original article

Ethics in Health Psychology

Some remarks from an outsider

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I am not an expert in ethics. I like being an explorer so that's why I agreed to try and write a few words about ethics in health psychology research and applied work in that area. Combining two disciplines of research areas quite often does result in finding unexpected results.

The APA, BPS, BHPS and comparable professional organizations for (health) psychologists provide researchers with rules and regulations regarding ethics about research and clinical work. I applaud the existence and enforcement of those regulations. However, my contribution is not about these issues, it is about exploring health psychology research in the context of the principles of medical ethics. The principles of medical ethics, if applied appropriately, should prompt us to conduct a deeper examination of the values and purpose of our research.

Most researchers consider Committees on (Medical) Ethics a pain in the neck. The bureaucracy involved with obtaining approval from those committees usually is quite exhaustive and time-consuming. We would expect that journals publishing research about human behavior would adhere to such criteria, with the editors playing a gatekeeper role. This, however, turns out to be not the case – at all. Too often researchers in the medical domain have failed to adhere to principles of medical ethics, with sometimes horrifying consequences (see for example Jones, 1981, on the Tuskegee experiment, where poor African Americans were research participants [victims is a better word] in whom effective medical treatment for syphilis was withheld on purpose by MDs who were fully aware of the horrific consequences). Obviously, health psychologists do not intentionally expose humans to contagious disease or to interventions that cause major physical damage. Nevertheless, studies in health psychology do run the risk of being unethical for other reasons – reasons germane to the nature of health psychology.

The four basic principles of medical ethics are:

Autonomy: people have a right to control what happens to their bodies.

Beneficence: all healthcare providers must strive to improve their patient's health, to do the most good for the patient in every situation.

Nonmaleficence: "First, do no harm" is the bedrock of medical ethics. In every situation, healthcare providers should avoid causing harm to their patients.

Justice: one should try to be as fair as possible when offering treatments to patients and allocating scarce medical resources (Runzheimer, & Larson, 2010).

Let's examine to what degree these four basic principles of medical ethics are adhered to by health psychologists in their work, and discuss some of the implications of the findings.

Method

I checked *Psychology & Health* and *Health Psychology Review*, starting with the most recent issues, for papers that in my view illustrate to

what degree health psychologists adhere to these four principles. The choice is nonrandom: I did my best to identify papers that seem to give rise to at least some questions regarding their ethics. I do not intend to criticize the authors or the papers. I merely wanted to see whether the four principles of medical ethics would give some insight into ethical issues in research done in health psychology.

I identified four examples, covering the four medical ethics principles in order to see whether they might illustrate problematic (medical) ethical issues in the research reported in the selected papers.

Results

The figure below attempts to illustrate the results of my method.

Principle	Health Psychology Equivalent	Paper
Autonomy	Primary prevention	Kaplan (1990; 2000)
Beneficence	Health psychology models	Ogden (2003; in press)
Nonmaleficence	Screening	Holtzman & Marteau (2000)
Justice	Outcomes	Kaptein (2011)

Figure 1. Four principles of medical ethics, proposed equivalents in health psychology research, and four commentaries on the principles of (medical) ethics as applied in health psychology

The first principle of medical ethics, autonomy, may be conceptualized as encompassing primary prevention in health psychology terms. Kaplan (2000) eloquently analyzed why **primary prevention** is in the behavioural – and not the medical - domain. "Primary prevention is usually based on a behavioral rather than a disease model. Diagnosis plays a lesser role because there is no disease to diagnose. Intervention is typical behavioral … interventions might also include public policy change …" (p. 383). I agree with Kaplan here. Nevertheless, research by health psychologists in the area of primary prevention may be tricky. The paper by Lange et al. (2013) in Psychology & Health may serve as an example of a health psychology study where a primary prevention view was applied to eating behaviour. Intentions and self-reported behaviour were studied. Health psychologists have been and still are involved in work on encouraging eating more healthily. Huge amounts of money have been spent on efforts to reduce the eating of high cholesterol food stuff, encouraging to eat more fatty fish – all sold under the guise of preventing cardiovascular diseases. The point is not that eating healthy may prevent illness. The point is that health psychologists may be acting unethically by joining the bandwagon of medical fashions.

The second principle of medical ethics, beneficence, can be linked with a highly popular activity in health psychology circles, i.e., developing and testing **theoretical models**. Does applying a theoretical model such as the Theory of Planned Behaviour (TPB) benefit the respondents in research about, for instance, sexual behaviour, problematic alcohol use, or living with psoriasis? Given the heated debates in Psychology & Health in recent issues about the value of this theoretical model and others, we adopt an arrogant stance: "we told you so

earlier" (Kaptein, 2011; Ogden, 2003, in press). Again, science by definition is closely associated with developing, testing, rejecting, revising, etc. theoretical models (Schwarzer, in press). My point is that most theoretical models in health psychology do not seem based in clinical reality and do not seem to benefit the human race considerably. Ogden defined them as 'uninteresting, blatantly obvious and ridiculous' (Ogden, 2003; Ogden, in press); I had the guts to conclude that it is time for health psychology 'to pick up the pieces and go home' (Kaptein, 2011).

Third, nonmaleficence ['primum non nocere' – first, do no harm], seems relevant in the context of **screening**. I maintain that screening is a sin. This goes for all types of cancer and for many other (risks for) diseases. Marteau is a leading author in the health psychology area who critically analyses thinking behind various screening programmes (Holtzman, & Marteau, 2000). Screening for breast cancer most likely does not lead to reductions of morbidity and mortality (Biller-Adorno, & Jüni, 2014). Attempts by health psychologists to try and increase attendance at breast cancer screening, therefore, quite likely are unethical (Brown, Gibney, & Tarling, 2013). Screening for colorectal carcinoma most likely does more harm than good, making efforts by health psychologists to try and motivate healthy persons to attend screening unethical (Manne et al., 2013). Attempts to introduce screening for lung cancer are wonderful for providing work for the medical system. It will only increase the length of suffering for identified patients.

The fourth potentially unethical principle is **outcomes**. "Behavior as the central outcome in health care" by Bob Kaplan (1990) belongs to one of my favorite papers. He points out how physiological measures (blood pressure, pulmonary function, etc.) are only intermediate outcomes in health care. In a recent exciting paper, 'health' was defined as 'the ability to adapt and to self manage' (Huber et al., 2011, p. 237). Many health psychologists, however, appear to be happy with outcome measures in their research that can be characterized as unreliable and meaningless (e.g., Coyne, & van Sonderen, 2011). Too many studies still assess self-reported intentions to perform assumed healthy behaviours in studies with psychology students or university staff as respondents (e.g., Berli et al., 2014; Caudroit et al., 2014). Medical ethics committees that evaluate research proposals about patients will not give their permission if the study would focus on outcomes, judged by experts to be meaningless. Comparable committees in social sciences schools should do the same: withhold their permission if the researchers propose studies with meaningless outcomes such as 'intentions to be physically active' or 'intention to use a condom', or questionnaires with questionable psychometric characteristics, or first year psychology students as respondents. Editors of journals in the area of health psychology who will take a comparable position and reject manuscripts that suffer these fatal flaws would be my heroes.

Discussion

Applying the four principles of medical ethics to health psychology research and applied work in the area seems an interesting undertaking – if one shares my critical views about a substantial part of research in health psychology. This paper is an attempt to extend principles laid down by professional societies in (health) psychology by pointing out that additional criteria of ethics may be relevant in health psychology. Adopting these views might even imply checking whether research proposals adhere to these principles – with the chance of them being rejected because

they are "ridiculous, blatantly obvious, boring, or typical of 'pick up the pieces and go home' research" (Kaptein, 2011; Ogden, in press).

We limited our paper to a few key journals in health psychology. It is our impression that had we included journals from the social psychology area we would have had a field day (given also the extremely embarrassing and damaging examples of fraud in those circles). We leave this to future researchers.

As said in the Introduction, I am not an expert in ethics. I do hope, however, that this contribution will help stimulate debate about ethical and unethical research in health psychology.

References

Berli, C., Loretini, P., Radtke, T., Hornung, R., & Scholz, U. (2014). Predicting physical activity in adolescents: The role of compensatory health beliefs with the Health Action Process Approach. *Psychology & Health, 29*(4), 458 – 474. doi:10.1080/08870446.2013.865028

Biller-Andorno, N., & Jüni, P. (2014) Abolishing mammography screening programs? A view from the Swiss Medical Board. *New England Journal of Medicine, 370*, 1965 – 1967. doi:10.1056/NEJMp1401875

Brown, S. L., Gibney, T. M., & Tarling, R. (2013). Busy lifestyles and mammography screening: Time pressure and women's reattendance likelihood. *Psychology & Health, 28*(8), 928 – 938. doi:10.1080/08870446.2013.766734

Caudroit, J., Boiché, J., & Stephan, Y. (2014). The role of action and coping planning in the relationship between intention and physical activity: A moderated mediation analysis. *Psychology & Health, 29*(7), 768 – 780. doi:10.1080/08870446.2014.884223

Coyne, J. C., van Sonderen E. (2012). No further research needed: Abandoning the Hospital and Anxiety Depression Scale (HADS). *Journal of Psychosomatic Research, 72*(3), 173 – 174. doi:10.1016/j.jpsychores

Holtzman, N. A., & Marteau, T. M. (2000). Will genetics revolutionize medicine? *New England Journal of Medicine, 343*, 141 – 144. doi:10.1056/NEJM200007133430213

Huber, M., Knottnerus, J. A, Green, L., van der Horst, H., Jadad, A. R., Kromhout, D.,... Smid, H. (2011). How should we define health? *BMJ, 343*, 235 – 237. doi:10.1136/bmj.d4163

Jones, J. H. (1981). *Bad blood: The Tuskegee syphilis experiment*. London: Free Press.

Kaplan, R. M. (1990). Behavior as the central outcome in health care. *American Psychologist, 45*(11), 1211 – 1220. doi:10.1037/0003-066X.45.11.1211

Kaplan, R. M. (2000). Two pathways to prevention. *American Psychologist, 55*(4), 382 – 396. doi:10.1037/0003-066X.55.4.382

Kaptein, A. A. (2011). Pick up the pieces and go home – on the demise of health psychology. *Health Psychology Review, 5*(1), 39 – 47. doi:10.1080/17437199.2010.520114

Lange, D., Richert, J., Koring, M., Knoll, N., Schwarzer, R., & Lippke, S. (2013). Self-regulation prompts can increase fruit consumption: A one-hour randomised controlled online trial. *Psychology & Health, 28*(5), 535 – 545. doi:10.1080/08870446.2012.751107

Manne, S. L., Kashy, D. A., Weinberg, D. S., Boscarino, J. A., Bowen, D. J., & Worhach, S. (2013). A pilot evaluation of the efficacy of a couple-tailored print intervention on colorectal cancer screening practices among non-adherent couples. *Psychology & Health, 28*(9), 1046 – 1065. doi:10.1080/08870446.2013.781601

Ogden, J. (2003). Some problems with social cognition models: A pragmatic and conceptual analysis. *Health Psychology, 22*(4), 424 – 428. doi:10.1037/0278-6133.22.4.424

Ogden, J. (2014). Time to retire the theory of

planned behaviour? One of us will have to go! A commentary on Sniehotta, Presseau and Araújo-Soares. *Health Psychology Review*. Advance online publication. doi:10.1080/17437199.2014.898679

Runzheimer, J., & Larsen, L.J. (2010). *Basic principles of medical ethics*. Chichester: Wiley.

Schwarzer, R. (2014). Some retirees remain active: A commentary on Sniehotta, Presseau and Araújo-Soares. *Health Psychology Review*. Advance online publication. doi:10.1080/17437199.2014.898407

Sniehotta, F.F., Presseau, J., & Araújo-Soares, V. (2014). Time to retire the theory of planned behaviour. *Health Psychology Review, 8*(1), 1 – 7. doi:10.1080/17437199.2013.869710

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