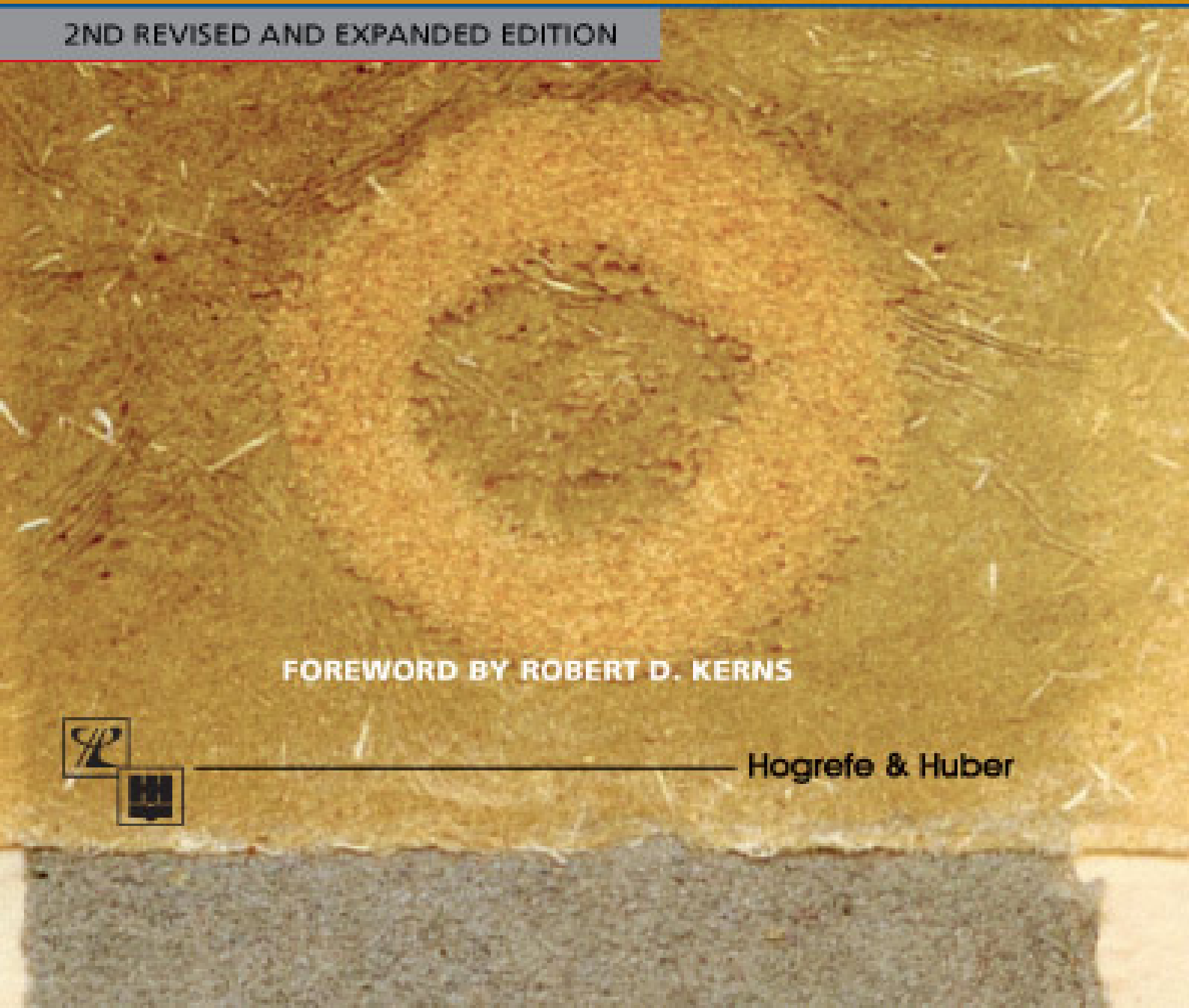
PAUL CAMIC · SARA KNIGHT

CLINICAL HANDBOOK OF HEALTH PSYCHOLOGY

A Practical Guide to Effective Interventions

2ND REVISED AND EXPANDED EDITION



FOREWORD BY ROBERT D. KERNS

Hogrefe & Huber

Clinical Handbook of Health Psychology

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A Practical Guide to Effective Interventions

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With a Foreword by Robert D. Kerns, Ph.D.

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Robert D. Kerns

Foreword

Looking back over a twenty-five year career as a clinical health psychologist, I can reflect on the relatively rapid emergence of a large and expanding body of knowledge about the role of psychological and interpersonal factors in the broadest possible array of health and illness issues and the ever-increasing influence the field has had on health practices and health policy. Our field has evolved into a sophisticated and rigorous science that now spans issues covering the entire life span and touching virtually every known health problem. Its influences on education from preschool through advanced professional and scientific training, almost regardless of the specific area of study, are increasingly apparent. Dissemination of knowledge informed by work in the field has garnered the public's interest in terms of lifestyle, prevention of illness and promotion of health, and expectations for healthcare. The breadth, and depth, of our field is enormous, and its promise for promoting quality of life, and even extending life, is compelling. Health psychology remains an exciting field, and one that captures the imagination and creativity of many who wish to influence the health and wellbeing of those around us.

Educating others about the breadth and complexity of the field of health psychology in a single text that is both meaningful and engaging clearly presents a series of challenges that few would have the nerve to undertake. Drs. Paul Camic and Sara Knight have once again risen to the occasion in their publication of this second edition of their previously successful book. Among all of the similar texts in the field, this one is at the top of my list.

The strengths of this text are numerous, but most important from my perspective is the success of these authors and their collaborators in capturing the excitement and enthusiasm that those of us who are immersed in this field continue to experience on a nearly daily basis. The editors' optimism about the potential of the field comes through loud and clear. In this sense the text stands to promote personal growth through an improved understanding of the interface between important psychological and interpersonal factors and health outcomes, and to encourage personal action informed by this knowledge and appreciation. At the same time it is likely to capture the attention of future scientists and health professionals and foster an interest in the pursuit of a deeper understanding of the potential relevance and importance of the field. For those considering a career in psychology, the text provides a sound foundation for future study and investigation by offering both information about the current state of the field and targets for future efforts to advance it.

Several additional strengths of the text are important to acknowledge. Contributing to the readers' understanding of even the most complex and challenging concepts are consistent efforts to promote integration and linkages across disparate domains and topics through the promotion of a unifying biopsychosocial perspective. This perspective serves as an important framework that will likely remain with the reader long after the course is completed. And, thankfully, and as opposed

to many other texts in the field, the "social" dimension of the model is actually emphasized, rather than being given scant attention. The authors are to be commended for their routine consideration of cultural influences on health and behavior and of the cultural competence of practitioners. The concluding chapters that specifically address issues such as the role of the social context, spirituality and religion, and ethnic minorities help to reinforce this critical, but often neglected, dimension.

The first chapter of the book, authored by its editors, sets the stage for a sequential and graded consideration of the breadth of the field and provides a firm foundation for the chapters that follow. The chapter begins with a brief historical perspective that highlights the emergence of the field and the challenges in defining a new area of investigation and practice within the context of existing areas of inquiry and the contemporary healthcare industry. It is in this context that the biopsychosocial perspective is introduced as a unifying framework for the remainder of the text. Emerging themes in our field are also introduced in this chapter, including the concepts of environment of care, health and illness as a continuum, integration of art and science, complementary and alternative medicine perspectives and approaches, the social, cultural, and spiritual contexts of healthcare, and the influence of health economics. Discussion of these issues serves to encourage the reader to have an eye to the future when considering more specific topics and areas of interest. The second chapter on assessment similarly provides a critical foundation for the remainder of the text by discussing a series of key parameters of clinical assessment and the role of assessment in case conceptualization and in informing treatment planning.

The success of the authors of this text in providing an integration of the science of health psychology and practice is another noteworthy strength. This integrative perspective is represented by the editors of the volume and by the authors of each chapter. The scholarship represented in each of the chapters is clearly evident, and represents the current status of theory and empirical foundations. Just as important is the emphasis on the practitioner's perspective and experience. For example, Van Egeren's chapter on assessment in health psychology tackles practical issues such as the "reticent patient" that offer the reader insight into some of the complexities and challenges of translating state-of-the-art science and empirical evidence into practice. As already noted, the specific attention to the cultural context in considering these translations is critically important when considering the rapidly shifting demographics of our society and our emerging global perspective.

The editors have made a wise decision in offering a volume that is organized around the consideration of specific diseases or areas of inquiry and practice. Again, their success in engaging leading scholars and practitioners in authoring these chapters represents their appreciation of the trend toward specialization in the field of health psychology and the practical utility of this organizational approach. Chapters on diseases or problem domains in which health psychologists have had their greatest influence in terms of scientific advances, practice, and policy have been selected to substantially reflect the breadth of our field. Topics included are cardiology, pulmonary medicine, pain and pain management, dental medicine, diabetes mellitus, gastrointestinal disorders, human immunodeficiency virus, multiple sclerosis, obstetrics and gynecology, oncology, and urological disorders. The consistent organization of each chapter's content aids the reader in examining similarities and differences across these areas of inquiry and practice and encourages the development of a broad and well-informed perspective on the field.

Each chapter begins with a presentation of information that serves to build a foundation about the disease or problem from a medical perspective. A consideration of issues particularly relevant to the health psychologist is subsequently introduced in a manner that, once again, promotes integrative thinking and consideration of the practical interface of the practice of clinical health psychology within the broader healthcare system. Specific attention to the role of

assessment, case conceptualization and treatment planning, and psychological intervention in the consideration of each disorder or problem domain is critical in further fostering this integrative and dynamic perspective. The presentation of a range of clinical problems that serve as targets for health psychological involvement within each domain serves to enhance the readers' awareness of the breadth of the field, opportunities for continued investigation, and the importance of continued efforts to promote change in our healthcare delivery system. The liberal use of tables helps to organize information. The routine inclusion of case examples serves to put a "real face" on the problems being addressed by clinical health psychologists. The consideration of specific professional practice issues in several of the chapters emphasizes the challenges being confronted by practitioners in the field and ongoing health policy issues.

All-in-all this is an exceptional volume that will appeal to educators and students alike. Congratulations to Drs. Knight and Camic and their coauthors for once again capturing the energy and excitement of the field of health psychology.

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January 2004

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Section III: Health and Illness – Community, Social, Spiritual, and Creative Involvement

Paul M. Camic & Sara J. Knight

Preface to the Second Edition

The emergence of health psychology over 25 years ago, and its continuing growth and development as an area of research and an applied area of practice, mean that it is now well established as a distinct field within psychology. Significant contributions continue to be made in the areas of health promotion, disease prevention, health education, and treatment. With regards to treatment, health psychologists are currently involved with a wide range of disorders representing most of the body's physical systems. The focus of this book is on the treatment and assessment of these disorders, encompassing ten physical systems of the human body.

This book is intended to be a practical resource for clinicians, psychology interns, and advanced graduate students, providing a reference for both the classroom and clinical settings. While this book is not a basic introduction to clinical health psychology for undergraduates, it is suitable for graduates students as well as new- or established-practitioners. We assume the reader is somewhat familiar with the specialty of health psychology and the basics of clinical assessment, and is also knowledgeable about the key interventions used in health psychology (e.g., brief psychotherapy, autogenic techniques, progressive muscle relaxation, biofeedback, cognitive-behavioral therapy, learning and conditioning theories, fundamental psychodynamics, hypnosis, relapse prevention, supportive therapy, etc.). Our purpose is to assist the reader in the translation of research and theory in health psychology and medicine into evidenced-based clinical interventions. We hope this text will help clinicians understand not only the technical knowledge required to work with medical patients, but also help them value the process of healing.

The idea for the first edition of this book came about when we both expressed a desire for a clinical health psychology text suitable for advanced graduate students and interns. At the time both of us taught in clinical psychology doctoral programs, encompassing the scientist-practitioner (SJK) and scholar-practitioner (PMC) models, which offered health psychology training as a specialty track. We were frustrated that most of the texts in health psychology were either an introduction to the field, and thus overly broad, or highly specialized and not suitable to the general health psychology practitioner. While there had been rich theoretical and empirical innovations in health psychology, there was little published guidance for the new clinician on how to actually apply these concepts and findings in therapeutic relationships with patients from diverse backgrounds seen in complex, multidisciplinary clinical settings. Our hope at the time of developing the first edition was to provide a text that was solidly grounded in empirical science, but also one that left room for clinical insight and creativity and an appreciation of the *healing process.* The very positive response to the first edition of the *Clinical Handbook of Health Psychology* confirmed what we saw as a need to link empirical research findings, clinical practice, and the sometimes less than clear components of the culturally influenced phenomenon of healing. We have continued this perspective in the second edi-

tion. This new edition includes advancements made in health psychology assessment and treatment since the publication of the first edition in 1998 and involves new chapters and significant revisions of existing chapters.

We are asking that the users of this handbook think about the concept of healing as they consider an intervention strategy. Healing is after all, what our patients are seeking, in one way or another. Healing is also a difficult concept to measure. We believe healing takes place in all effective therapeutic relationships. Healing, for some, may mean being able to breathe without a ventilator and finally leaving the hospital. For others it may mean chemotherapy has stopped the progression of cancer cells and they are beginning to feel a bit of joy at being alive. For some of the people we work with, healing may mean coming to terms with dying or with pain that will always remain part of their lives.

In two initial organizing chapters, we introduce the concept of healing as an art and science. Here, we provide a context for the current practice of health psychology interventions and assessment in light of current trends and controversies. Chapters 3 through 12 are the primary focus of this handbook. Each chapter discusses the biopsychosocial aspects of an area of health psychology practice, including cardiovascular disease, respiratory illnesses, chronic pain, dental health, diabetes and other endocrine disorders, gastrointestinal disease, multiple sclerosis, human immunodeficiency virus, reproductive concerns, cancer, and urologic dysfunctions. For each, we consider referral questions, screening and psychological assessment, psychological interventions, and ethical and professional practice issues.

How to help someone heal is one of *the* most difficult questions we encounter in clinical practice. To begin to address the complexities of the healing process, our concluding chapters consider a number of themes that intersect the practice of health psychology–social relationships, spirituality, personal expression, and culture.

Certainly psychodynamic and humanistic psychotherapy as well as relaxation training, hypnosis, cognitive-behavioral therapy, and biofeedback can all help to reduce *symptoms,* but this may not be the same as helping someone to heal. Many turn to their belief in a higher power to help them do this. While many health psychology practitioners seem uncomfortable about an immeasurable "God" or a belief in spirituality, most other North Americans do not share this discomfort. Utilizing a patient's spiritual belief system is vitally important in the healing process for many people, whether the psychologist agrees with the beliefs or not. Chapter 15 considers this issue.

Another area that can contribute to healing is personal expression through the arts. Such well known institutions as Duke, UCLA, and the University of Florida Medical Center among many others, have formally developed arts-medicine programs for adult and pediatric medical patients. Expressive therapy training, which uses visual, movement, and sound arts, is rarely available in clinical or health psychology graduate programs. We have included a chapter introducing the field of medical art therapy. This chapter discusses basic tools such as imagery and visual expression that health psychologists can employ in their work.

Family, friends, and community can also be part of the healing process, and this is addressed in Chapter 14. A clinical intervention without considering the environment of the client may fail. The environment of one's family, friendship network, and living and working communities often needs to be *involved* in the process of helping the patient "to get better." The health psychologist's use of family and community should consider broadly the social network that is important to the patient's health and well-being: Inviting grandparents to a family session may help insure the success of a nutritional program for a Latino teenager recently diagnosed with AIDS more efficiently than a therapy using behavioral reinforcement; acknowledging a female patient's female partner (significant other) as a family member when the diagnosis of multiple sclerosis is given invites cooperation of that family member in the battle with this disease.

Finally, while we have much to offer our patients to alleviate suffering and to improve well-being, our interventions are only as effective as they are consistent with the culturally based preferences and values of patients and their families. The final chapter, Chapter 17, considers the cultural context of healing, and echoes our call for the inclusion of clinical material and research relevant to multicultural populations. This chapter discusses the challenges of involving minorities in health risk reduction interventions and provides a framework for insuring that our interventions reflect the concerns of individuals from diverse backgrounds.

We hope the information contained in the second edition of this text adds to your understanding of the physical systems and corresponding interventions that are the focus of the work of clinical health psychologists. Health psychology is an exciting and expanding field. We have enjoyed our many years of involvement as participants in the birth and maturation of this specialty. Both of us have worked as clinicians, instructors, researchers, and supervisors and have many people to thank who have been helpful in our development along the way.

To the many patients who taught us about suffering and healing, to our supervisors and mentors, to our students and colleagues, to our partners and families, we thank each of you. We would also like to thank Larry Wilson for his artwork for the cover of this volume and our editors at Hogrefe & Huber for their continued support and confidence.

Paul M. Camic, Chicago, IL
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Paul M. Camic, Ph.D., Professor of Psychology & Cultural Studies, Columbia College Chicago and adjunct Professor of Clinical Psychology, Chicago School of Professional Psychology. Recent publications include *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design* with J. Rhodes and L. Yardley (2003), American Psychological Association.

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Section I

Foundations of Practice

Sara J. Knight & Paul M. Camic

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Health Psychology and Medicine: The Art and Science of Healing

A Brief Evolutionary History

The use of psychological therapies in the treatment of health problems has a very long history. Early Egyptians, Ancient Greeks, as well as Asian cultures believed imbalances within the mind and soul can cause physical illness. Pergamum, on the west coast of Asia Minor in approximately 100 B.C., offered treatments consisting of rest, massage, herbal potions, time spent at spas and more radically, a change in lifestyle for physical and mental distress. Many indigenous cultures in North and South America and Africa have had, as part of their belief systems, the importance of the soul's affect on the body. The attention and curiosity concerning what influences physical health, has been a matter of speculation and inquiry for nearly all cultures throughout recorded history.

The contemporary beginnings of health psychology as a discipline can be traced to the two leading psychologists of the early 20th century, William James at Harvard and G. Stanley Hall at Clark. James (1922) contended that the cause of work-related nervous problems was not the amount or nature of the work, but in the needless hurry, tension and anxiety produced by one's approach to the task. Hall (1904) believed health to be a medial value in development, and not something that should be left only to physicians. He was especially concerned with hygiene, preventive medicine and the concept of wholeness, all of which he felt to be embedded philosophically in the ideal of health.

The period between 1930 and the mid-1950s saw psychology nearly exclusively focus on the assessment of mental disorders and all things involving intelligence, motivation, memory and the mind. The problems of physical health and well-being were left to physicians and most notably to the emerging field of psychosomatic medicine. As psychosomatic medicine concepts grew in popularity, however, by the end of the 1950s, more psychologists began to investigate problems of mind-body interaction. Psychoanalytic theories strongly influenced psychosomatic medicine. While this theoretical view proved intellectually rich, few cures were produced. In contrast, the growing awareness of behaviorism in the 1950s and 1960s produced alternative, empirically-derived behavioral explanations for psychosomatic illnesses. Gradually, through the 1970s and 1980s, the underlying psychoanalytic perspective toward mind-body problems gave way to a more empirically supported psychophysiological approach.

The psychophysiological approach is based on a bidirectional model involving physiological factors, the immune system, behaviors, emotions and the environment (simply put, we are discarding the one-way cause and effect street for the avenue that is interactive and definitely two-way). The bidirectional model is the basis for the *clinical* method of assessment and treatment known as the biopsychosocial paradigm, which currently dominates

clinical health psychology. As the name implies, a biopsychosocial approach takes into consideration the three domains of biological-physiological, psychological-behavioral and social-environmental, when evaluating clients. This paradigm allows clinicians to more fully consider complex interactions (e. g., the effects of racism, sexism or homophobia on emotions and physical functioning), in addition to assessing "traditional" biological and psychological domains. Inherent in this approach is the view that the health psychologist is a member of the health care team and has much to contribute to the well-being and welfare of people. Health psychologists are seen as health care, rather than mental health care, professionals thus dissolving the artificial boundary between problems of the mind and problems of the body.

The Healing Relationship

The biopsychosocial model became the focus of practitioners and scientists from a variety of disciplines — psychology, nursing, medicine, public health — who began to describe their work and its conceptual basis as behavioral medicine. The Yale conference on behavioral medicine in 1977 offered one of its first definitions as "the field concerned with the development of behavioral-science knowledge and techniques relevant to the understanding of physical health and illness and the application of this knowledge and these techniques to prevention, diagnosis, treatment, and rehabilitation. Psychosis, neurosis, and substance abuse are included only insofar as they contribute to physical disorders as an endpoint" (Schwartz & Weiss, 1977). While psychologists figured prominently in the inception of behavioral medicine, the field is inclusive of any discipline, including health psychology, that might play a role in its science and practice.

Health psychology evolved as a specialty within professional psychology. Beginning in the late 1970s as a Division within the American Psychological Association, the field has grown rapidly. In 1980, a definition of health psychology was adopted by the Division: "Health psychology is 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, illness, and related dysfunction, and the analysis and improvement of the health care system and health policy formation" (Stone, 1987). With minor modifications, this definition remains the "official" definition of the Division of Health Psychology.

This and other widely cited definitions of health psychology frame it in terms of its goals — the application of psychological theory and research in the prevention and treatment of medical disorders (Matarazzo, 1980; Millon, 1982). Other goals are directed to health care systems and health policy (Matarazzo, 1992). Whereas clinical psychology has its roots in inpatient psychiatry, health psychology is more identified with medicine and surgery. The focus of health psychology is not on treating mental illness. Rather, health psychology is oriented toward an integration of psyche and soma so as to bring about optimum health to those people with a medical illness or disease. It incorporates the social aspects of health and the health care system.

The goals outlined in these definitions of health psychology have given direction and focus to an emerging field. For clinical health psychologists working in medical settings, these goals have given shape to clinical services. The health psychologist's work is directed toward the health of the entire person. It is not limited by mind-body dualistic thinking but sees the mind very much connected to the body *and* sees the environment impacting on, and being impacted upon by, the patient.

Regardless of the setting where we meet with our patients, of the types of problems that we treat, or of the treatments we use, it is the quality of the relationship between professional and client that begins and sustains the healing process. It is this process of healing — meaning to restore to wholeness and health — that both mystifies and comforts us as clinicians. This is the process through which the clinical health psychologist, other

health professionals, and the patient work together toward the goals of physical, psychological and social health implied in the biopsychosocial model. For clinical health psychologists, this is the process through which we translate theory and research into the art of care. Perhaps the Etruscan priests of 300 B. C. E. Tuscany, or the Hopi *tuhikya* of 1600 A. D. southwestern North America, or the present day Aztec *curanderos* of Mexico, all have this ability in common. Although the word *healing* has never appeared to our knowledge in any Division of Health Psychology, Society of Behavioral Medicine or American Psychosomatic Society journal, it is what we as health professionals *do*.

In a clinical guidebook for health psychology, we are especially interested in conveying the health psychologist's role in the healing process. By healing, however, we do not mean that it will always be possible for patient to attain a state of complete health. Throughout the text there are examples of healing that involve an individual's adjustment to chronic or life threatening disease and healing that occurs at the end of life. Our purpose in developing this text was to describe across a range of medical specialties the translation of health psychology to clinical practice. To establish our objectives and scope, we drew heavily from previous definitions of health psychology. To bring alive the science and art in clinical health psychology, however, we emphasize the health psychologist's contributions to the healing process. With these principles and goals, our working definition of clinical health psychology has been the integration of knowledge from behavioral, social, and biomedical sciences and from the clinical arts and the application of this knowledge to the healing of human beings — psychologically, physically, socially, and spiritually — at all points along the health and illness continuum.

Emerging Themes

The Environment of Care

With their work based on the biopsychosocial model, health psychologists are concerned with medical, psychological, social, community, and spiritual context of health care. The work of health psychologists, therefore, is not limited to the office setting, the traditional venue for clinical psychology. Health psychologists practice in medical and surgical clinics and inpatient units, in community health clinics, in schools, on reservations, in health maintenance organizations, on managed care boards, in rehabilitation settings and in nursing homes.

Outside the therapist's office, most clinical health psychologists find themselves working in complex, multidisciplinary environments. Those working in medical and surgical clinics and inpatient units, for example, are likely to interact with physicians from multiple specialties in medicine and surgery, nurses from multiple specialties, unit clerks, pharmacists, dieticians, occupational therapists, physical therapists, medical technicians, social workers, chaplains, hospital administrators, volunteers, and others. Add to that, in a teaching hospital, the clinical health psychologist works with physicians, nurses, and others at various levels of training and experience.

Intervention Targets Along the Health and Illness Continuum

The health psychologist's work is broad in scope. The focus of health psychology is not exclusively on the healthy individual. Health psychologists work with individuals of various levels of health and illness along a continuum from complete health to dying and death (Antonovsky, 1987). The health psychologist may direct an intervention to disease prevention in an individual who has not experienced an illness, but who engages in behaviors that present a risk for disease, such as smoking. Other health psychologists focus on existing symptoms, such as in a patient who experiences chronic pain or urinary incontinence. In chronic and life threatening illness, health psychologists may use psychological methods to reduce patient suffering and to promote adjustment to illness. Even at the end of a patient's life, a health psychol-

ogist may help an individual and family resolve conflicts or accomplish an important, yet unfulfilled, life goal.

Integrative Treatment

The tools employed vary nearly as much as the settings where patients are seen and the problems which patients bring to treatment. Supportive psychotherapy, behavior analysis, brief dynamic therapy, existential therapy, biofeedback, hypnosis, expressive therapy, a variety of stress reduction and relaxation training strategies, and cognitive-behavioral therapy, among others, are frequently used interventions. Health psychologists rely on a variety of treatment modalities as well. Individual, group, family, and couples therapies play important roles in the health psychologist's repertoire.

The biopsychosocial model considers patient needs as multifactorial and dynamic. Often the health psychologist integrates treatment systems and modalities to provide care as the patient's needs evolve during the course of an illness. Early in the course of a patient's illness, the health psychologist might use structured approaches, such as stress inoculation training, to strengthen the patient's ability to cope with disease and treatment. Later in the illness, the health psychologist might rely more on existential approaches as the patient's needs turn to understanding the meaning of surviving a life threatening event or of facing dying and death.

The very nature of health psychology practice and the integration of treatment modalities, brings health psychologists into situations in which they may assume multiple roles with patients. For example, the health psychologist meeting with the patient in a hospital room may interact with family members and other staff members involved in the patient's care. In such situations, health psychologists may incorporate multiple treatment modalities such as individual and family therapy. The clinical health psychologist's flexibility and ability to integrate treatment modalities may be important in providing timely, cost effective interventions that otherwise would not be possible due to lengthy referral processes and the expense of involving multiple professionals (Tovian, 1991). On the other hand, according to their professional and ethical standards, psychologists avoid multiple roles in their work with patients, especially where dual roles may compromise the best interest of the patient. Because of the adverse potential of dual roles, these situations require thoughtful consideration of professional standards and ethics, especially in evaluating the impact on patient well-being. Consequently, to avoid assuming multiple roles with a patient, the health psychologist may coordinate care across several health care professionals, each providing an aspect of care, such as group support, individual treatment, and marital therapy, all important in addressing the patient's complex needs.

The Art and Science of Care

While existing definitions of health psychology emphasize scientific and technical knowledge, Belar and Deardorf (1985) highlight the health psychologist's personal qualities, such as warmth, openness, flexibility, as crucial aspects of the practice of health psychology. Because of the centrality of the professional and patient relationship in health care, it is important for the health psychologist to understand and be aware of these personal qualities and their stimulus value that may assist or interfere with forming therapeutic relationships with patients. Each health psychologist will contribute a distinct set of skills, experiences, and personal qualities to the relationship with the patient. Each patient brings to the relationship distinct concerns, needs, and resources. Ultimately, this relationship forms the context within which the health psychologist translates theory, research, and clinical knowledge into practice. It is this relationship that makes health psychology an art, as well as a science.

Complementary and Alternative Therapies

Interest in complementary and alternative medicine (CAM) approaches is not new. In

North America, the last two centuries have seen spiritualists, herbalists, healers, homeopaths, naturopaths, osteopaths, hypnotherapists, acupuncturists, chiropractors, rolfers, acupressurists and psychologists, speak about their abilities to help people heal, cure, manage and cope with physical ailments. Recent interest in CAM encompasses entire systems of medicine such as Chinese medicine and Ayurvedic medicine as well as specific interventions such as botanicals, massage therapy, and imagery. Although many psychologists may bristle at the suggestion they are an "alternative" approach to traditional medical practices, this is how we are seen by many people seeking help for physical symptoms. Even when psychological intervention is not seen as an alternative therapy, but as *complimentary* treatment, it may be the psychologist whom the patient confides about their interest in alternative approaches. It is for these reasons that the health psychologist needs to be familiar with CAM.

A 1993 study by Eisenberg of over 1500 adults found extensive use of alternative therapeutic approaches. In this study, 34% reported using at least one unconventional (alternative) therapy. The most frequent use of alternative therapies was for back problems, anxiety, depression, headache, chronic pain and cancer. The most common therapies used were relaxation, massage, imagery, spiritual healing, weight loss programs, prayer and exercise programs. An earlier study by Verhoef (1990) reported on the extensive use of alternative medicine by patients with gastrointestinal disorders.

The interest in complementary and alternative therapies has not gone unnoticed by the National Institutes of Health with its establishment of the National Center for Complementary and Alternative Medicine. It is the responsibility of this office to develop basic and clinical research initiatives, educational grants and contracts, and outreach mechanisims to further study and educate professionals and the public about complementary and alternative approaches to medical therapies. In 1996 responding to both Federal governmental initiatives and popular demand, Kings County (Seattle) in Washington State, became the first municipality in the United States to open a publicly funded alternative medicine clinic. Clinics such as these do not disregard traditional allopathic medicine, but rather incorporate other approaches as complimentary.

Within the practice of clinical and counseling psychology, it is health psychology and behavioral medicine that are seen as alternative approaches. In addition, meditation, hypnosis, eye movement desensitization and retraining (EMDR), biofeedback, imagery and relaxation therapies are all viewed as alternatives to counseling and psychotherapy. An oncologist may be just as critical of a person with cancer seeing an herbalist as a psychoanalyst may be of someone seeking relaxation training for anxiety. It is not our position to either endorse or criticize alternative medicine approaches. Instead, we urge all health psychologists to be aware that many of our patients will engage in alternative treatments that either they have self-initiated or have sought out a professional. Helping the patient assess the quality and effectiveness of the alternative therapy is an important role of the health psychologist. Often, incorporating the alternative therapy as a complimentary approach, along side the traditional treatment, provides a good balance for patient and health care professionals.

Social, Cultural and Spiritual Considerations

The last ten years has seen a tremendous increase in interest in the health of diverse populations and in understanding the complex relationships among the interaction of social relationships, culture, spirituality, and health. It is as if psychology had just discovered the importance of these interrelationships, which have been known to anthropologists and sociologists since the beginning of the 20th century. As North America truly becomes more culturally diverse and, as a student described to one of us (PMC), much more like a salad than a melting pot, walking the line between what is politically correct in recognizing cultural differences and what is

clinically useful, is not always uncomplicated. Seeking to help underserved and poorly served populations, while at the same time not wanting to clump all members of any cultural or ethnic group into one category (e. g., all Latinos value spirituality; all Asians prefer behavioral and medical explanations; all lesbians are monogamous, etc. …) is challenging indeed. In developing this text, we asked each contributing author to include clinical examples utilizing members of different cultural groups when possible.

Finance and the Healing Process

The issue of whether a patient has a "physical" disorder or a "mental" problem continues to influence the delivery of health care services. Until recently, most insurance companies and managed care entities insisted that patients seen by a clinical health psychologist receive a Diagnostic and Statistical Manual (DSM) (i. e., psychiatric) diagnosis to obtain reimbursement. However, many of the patients seen in health care settings by clinical health psychologists are referred for treatment of the psychological and social dimensions of physical health problems, rather than for treatment of the psychiatric disorders that are represented in the DSM classification system. Consequently, although a health psychologist may be *directly* treating a medical condition, without an accompanying psychiatric diagnosis, treatment may not be approved and services may not be reimbursed. In the last several years, and after American Psychological Association Practice Directorate advocacy, the American Medical Association committee responsible to Current Procedural Technology (CPT) codes expanded this system to reflect psychosocial services to patients and families with physical health diagnoses. These health and behavior CPT codes provide a means for health psychologists to bill for assessment and intervention services that address the psychological, cognitive, behavioral, and social factors influencing a person's physical health and well-being. The health and behavior codes reflect a wide range of services provided by clinical health psychologists including individual, group, and family interventions used in the management of pain, fatigue, and other symptoms in cancer care or cognitive and behavioral approaches to dietary and exercise behaviors recommended in diabetes treatment.

While the new CPT codes represent a major shift in considering the psychological and social aspects of health, it unfortunately remains unusual outside of managed care settings to receive reimbursement for health promotion activities and other health enhancement strategies. Hence, the business of health care in the United States remains focused on treating illness, not on modifying behaviors, prevention, or on learning new coping skills. Although this volume does not have within its scope a discussion of health care policy or health promotion, clearly this is an important area for health psychology and medicine.

Health psychology has much to contribute regarding health promotion and health risk behaviors. Research continues to expand the intervention possibilities in these areas. However, without a change in current health care policy, promotion and prevention activities continue to be under financed. Sadly, nothing short of a fundamental shakeup of both organized medicine and the insurance industry will likely change this situation. Less money is to be made in health promotion and illness prevention activities and therefore less prestige is associated with these areas of research and intervention.

New Opportunities

As health psychology has evolved, new roles and opportunities for clinical practice have emerged. In the five years, since the first edition of the Clinical Handbook of Health Psychology, there has been greater recognition of the integral relationship between mental and physical health (Baum & Posluszny, 1999; U.S. Department of Health and Human Services, 1999; WHO, 2001). In 2001 the Accreditation Council for Graduate Medical Education (ACGME) instituted a requirement that residency programs develop pilot programs that promote an integrated collab-

orative approach to care, partnering with other health professionals such as psychologists. This has opened new opportunities for health psychologists in end-of-life care and palliative medicine (Twillman, 2002), primary care (McDaniel, Belar, Schroeder, Hargrove & Freeman, 2001), and geriatric medicine (Zeiss & Thompson, 2003) and other medical specialties that cut across the areas of practice represented in this edition of the Clinical Handbook of Health Psychology. Health psychologists find themselves as before practicing in an increasingly complex multidisciplinary environment and in unfamiliar clinical settings. This has led to examination of the current and potential contributions of psychologists to these areas and a delineation of the education and training needs of psychologists to equip them to work in these settings. While new opportunities are challenging, many health psychologists find the expansion and integration of behavioral health and medical care to be among the most exciting and rewarding aspects of this work.

Conclusion

Progress toward integrating a biopsychosocial paradigm in health care has been slow. The World Health Organization (WHO, 1997) has described the relationship between physical health and mental health services as often counterproductive and called for "a new alliance" between physical and mental health disciplines. In many ways, however, health psychology exemplifies the movement toward integrating psychological, social and biomedical knowledge.

The chapters which follow describe the health psychologist's participation in the patient's healing process. Each author provides a broad and rich view of the clinical practice of health psychology in their areas of practice within medicine. Each gives a brief introduction to the biomedical concepts basic to practice in the area. Each describes how the health psychologist might integrate behavioral and social science knowledge and methods in clinical practice. The chapters reflect the multidisciplinary context of the work of the health psychologist, the characteristic integration of treatment systems and modalities, and the psychologist's participation in healing relationships with patients. Four closing chapters discuss themes important to healing — social networks, spirituality, personal expression, and ethnic diversity.

Describing health psychology as involving a lifetime of learning, Miller (1987) emphasizes that it will be important for students of health psychology to have confidence in learning on their own. For most of us in health psychology, our careers started with the challenges of learning unfamiliar terms and protocols, developing relationships with professionals from diverse disciplines, and negotiating new environments outside the office setting. We struggled with the application of behavioral and social science knowledge in the context of rapid changes in medical technology and health care financing. For many of us, the continued learning is part of the appeal of clinical health psychology. For the reader, we offer the text in this spirit to provide a basis for and to capture the excitement of professional development in clinical health psychology.

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2

Assessment Approaches in Health Psychology: Issues and Practical Considerations

The fundamental conceptual framework within health psychology is the biopsychosocial model (Belar & Deardorff, 1995; Smith & Nicassio, 1995). Engel (1977) in his landmark article described the limitations and inadequacies of the focus on biological processes and the exclusion of psychosocial factors in the traditional approach to medical care. He proposed the biopsychosocial model as an alternative. The biopsychosocial conceptual framework provides an integrated systems approach for the assessment of biological, psychological, and social factors that contribute to health and illness. This model assumes multifactorial, bi-directional, and indirect as well as direct causal mechanisms. Smith and Nicassio (1995) point out that the biopsychosocial model does not provide a unifying theory but rather a broad conceptual framework. Applying the biopsychosocial model to assessment means that health psychologists need to assess and utilize data across all three domains to provide a comprehensive understanding of the patient. Some of the assessment approaches and targets of assessment overlap with those familiar to mental health professionals. However, information related to the pathophysiology of medical diseases, medical procedures, the health care system, and the conceptual framework of health care providers are also essential elements of the assessment process and are unique to the medical setting (Smith & Nicassio, 1995). The challenge for the health psychologist is to truly integrate these different sources of information to provide an understanding of the interrelationship of biological, psychological, and environmental factors with the end result of increasing clinical utility.

In this chapter, I discuss issues and practical considerations in (a) conceptualizing the purpose of the assessment, (b) interviewing medical patients, (c) considering sociocultural issues in the assessment process, (d) the use of traditional assessment approaches with medical patients, and (e) the future of biopsychosocial assessment in health psychology. The intent of this chapter is to identify some organizing issues which are useful in guiding psychological assessment of medical patients. It is beyond the scope of this chapter to review specific assessment approaches in health psychology. Assessment strategies related to specific medical problems are detailed in chapters three through thirteen. The importance of assessing the social network of the patient will be discussed in chapter fourteen. Chapter fifteen introduces assessment issues concerning spirituality and religion. Chapter sixteen presents the emerging assessment possibilities of visual expression and imagery.

Purpose of the Assessment

The purpose for conducting an assessment focuses the content of the information being

gathered and determines the selection of instruments and methods. The two most common purposes of psychological assessment are diagnosis and treatment planning. These two purposes are general functions of assessment shared with psychologists in mental health settings and have been identified by health psychologists as the two most frequent purposes for assessment (Stabler & Mesibov, 1984; Piotrowski & Lubin, 1990). In recent years, screening has become increasingly prevalent in medical settings and especially in primary care. Derogatis and Lynn (2000) note that screening is best described as a "preliminary filtering technique" that is designed to identify individuals in need of further evaluation. In addition to the function of assessment in diagnosis and treatment, the function of screening and its impact on the assessment process in health psychology will be discussed in this section.

Diagnosis

When the focus of assessment is diagnosis, typically this means diagnosis utilizing the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed; DSM-IV; American Psychiatric Association, 1994). There has been widespread adoption by the mental health community in the United States of the DSM-IV as the diagnostic system for psychological disorders. Scientific journals and review boards for funding utilize DSM-IV categories (Follette & Hout, 1996). DSM-IV diagnoses are also widely used in clinical settings and are required for third-party reimbursement.

There are advantages to having a common system of classification which can be utilized for multiple purposes (e. g., treatment decisions, facilitating communication among professionals of different disciplines, administrative decisions). However, a number of problems have been noted with the DSM-IV system of diagnosis (see Follette, 1996). Regardless of your stance on the relative strengths and weaknesses of the DSM-IV, the DSM-IV is the classification system that is used in medical settings. The *International Classification of Diseases* (10th ed; ICD-10; World Health Organization, 1992) is the classification system used by physicians and is the system of classification for medical disorders that interfaces with the DSM-IV. Therefore, it is important to learn to use the DSM-IV system well and to be familiar with the ICD-10 system. I will discuss four diagnostic issues: the problem of tautological reasoning, limitations of the DSM-IV in conceptualizing problems from a biopsychosocial model, the problem of diagnostic categories that have pejorative connotations, and the limitations of a mental health nosological system when used in medical settings.

The problem of inferring causality to a diagnosis for the very symptoms that define the diagnostic category is an example of tautological reasoning. For instance, attributing a patient's angry outburst to the diagnosis of borderline personality disorder given that inappropriate anger was one of the symptoms that resulted in the diagnosis is tautological. The problem with tautological reasoning is that it gives an illusion of an explanation rather than a true understanding. The following example illustrates this point. A physician consulted with me regarding the diagnosis of a patient she had had a difficult interaction with during a medical appointment. The physician clearly wanted to understand this patient better so that she could work more effectively with her in the future. Instead of focusing on the issue of diagnosis, the consultation was focused on assessing the interaction with the patient and on developing a useful strategy for future visits.

Diagnoses that contribute to mind-body dualism are especially problematic from a biopsychosocial perspective. Mind-body dualism underlies referral requests for a psychological assessment of the functional etiology (as opposed to organic etiology) of the patient's physical symptoms. Toner (1994) has noted that "nearly every medical specialty has identified a functional somatic syndrome" (p. 157). The DSM-IV diagnostic category of *pain disorder associated with psychological factors* has replaced the earlier category of *psychogenic pain* and is a much-needed improvement. With this diagnostic category, it is possible to identify both psychosocial and medical factors as contributory to the pain. However,