LONDON SOUTH BANK UNIVERSITY

unit guide

Health Psychology

TPS-3-304

Department of Psychology, Faculty of Arts and Human Sciences

2010-2011

become what you want to be

1. Basic Data

Unit Title	Health Psychology
Level	3
Reference Number	TPS-3-304
Credit Value	15
Semester	1
Subject Area	Psychology
Free Elective	No
Student Study Hours	150 hours
Contact Hours	48 hours – lecture/seminar teaching
Student Managed Learning	102 hours
Pre-requisites	None
Co-requisites	None
Excluded Combinations	None
Assessment Method	Coursework: 2500 health promotion evaluation (40%) Examination (60%) – Two hour unseen
Unit Co-ordinator Block.	Prof Ian Albery, Room E43D, Extension Ext: 5856 Email: alberyip@lsbu.ac.uk
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2. Short Description

Morbidity and mortality have been shown to be influenced significantly by various socio-demographic factors like age, social class and education. However, which factors create the link between these inputs and outputs is less clear. This unit will explore theoretically based psychological processes and mechanisms (e.g. cognitive dispositions and beliefs, social support) which have been shown to relate social inputs with health outcomes.

3. Aims

The unit aims are:

- To provide students with the opportunity to acquire knowledge about the ways in which social inputs and health outcomes are influenced by psychological mechanisms.
- To allow students to explore the theoretical and applied basis of psychological research on health-related outcomes.
- To provide students with the opportunity to develop skills and confidence in the use of IT resources and database (e.g. Psychinfo, Medline) for access and retrieval of health-related psychological literature.
- To offer students the opportunity to develop critical and analytic skills in the assessment of their own and others' theoretical ideas vis-à-vis psychological processes and health.

4. Learning Outcomes

At the end of the unit students will:

- Understand the basic, theoretical and applied factors important for the study of psychological mechanisms of health-related inputs and outcomes.
- Demonstrate this comprehension concisely and accurately through discussion and writing.
- Demonstrate the ability to accrue and review relevant material and literature.
- Demonstrate the ability to summarise appropriate material and critically appraise this material.
- Demonstrate the ability to construct arguments on the basis of scientific evidence.
- Develop the ability to critically evaluate research in health psychology.
- Demonstrate the ability to consider the implications of an understanding of psychological processes in health for health care practice and intervention.

5. Key and Cognitive Skills

This unit will assist students' development of the following skills:

- Critical analysis and evaluation of distinct theoretical and applied approaches for assessing scientific questions.
- Methodical, analytical and clear written and oral communication skills.
- Successful access of relevant research literature and other databases.

6. Teaching and Learning Pattern

Teaching on each unit is organised into two five-week blocks. Two weeks (week 6 and week 12) in each semester are for self-managed study time. These consolidation weeks give you an opportunity to catch up on your reading and we expect you to use them for independent study. Under exceptional circumstances, such as staff illness or University closure, week 6 and week 12 may need to be used to deliver course material so please be prepared to attend, if necessary, in those weeks.

7. Introduction to studying the unit

Various socio-demographic factors such as age, marital status and social class have been shown to be related to the experience of various health outcomes. In this way morbidity and mortality statistics are associated with such inputs. The direct or indirect link between inputs and health-related outcomes is the subject of debate and on-going epidemiological and psychological research. For psychologists is it assumed that the effects of socio-demographic inputs on health outcomes are likely to be mediated or moderated by various psychological processes and mechanisms. For instance, the relationship between the age of a car driver and accident involvement may be accounted for by various mediating factors like social deviance. The younger a person is, the more likely they are to drive too fast, jump red lights, and so on, which puts them at increased risk of having a road accident. It is the study of these intervening variables that some health psychologists are interested in. More recently, work on the study of such theoretically based processes has been extended towards the design and implementation of interventions to alter the ways people think, feel and behave in terms of health compromising activities. This course is examines the ways in which psychological mechanisms and processes mediate or moderate the effects of social inputs on health-related outcomes.

The unit will assess the role of psychophysiogical, cognitive and affective psychological and social psychological factors in the onset, maintenance and intervention/treatment of the major negative health outcomes. These factors have been identified for action in the UK Government's consultative and strategic papers on the Health of the Nation (UK Department of Health, 1991, 1992) and Our Healthier Nation (Department of Health, 1998). These papers identified a number of key areas for action in the long-term. The key areas are coronary heart disease and stroke, cancers, mental illness, HIV/AIDS and sexual health and accidents. Familiarity with the Health of the Nation and Our Healthier Nation documents is

important for awareness of the overall strategic guidelines and national policy health psychologists at present work within. The Health of the Nation and Our Healthier Nation strategies argue that to address the key areas is fundamental for 1) increasing life expectancy and 2) maximising the years lived free of ill-health (promoting healthy lifestyles, increasing quality of life etc). With such obvious contemporary relevance for the practice of professional health psychologists, health promotion workers and others, it is intended that discussion of health outcomes within a psychological framework be guided by such health strategies.

8. Unit Content

In week one we will define health and the psychology of health, and place the psychological study of health in a contemporary context by considering Government proposals to tackle ill-health and inappropriate health behaviours. Week two will be devoted to the study of social inequalities and health. The third, fourth and fifth weeks will be dedicated to a critical examination of various psychological and social psychological models and theories that have been utilised to advance the study of psychological mechanisms and health. Week 7 will introduce the role of optimistic bias in the study of health behaviour while week 8 introduces a new much under researched area of health psychology, namely the role of habitual processes in understanding why people take or do not take health precautions. Weeks 9 and 10 will examine the relationship between stress, coping and social support and health. Week 11 focuses on doctor-patient communication and adherence to healthy regimes. Week 12 will be a revision session. A summary of the unit content is given below.

Week	Topic Area
1	Defining health and health psychology (IA).
2	Social inequalities in health – inputs, outcomes and processes (IA).
3	Models of health behaviour 1: HBM, PMT, SCT, TPB, TRA (HG).
4	Models of health behaviour 2: SRM, ego depletion, implementation intentions (HG).
5	Models of health behaviour 3: TTM, PAPM, HAPA (IA).
6	Consolidation week.
7	Optimistic bias in health related decision making (IA).
8	Habit in health behaviour (IA)
9	Theories of stress, health and illness (HG).
10	Moderators of stress-illness relationship (HG).
11	Doctor-patient communication and adherence (HG)
12	Consolidation week.

9. Weekly Teaching and Learning Programme

Week 1. Defining health and health psychology.

The first session will act as a general introduction to the course. We begin by examining how health is defined and how such definitions may be dependent on the philosophical position or 'outlook' an individual has. We then move on and attempt a definition of health psychology. It will be emphasised that although a broad definition is possible, the discipline is a multi-faceted one. Having made such definitions, we will then explore why health psychology as a discipline may be important for understanding morbidity and mortality statistics.

Objectives:

- Provide a general overview of the course.
- Consider definitions of health and health psychology.
- Place the application of psychology for the study of health processes in a general working context.

Learning Outcomes:

At the end of the session students will:

- Have an comprehension of the aims and objectives of the Unit.
- Understand the academic complexities involved in defining health from various health-related philosophical positions.
- Have considered and critically discussed definitions of health psychology, and how the discipline is important for intervention in behaviours related to health.
- Be practised in the use of epidemiological statistics for detailing mortality and morbidity rates.

Readings:

- **E** Matarazzo, J.D. (1980) Behavioural health and behavioural medicine. Frontiers for a new health psychology. American Scientist, 35, 807-817.
- Seedhouse, D. (1986) Health: The Foundations for Achievement. Chichester: Wiley. pp 1-8.

Week 2. Social inequalities in health: inputs, outcomes and processes

This session will assess findings that have shown that there are notable differences in the health status according to a number of socio-demographic factors. The main focus of this session will be to discuss whether this relationship between social inputs and health outcomes is direct or the result of mediating processes, and in particular, psychological processes. We will critically appraise a number of formative studies that argue in favour of social inequalities in health. In addition, a general model

(Rutter & Quine, 1996; Rutter, Quine and Chesham, 1993) which addresses the possible mediating nature of psychological mechanisms for describing the social input-health outcome association will be presented and evaluated. Also, we will discuss the applied ramifications of such an approach by assessing why it may be important that health psychologists are aware of these mechanisms. Particularly the role of health psychology for the design and evaluation of health-related interventions to reduce the likelihood of illness and increase the likelihood of well being will be discussed.

Objectives:

- Consider that health status may be attributable to known social inequalities.
- Understand that psychological processes may have a mediating or moderating influence when assessing the relationship between social inputs and health-related outcomes.
- Consider the Rutter et al model (1993) which identifies possible mediating psychological mechanisms.
- Consider the applied implications in terms of health interventions of such an approach, and how such interventions are important in reducing social inequalities in health.

Learning Outcomes:

At the end of the session students will:

- Comprehend that for any discussion of health outcomes one must always consider that there are known social inequalities that affect health, and may also influence health beliefs and health behaviours.
- Understand that psychological processes, among others, act as mediators between social inputs, health behaviours and health outcomes.
- Appreciate that interventions for detrimental health behaviours need to be designed and implemented within a framework of social inequalities.

Readings:

- Adler, N.E., Boyce, T., Chesney, M.A., Cohen, S., Folkman, S., Kahn, R.L. & Syme, S.L. (1994) Socio-economic status and health. American Psychologist, 49, 15-24.
- Adler, N. & Matthews, K. (1994) Health Psychology: why so some people get sick and some stay well? Annual Review of Psychology, 45, 229-259.
- **E** Marmot, M.G. et al (1991) Health inequalities among British civil servants: the Whitehall II study. Lancet, 337, 1387-1393.
- **E** Rutter, D.R. & Quine, L. (1996) Social psychological mediators of the relationship between demographic factors and health outcomes: a theoretical model and some preliminary data. Psychology and Health, 11, 5-22.

Week 3. Models of health behaviour 1: HBM, PMT, TRA & TPB

Early investigations of health behaviours concentrated primarily on demographic and socio-demographic factors. Individuals were described as either engaging in health behaviours or not according to their age, gender or socio-economic status. Although we have shown that such epidemiological research is fundamental for identifying social inequalities in health, we also argued that that such findings may be limited in terms of health behaviour interventions because they do not offer process explanations. This session is the first of three in which we will explore the theoretical foundations of the study of psychology and health, health perceptions and health behaviour. We will identify those models that have been utilised to examine those psychological processes which may link socio-demographic inputs with the experience of health outcomes. These models include those derived from the health behaviour/psychology literature (e.g. the Health Belief Model and Protection Motivation Theory) and also those derived from general social cognition models (e.g. Theory of Reasoned Action, Theory of Planned Behaviour). We will discuss the relevance of these models for the study of health behaviours and critically explore the main similarities and differences between the approaches. We will also undertake a practical examination of two or three of the models (i.e. the Health Belief Model and /or the Theory of Planned Behaviour) by attempting to devise the types of issues/questions that need to be included in a study of particular health behaviours.

Objectives:

- Identify the major theoretical models that have been utilised to study health behaviour.
- Consider models that have been developed for the specific interpretation of health behaviour (e.g. Health Belief Model, Protection Motivation Theory).
- Consider models that have been developed from the social cognition literature for the study of health behaviour (e.g. Theory of Reasoned Action, Theory of Planned Behaviour).
- Compare and contrast such theoretical interpretations of health behaviour.
- Understand how such models have advanced and defined the study of psychology and health.

Learning Outcomes:

At the end of the session students will:

- Have an appreciation of the main models and theories used in the psychological study of health behaviours.
- Understand the similarities and differences between these models.
- Recognise how such theorising is important for intervention in health behaviour.

Readings:

E Norman, P., Boer, H. & Seydel, E.R, (2005) Protection Motivation Theory. In Conner, M. & Norman, P. (Eds.) Predicting Health Behaviour. Buckingham: Open University Press, pp.81-126.

E Abraham, C. & Sheeran, P. (2005). The Health Belief Model. . In Conner, M. & Norman, P. (Eds.) Predicting Health Behaviour. Buckingham: Open University Press, pp.28-80.

E Armitage, C. J. & Conner, M. (2001) Efficacy of the theory of planned behaviour: a meta-analytic review. British Journal of Social Psychology, 40, 471-499.

E Luszczynska, A. & Schwarzer, R. (2005) Social Cognitive Theory. In Conner, M. & Norman, P. (Eds.) Predicting Health Behaviour. Buckingham: Open University Press, pp.127-169.

Milne, S., Sheeran, P. & Orbell, S. (2000) Prediction and intervention in health-related behaviour: A meta-analytic review of protection motivation theory. Journal of Applied Social Psychology, 30, 106-143.

Week 4. Models of health behaviour 2: SRM, SCT & implementation intentions

Last week's session identified a number of theoretical models which have developed specifically for the study of health behaviour, or else have been adapted from the social cognition literature and applied for the study of psychological processes in health. This week we will continue the same trend and cover some other social cognition and health behaviour models (Social Cognitive Theory and Self-Regulatory Model). Research shows that social cognition models predict between 40-50% of variance in intention and only 19-38% of variance in behaviour (Armitage & Conner, 2001). We will also explore how the use of implementation intentions might help us turn intentions into behaviour and discuss some evidence. Specifically we will explore those psychological factors that have been proposed to account for individual differences between people in the experience of and response to health threats. Such factors include self-efficacy, outcome expectancies and planning. We will critically explore each of these factors, and examine how the study of such concepts has aided the understanding of process explanations for health behaviours. Also, we will identify how those theoretical models discussed in the previous session can account for these individual differences.

Objectives:

- Consider models that have been developed for the specific interpretation of health behaviour (e.g. the Self-Regulatory Model of Illness Behaviour).
- Consider models that have been developed from the social cognition literature for the study of health behaviour (e.g. the Social Cognitive Theory).
- Understand how to overcome the intention-behaviour gap (implementation intentions)
- Understand how such models have advanced and defined the study of psychology and health.

Learning Outcomes:

At the end of the session students will:

- Have an appreciation of these models and theories used in the psychological study of health behaviours.
- Recognise how such theorising is important for intervention in health behaviour.

Readings:

E Leventhal, H., Benyamini, Y., Brownlee, S., Diefenbach, M., Leventhal, E.A., Patrick-Miller, L. & Robitaille, C. (1997) Illness representations: theoretical foundations. In K.J. Petrie & J.A. Weinman (Eds.) Perceptions of Health and Illness. Amsterdam: Harwood, pp. 19-45.

Plus

O'Connor, S, M., Jardine, A. G., & Millar. K. (2008) The prediction of self-care behaviors in end-stage renal disease patients using Leventhal's Self-Regulatory Model Journal of Psychosomatic Research, 65 191-200

Or

Urquhart Law, G., Kelly, T.P., Huey, D & Summerbell. C. (2002) Self-management and well-being in adolescents with diabetes mellitus:: Do illness representations play a regulatory role? Journal of Adolescent Health, 31, 381-385

And

E Gollwitzer, P.M. & Sheeran. P. (2006) Implementation Intentions and Goal Achievement: A Meta-analysis of Effects and Processes. Advances in Experimental Social Psychology 38, 69 - 119

E Hagger, M.S., Wood, C., Stiff, C. & Chatzisarantis. N.L.D. (2010) Ego depletion and the strength model of self-control: A meta-analysis. Psychological Bulletin, 136, 495-525

Gollwitzer, P. M. (1999). Implementation intentions: Strong effects of simple plans. American Psychologist, 54, 474-483.

Sheeran, P., Milne, S., Webb, T. & Gollwitzer, P. M. (2005) Implementation intentions and health behaviour. In Conner, M. & Norman, P. (Eds.) Predicting Health Behaviour. Buckingham: Open University Press, pp.276-323.

Week 5. Models of health behaviour 3: TTM, PAPM & HAPA

In previous sessions a number of models have bee identified that explain individual decisions making in terms of a linear model. That is, individuals are assumed to form intentions to behave and actually behave in a predictable fashion given various factors such as beliefs, social norms, expectancy perceptions, optimistic biases, and so on. In this session we will explore various models that propose individual decision making processes and behaviour can be viewed in terms of precise decision making *stages*. These stages are qualitatively different from one another and depend on distinct cognitive or affective processes. These models are of particular importance because they detail factors and processes that may be important for understating behavioural change. The models we will study are the transtheortical model of behaviour change (also known as the stages of change model), the health action process approach and the precaution adoption process model.

Objectives:

- Consider models that have been developed for the specific interpretation of health behaviour change (e.g. the TTM, HAPA, PAPM).
- Understand how these models differ from other approaches in terms of the underlying stage perspective adopted.
- Consider which factors are important for the operation of health-related decision-making and how this is reflected in behaviour change.

Learning Outcomes:

At the end of the session students will:

- Define the concept of *stage* in health-related decision-making models.
- Identify the key similarities and differences between stage and non-stage based models of health behaviour.
- Identify the key differences and similarities between the TTM, HAPA and PAPM.
- Report how these models aid our understanding of how and why people change behaviour and how this is relevant for health-related decision-making.

Readings:

E Weinstein, N.D. & Sandman, P.M. (1992) A model of the precaution adoption process: evidence of the home radon testing. Health Psychology, 11, 170-180.

Weinstein, N.D., Rothman, A.J. & Sutton, S.R. (1998) Stage theories of health behaviour: conceptual and methodological issues. Health Psychology, 17, 290-299.

E Prochaska, J.O., DiClemente, C.C. & Norcross, J.C. (1992) In search of how people change: applications to addictive behaviours. American Psychologist, 47, 1102-1114.

E Schwarzer, R. (1999) Self-regulatory processes in the adoption and maintenance of health behaviours: the role of optimism, goals and threats. Journal of Health Psychology, 4, 115-1127.

Sutton, S.R. (2005) Stage theories of health behaviour. In Connor, M. & Norman, P. (Eds.) Predicting Health Behaviour (Second Edition). Buckingham: Open University Press.

Week 6. Consolidation Week

During this session there will be no scheduled teaching activities. This will give you the opportunity to start work on your coursework assignment and undertake any reading and preparation related to the course. Staff will be available in their offices during the scheduled teaching times for students to attend for tutorials on the course.

Week 7. Optimistic bias and risk perception in health-related decision-making

In previous sessions we have identified a number of theoretical models which have developed specifically for the study of health behaviour, or else have been adapted from the social cognition literature and applied for the study of psychological processes in health. This week we will extend this literature and consider other factors which have been considered as fundamental for the study of those psychological mechanisms which mediate or moderate the socio-demographic input-health outcomes associations. Specifically we will explore those psychological factors that have been proposed to account for individual differences between people in the experience of and response to health threats. One such factor is called optimistic bias or the observation that people tend to perceive that good things will happen to them and bad things will not when compared to other people. People have a perception of invulnerability to negative health outcomes. We will explore why people hold these illusory biases and how this may relate to the decision to undertake health related adaptive or maladaptive behaviour. We will also consider how this work may aid our understanding how changing people's health related behaviours.

Objectives:

- Identify factors that have been utilised to study individual differences in health behaviour.
- Critically appraise evidence that suggests that positive illusions, comparative optimism and optimistic bias offer psychological explanations as mediation and moderation variables between social input and health outcomes.
- Understand the role of optimistic bias in the adoption of adaptive and maladaptive health behaviours.
- Understand how evidence from optimistic bias can advanced the study of interventions designed to encourage positive health behaviours.

Learning Outcomes:

At the end of the session students will:

- Define the concept optimistic bias, comparative optimism and unrealistic optimism.
- Understand how optimistic bias id operationalised for empirical study.
- Report how optimistic bias is important for understanding health related decision making.
- Report the key factors important for the operation of unrealistic optimism and how these factors may be informative for designing effective interventions.
- Report how these models aid our understanding of how and why people change behaviour and how this is relevant for health-related decision-making.

Readings: NB: Pick any two of these readings and be prepared to discuss them in the class.

McKenna, F.P. (1993) It won't happen to me: unrealistic optimism or illusion of control. British Journal of Psychology, 84, 39-50.

Albery, I.P. & Messer, D. (2005) Comparative optimism about health and non-health events in eight and nine year old children. Health Psychology, 24, 316-320.

Taylor, S.E. & Brown, J.D. (1988) Illusion and well-being: A social psychological perspective on mental health. Psychological Bulletin, 103, 193-210.

E Van der Plight, J. (1998) Perceived risk and vulnerability as predictors of precautionary behaviour. British Journal of Health Psychology, 3, 1-14

E Weinstein, N. (1982) Unrealistic optimism about susceptibility to health problems. Journal of Behavioral Medicine, 5, 441-460.

E McKenna, F.P. & Albery, I.P. (2001) Does unrealistic optimism change following negative experience. Journal of Applied Social Psychology, 31, 1146-1157.

Jessop, D., Albery, I.P., Rutter, J. & Garrod, H. (2008) Understanding the impact of mortality-related health information: a terror management theory perspective. Personality and Social Psychology Bulletin, 34, 951-964.

Myers, L.B. & Frost, S. (2003) Smoking and smoking cessation: modifying perceptions of risk. In Rutter, D. & Quine, L. (Eds.) Changing Health Behaviour. Buckingham: Open University Press.

Week 8. Habit in health behaviour

According to some theorists the best predictor of future behaviour is past behaviour (Sutton, 1997). Very recently health psychologists have become interested in understanding the role of habitual processes in health related behaviour. You may remember that one characteristic of Gollwitzer's implementation intentions (Week 4) is that decision making may operate at a processing level which the individual is unaware i.e. am implicit processing level. Other academics have argued for the role of habit in social behaviour. You may have come across this in your discussion of the TPB/TRA (Week 3). Much of the work has been carried out in the field of addiction although more recently work has started to emerge that identifies cognitive processes that operate at this implicit level and may be important for understanding habit. In this session we will explore some of this evidence and examine how understanding health behaviour according to habitual properties may be important for designing methods for changing behaviour.

Objectives:

- Identify how the study of habitual processes is important for understanding why people do or do not undertake health behaviours.
- Identify key components of habit.
- Appreciate the independent role of habitual processes in understanding how to change individual's unhealthy behaviours.

Learning Outcomes:

At the end of the session students will:

- Define the concept of habit and its important in understanding health related behaviour and decision making.
- Outline component processes and key features of habitual behaviour.
- Outline methods used to assess the role of habitual processes in health related decision-making.

- Conceptualise how interventions have to embrace knowledge derived from research on habit in understanding why people may not change their behaviours even though they have explicit intentions to do so.

Readings:

E Moss, A.C. & Albery, I.P. (2009) A dual process model of the alcohol-behaviour link for social drinking. Psychological Bulletin, 135, 516-530.

Erblich, J., Montgomery, G.H., Valdimarsdottir, H.B., Cloitre, M. & Bovbjerg, D.H. (2003) Biased cognitive processing of cancer-related information among women with family histories of breast cancer: evidence from a cancer Stroop task. Health Psychology, 22(3), 235-244.

Munafo, M.R. & Stevenson, J. (2003) Selective processing of threat-related cues in day surgery patients and prediction of post-operative pain. British Journal of Health Psychology, 8, 439-449.

E Danner, U.N., Aarts, H. & de Vries, N.K. (2008) Habit vs. intention in the prediction of future behaviour: the role of frequency, context stability and mental accessibility of past behaviour. British Journal of Social Psychology, 47, 245-265.

Stacy, A.W., Newcomb, M.D. & Ames, S.L. (2000) Implicit cognition and HIV risk behaviour. Journal of Behavioral Medicine, 23(5), 475-499.

Stacy, A.W, Ames, S. & Leigh, B.C. (2004) An Implicit Cognition Assessment Approach to Relapse, Secondary Prevention, and Media Effects. Cognitive and Behavioral Practice, 11(2), 139-149.

E Sheeran, P., Aarts, H, Custers, R., Rivis, A., Webb, T.L. & Cooke, R. (2005) The goal-dependent automaticity of drinking habits. British Journal of Social Psychology, 44(1), 47-63.

Ouellette, J. & Wood, W. (1998) Habit and intention in everyday life: the multiple processes by which past behaviour predicts future behaviour. Psychological Bulletin, 124, 54-74.

Sutton, S.R. (1994) The past predicts the future: interpreting behaviour-behaviour relationships in social psychological models of health behaviours. In Rutter, D.R. & Quine, L. (Eds.) Social Psychology and Health: European Perspectives. Alcershot: Avebury.

Week 9. Theories of stress, health and illness

In this session will see different definitions of stress as a stimulus and a response to an event. We will then examine Lazarus's model of stress and how this adds to our

understanding of stress. We will also examine acute and chronic stressors by giving some examples. Finally, we will cover evidence outlining physiological processes related to stress and how this might impact upon physical health (e.g. CHD, cancer).

Objectives:

- Define stress and understand how we can study stress
- Illustrate the models of stress and discuss the critical role of cognitive appraisal
- Differentiate between acute and chronic stressors
- Identify physiological processes of stress and its influence on health
- Understanding how stress is linked to various diseases (e.g. CHD, cancer)

Learning Outcomes:

At the end of the session students will:

- Understand stress and various forms of stress
- Comprehend the important role of cognitive appraisal in stress
- Understand the role of physiological processes caused by stress
- Comprehend the stress – physical health link

Readings:

E Lazarus, R. S. (1993). From psychological stress to the emotions: a history of changing outlooks. Annual Review of Psychology, 44, 1-21.

E Cohen, S., Frank, E., Doyle, W. J., Skoner, D. P., Rabin, B. S. & Gwaltney, J. M. (1998). Types of stressors that increase susceptibility to the common cold in healthy adults. Health Psychology, 17, 214-223.

E Bunker, S. J., Colquhoun, D. M., Esler, M. D. et al. (2003). Stress and coronary heart disease: psychosocial risk factors. Medical Journal of Australia, 178, 272-276.

E McKenna, M. C., Zevon, M. A., Corn, B. & Rounds, J. (1999). Psychological factors and the development of breast cancer: a meta-analysis. Health Psychology, 18, 520-531.

Nicholson, A., Fuhrer, R. & marmot, M. (2005). Psychological distress as a predictor of CHD events in men: the effect of persistence and components of risk. Psychosomatic Medicine, 67, 522-530.

YOU WILL BE GIVEN A READING ON PSYCHONEUROIMMUNOLOGY TO SHARE WITH THE CLASS NEXT WEEK

Week 10. Moderators of the stress-illness relationship

In this session, we will cover the coping models and various coping strategies suggested by Lazarus (1979). We will then discuss how different coping strategies might affect health outcomes differently. Also literature shows that various personality factors (e.g. hostility), cognitions (e.g. efficacy) and emotions (e.g. depression) are linked to specific coping responses and illness outcomes. We will discuss these in detail by using various examples. Finally, we will identify evidence which shows that external social support influences the stress appraisal process and illness outcomes.

Objectives:

- Illustrate how stress may influence health and illness
- Discuss different coping styles and strategies
- Identify key personality factors that has positive or negative impact on health
- Identify key cognitions that has positive or negative impact on health
- Identify key emotions that has positive or negative impact on health
- Examine the direct and indirect influences of these factors on stress outcomes
- Evaluate the role of social support on stress appraisal and illness outcomes

Learning Outcomes:

At the end of the session students will:

- Understand the coping theory and different coping strategies
- Understand the role of different coping strategies on health
- Identify various aspects of personality (e.g. hostility), cognitions (e.g. efficacy) and emotions (e.g. depression) and the related coping response and illness outcomes
- Understand the role of social support on health and illness outcomes

Readings:

E Bedi, G. & Brown, S. L. (2005). Optimism, coping style and emotional well-being in cardiac patients. British Journal of Health Psychology, 10, 57-70.

E Gidron, Y., Hassid, A., Yisrael, H. & Biderman, A. (2005). Do psychological factors predict occurrence of influenza-like symptoms in vaccinated elderly residents of a sheltered home? British Journal of Health Psychology, 10, 411-420.

E Korotkov, D. & Hannah, T. E. (2004). The five-factor model of personality: strengths and limitations in predicting health status, sick-role and illness behaviour. Personality and Individual Differences, 36, 187-199.

E Adler, N. E. & Matthews, K. A. (1994). Health psychology: why do some people get sick and some stay well? Annual Review of Psychology, 45, 229-259.

Uchino, B. N., Cacioppo, J. T. & Kiecolt-Glaser, J. K. (1996). The relationship between social support and physiological processes: a review with emphasis on underlying mechanisms and implications for health. Psychological Bulletin, 119, 488-533.

Week 11. **Doctor-patient communication and adherence**

Literature suggests that as many as 50% of patients do not adhere to their doctor's recommendations (Ong et al., 2005). Moreover, lack of adherence increases when there is a behaviour change such as quitting smoking, weight control and exercise. Research shows that there are doctor (e.g. language) and patient (e.g. anxiety) specific factors that affect adherence as well as factors related to the treatment regimen (e.g. complexity). In this session, we will identify both the patient and physician factors and we will also discuss about main models of doctor-patient relationship and models of compliance.

Objectives:

- Outline the nature and different styles of communication
- Describe adherence and examine the prevalence of non-adherence
- Illustrate the factors influencing adherence and non-adherence
- Identify important doctor and patient characteristics
- Identify relevant models of adherence (compliance)
- Discuss assessment of adherence

Learning Outcomes:

At the end of the session students will:

- Understand different communication styles between doctors and patients
- Describe adherence and factors influencing adherence and non-adherence
- Appreciate various doctor and patient characteristics that have impact on adherence
- Comprehend the role of health psychologists in designing interventions to increase adherence

Readings:

E Chesney, M. (2003). Adherence to HAART regimens. AIDS Patient Care and STDs, 17, 169-177.

E Farquharson, L., Noble, L. M., Barker, C. & Behrens, R. H. (2004). Health beliefs and communication in the travel clinic consultation as predictors of adherence to malaria chemoprophylaxis. British Journal of Health Psychology, 9, 201-217.

E Ong, L. M. L., DeHaes, J. C. J. M., Hoos, A. M & Lammes, F. B. (1995). Doctor-patient communication: a review of the literature. Social Science and Medicine, 40, 903-918.

Bensing, J. M. & Verhaak, P. F. M. (2004). Communication in medical encounters. In Kaptein, A. & Weinman, J. (Eds.) Health Psychology. Oxford: BPS Blackwell, pp.261-287.

Week 12. Consolidation Week

There will be no readings assigned for this session. However, students are expected to be preparing for revision of the unit content. The teaching team will be available in their offices during the normal teaching period of the unit. Students can sign up to discuss any areas of the unit that require further clarification and reappraisal for them.

10. Assessment

The unit will have the following components for assessment:

- Students will be expected to write a 2,500-word evaluation of a piece of health promotion. Coursework counts for 40% of the overall unit mark.

- Students will also be expected to sit an unseen two-hour examination. This will comprise 60% of the total Unit mark.

Please visit the Faculty web site for submission dates and examination timetables
http://www1.lsbu.ac.uk/current.student/ahstimetables.shtml

Please see the Psychology Course Guide 2010-2011 for information on
- submission procedures
- penalties for late or non-submission
- possible requests for submission of coursework to Turnitin
- marking criteria

11. Learner Support Material

Core Text.

Albery, I.P. & Munafo, M. (2008) Key Concepts in Health Psychology. London: Sage.

Morrison, V. & Bennett, P. (2006) An Introduction to Health Psychology. Harlow: Prentice Hall.

The following books are also particularly relevant:

Connor, M. & Norman, P. (2005) Predicting Health Behaviour (Second Edition). Buckingham: Open University Press.

Ogden, J. (2004) Health Psychology: A Textbook (Third Edition). Buckingham: Open University Press.

Suls, J. & Wallston, K.A. (EDS.) (2003) Social Psychological Foundations of Health and Illness. Oxford: Blackwells.

Salovey, P. & Rothman, A.J. (Eds.) (2003) Social Psychology of Health. Hove: Psychology Press.

Taylor, S.E. (2003) Health Psychology (Fifth Edition). New York: McGraw-Hill.

Sarafino, E.P. (1998) Health Psychology: Biopsychosocial Interactions (Third Edition). New York: Wiley.

Stroebe, W. (2000) Social Psychology and Health (Second Edition). Buckingham: OpenUniversity Press.

Background Texts.

Baum, A., Newman, S., Weinman, J., West, R. & McManus, C. (1997) (Eds.). Cambridge Handbook of Psychology, Health and Medicine. Cambridge: Cambridge University Press.

Bernard, L.C & Krupat, E. (1994) Health Psychology: Biopsychosocial Factors in Health and Illness. London: Harcourt Brace.

Bishop, G.B. (1994) Health Psychology: Integrating Mind and Body. Boston: Allyn and Bacon.

Buuk, B.P. & Gibbons, F.X. (1997) (Eds.). Health, Coping and Well-Being: Perspectives from Social Comparison Theory. Mahwah: Lawrence Erlbaum.

Norman, P., Abraham, C. & Conner, M. (2000) Understanding and Changing Health Behaviour. Amsterdam: Harwood.

Petrie, K.J. & Weinman, J. (1997) (Eds.). Perceptions of Health and Illness. Amsterdam: Harwood Academic.

Pitts, M. & Phillips, K. (1998) (Eds.). The Psychology of Health. London: Routledge.

Rutter, D.R. & Quine, L. (2002) (Eds.) Changing Health Behaviour. Buckingham: Open University Press.

Rutter, D.R. & Quine, L. (1994) (Eds). Social Psychology and Health: European Perspectives. Aldershot: Avebury.

Rutter, D.R., Quine, L. & Chesham, D.J. (1993) Social Psychological Approaches to Health. London: Harvester Wheatsheaf.

Sutton, S., Baum, A. & Johnston, M. (2004) (Eds.) The Sage Handbook of Health Psychology. London: Sage

Skevington, S.M. (1995) Psychology of Pain. Chichester: Wiley.

Steptoe, A. & Wardle, J. (1994) Psychosocial Processes and Health: A Reader. Cambridge: Cambridge University Press.

Main Journals

During the course it is probably worth spending a bit of time each week browsing the current periodicals section in the library. For your guidance here is a list of the journals I regularly take a glance at. For those journals not subscribed to by South Bank University library, you can still obtain the most recent paper listings by using one of the search databases (e.g. Psychlit, BIDS etc) or else find the journal on the Internet. Although you won't necessarily be able to get complete papers, you should at least be able to obtain individual paper titles and maybe even abstracts.

British Medical Journal
British Journal of Health Psychology
British Journal of Social Psychology
British Journal of Clinical Psychology
Health Psychology
Journal of Personality and Social Psychology
Psychology and Health
Social Science and Medicine
The Lancet
Journal of Health Psychology
Journal of Health and Social Behaviour

Reference Sources: Office of National Statistics (ONS)

General Household Survey
ONS/OPCS Series DH2 and DH3 (mortality figures)
Social Trends
Population Trends
Regional Trends
Prescott-Clarke & Primatesta (Eds) (1996, 1997, etc The Health Survey for England (series HS, Nos 5 and 6)
Bridgwood, Malbon, Lader, & Matheson (Eds) Health in England 1995, 1996, What People Know, What People Think, What People Do.

Websites

As well as using the textbooks, journals and databases to access relevant literature on health psychology, it is also probably worth your while using the Internet to explore the numerous websites that address issues related to the psychology of health. For your information, I have listed below a number of such sites, and I would encourage taking at look at them over the course of the unit, and explore any other sites you might find. You never know you might even find information that is useful for revision and answering essay questions.

1. http://www.ehps.net – European Health Psychology Society.
2. http://www.bps.org.uk/sub-syst/division/dhp/default.htm – Division of Health Psychology within the British Psychological Society.
3. http://www.apa.org/about/division/div38.html – Division of Health Psychology within the American Psychological Association.
4. http://www.psy.miami.edu/isbm – International Society of Behavioural Medicine.
5. http://www.psychologie.de – Health Psychology in Germany.
6. http:/www.is.dal.ca/~hlthpsyc/hlthhome.htm – Health Psychology Section of the Canadian Psychological Association.

Professor Ian Albery
Helen Graves
August 2010