPA five years and the BPS six years to complete. Similar periods will, no doubt, be required for any new system to be thoroughly tried and tested. Judgments about what a health psychologist should know and be able to do are based on extant beliefs, values, and aspirations, and little else but intuition. Consequentially, committee decisions about the objectives and content of education and training are highly contentious.
Despite being a relatively new area of applied psychology, health psychology is developing at an astonishing rate. New health psychology programs are being introduced, textbooks are appearing continuously and going into second, third, and fourth editions, and the academic journals are expanding and flourishing. Health psychology has a real potential to have a positive impact on the health of society. Yet the definition of health psychology is still in contention and there are at least two quite different approaches to the field. In a recent essay, the first author suggested that four styles of working are beginning to emerge: clinical, public, community, and critical health psychology (Marks, 2002b).

In a recent debate in the BPS Division of Health Psychology’s newsletter, *Health Psychology Update*, Bolam (2001) asked, “Whom does professionalization advantage, and at what cost?” Bolam suggested that any abstract attempt at a definition inevitably obscures the complex web of social, institutional, historical, and economic forces from which health psychology has emerged. He suggested that the argument that health psychologists “owe it to the public” to be professional is only part of the story. Bolam felt little confidence in the claim that health psychology has a unique set of techniques to offer the health care system. Bolam argued that professionalization is really about “self-promotion and the struggle to increase access to resources and power.” What health psychologists gain comes at a cost, however, and identity is not only about claiming what health psychologists are, but also what they are not. Health psychologists should challenge the biologically reductionist tendencies and the hierarchical structures of biomedicine by introducing new discourses about people and health. Bolam suggests that “Instead of challenging the biologically reductionist tendencies and hierarchical structures of biomedicine by introducing new discourses of people and health, we replicate the very mistakes we could help to remedy, merely aspiring to be further up the table.” This leads to a concern that the current mainstream training proposals in the United States, Europe, and the United Kingdom are strongly influenced by the biopsychosocial model that could stifle the development of the field.

Michie (2001), on the other hand, contra Bolam, argued that professionalization “does not just benefit health psychologists . . . but also benefits recipients of psychological services, employers, policymakers, and the public. It benefits everybody to know who we are and what we do” (p. 18). A definition, at least of the core concept, is essential for the progress of science and for strategic development of its application. Professionalization helped to ensure minimum standards of practice and accountability.

Sykes (2001) entered the debate with the thought that it was the health psychologists’ responsibility to practice only in those areas where they have been trained and have a level of competence. Consumers, patients, clients, and communities need to feel confident that health psychologists have been fully trained to deliver evidence-based services. Clients have a right to know who health psychologists are and what services they are competent to deliver.

Have the current education and training proposals left unrecognized a lot of work that health psychologists do, or could do? For example, health psychologists can work not only within the health service delivery model but from a communitarian perspective, following a model of community action and research. Community action requires a unique set of skills. These include communication and negotiation skills, the art of unlearning, appropriately empowering others, flexibility, a great amount of perseverance, and a belief in a vision. Working alongside others on an equal footing is the order of the day, not offering a service, but sharing an action. This type of work is as much in need of a professional approach as any other. Thus, the debate has turned full circle and reflects the differences between the two models of training discussed earlier, the clinical treatment of illness approach versus the community health promotion approach.

Despite these differences in opinion, there is a central theme in the debate: making health improvement the main priority for health psychology. Such debates should be viewed positively because an applied discipline must continuously reflect and be open to change.

**ETHICAL AND POLICY ISSUES**

Professional health psychologists are expected to comply with the ethical codes of their national associations. However, ethics must not be viewed simply as a set of principles for dealing with special or specific circumstances when dilemmas occur. Every action, or inaction, in health care has an ethical dimension (Seedhouse, 1998). In this section, we review issues of a policy nature that highlight ethical issues for health psychologists and all other health care professionals.

**Poverty and Inequality**

All people have an equal right to health and health care. That contemporary societies have large health variations is readily apparent (Carroll & Davey Smith, 1997; Wilkinson, 1996). Of major significance in both developed and developing societies is poverty. In pursuit of health-for-all, the health care system must strive to equalize the opportunities of all members of society. This principle requires psychologists to provide their services (whenever possible) to all people
regardless of gender, age, religion, ethnic grouping, social class, material circumstances, political affiliation, or sexual orientation. When access is low, or when there is evidence of greater needs, special efforts should be made to target services to those with the poorest access or greatest need (e.g., refugees, the homeless, lower income groups). Policy decisions concerning the allocation of resources to these needy groups both inside and outside of the health care system are about ethics as much as politics.

Economics
The demand for health care exceeds supply. This fact has economic implications for services. First, it is necessary to provide services according to the health needs of all client groups. Second, it is necessary to analyze health care economically. This means that cost-benefit analyses and evidence of cost-effectiveness should be utilized in making decisions about services. It is likely that some psychological interventions are able to provide more cost-effective options than pharmacological and medical treatments (Sobell, 1995). However, the evidence to provide definite support of this claim is often not available. If psychological interventions are to be more widely employed, it is necessary that more effort and resources be devoted to economic analyses of their cost-effectiveness. Third, whether we like it or not, health services have to be rationed. Unless we accept the philosophy that those who receive a service are those who can afford it (or the insurance premiums), the decision about who receives or does not receive a service is both political and ethical in nature. In many countries, psychology services are in short supply and among the least accessible and most rationed. Yet rationing is rarely discussed in the psychology literature.

New Technologies
New scientific and medical technologies are having dramatic effects on the cost-effectiveness, efficiency, and competence of health care (e.g., microsurgery, organ transplantation, genetic testing/screening, gene therapy, in vitro fertilization). Genetic information and its communication to individuals and families are sensitive issues that have both psychological and ethical implications (Lerman, 1997). Following the production of a sheep clone, “Dolly” (Wilmut, Schnieke, McWhir, Kind, & Campbell, 1997), the cloning of humans is likely soon to become technically possible. In spite of reassurances from a professor of fertility studies (Winston, 1997), this prospect raises profound ethical questions among health professionals, patients, and families (Human Genetics Commission, 2000). There may be biological, psychosocial, or moral implications that have not yet been adequately conceptualized.

Not only do new technologies increase the need for public understanding and debate, they require medical scientists and health professionals to be completely open and honest about the benefits, risks, and possible sequelae of treatments and procedures. Communication, counseling, and informed consent are becoming increasingly vital elements of health care (Marteau & Richards, 1996). However, it is recognized that providing people with genetic information on risk may not increase their motivation to change behavior and in some cases may even decrease their motivation (Marteau & Lerman, 2001). In these areas, psychologists should play a major role.

The Aging Population
Demographic data show that the Western population is aging. In Europe in January 1993, there were 117 million people aged 50 years and over (32%) and nearly 75 million aged 60 and over (20%) in the 15 countries of the European Union. The latter will increase to over 25% by the year 2020. In terms of health policy, the most significant increase is in the numbers of people who are 80 years or more, particularly women, large numbers (48%) of whom live alone, especially in northern Europe (Walker & Maltby, 1997).

An increasingly prevalent combination of frailty, poverty, and social isolation is making older age a time of significantly reduced quality of life. This is particularly true for the increasing numbers of people suffering from Alzheimer’s disease, or other forms of dementia, and their informal caregivers (European Alzheimer Clearing House, 1997). A report from the Eurobarometer surveys suggests that poverty, age discrimination, fear of crime, and access to health and social care are significant barriers to social integration among older people (Walker & Maltby, 1997). On the more positive side, the surveys suggest that, “Just under one-quarter of older people were very satisfied with their lives, more than half fairly satisfied and only one in five not satisfied” (p. 122). Promotion of social integration of older people, particularly those living alone, presents a major challenge for the future. Health psychologists will need to work closely with other professionals to find new ways of enhancing social integration and well-being of older members of the population and their caregivers.

CONCLUSIONS
Health psychology is a research field that entered the marketplace of health care quite recently. Competing and contrasting definitions suggest different approaches to the enterprise. The
mainstream approach is modeled on health service provision similar to clinical psychology, but dealing principally with physical health and illness. It is founded on what is termed the “biopsychosocial” model. This approach is sometimes referred to as “clinical health psychology.” Another approach is modeled on community action and research and deals with the promotion of well-being in its social and community context, a kind of psychological health promotion. The different approaches have different philosophies, methods of working, models of training, goals, and objectives. Up to the present, little effort has been directed toward integrating these two approaches. Perhaps they are resistant to integration.

Professionalization in health psychology is a problematic exercise. Some contend that it has occurred too soon, before there is sufficient evidence to play on the same field with the “big-hitters” of the more established health professions (medicine, nursing, dentistry). Others argue that it is necessary to credentialize practitioners as soon as possible with registration procedures following approval of their training and supervised experience. Others argue that the health service provider model limits the development of health psychology. While the debate continues, education and training programs are proceeding apace. Training programs in the United States were established at least 10 years earlier than in most of the rest of the world. Core elements of health psychology competence agreed to by three independent panels are research, consultancy, and teaching and training. Other skills, viewed as optional by some panels and as mandatory by others, include: interventions for individuals and systems; communication skills; counseling skills; and assessment and evaluation skills. New programs are currently being developed and it would be a valuable exercise to evaluate progress in another decade’s time.

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