

Editorial

Behavioural medicine – what's new about it?

Behavioural medicine is a growth industry. The last few years have witnessed the foundation of numerous behavioural medicine units with a service commitment in the U.S.A., together with the inauguration of a Society for Behavioral Medicine. The volume of literature is also expanding rapidly. Apart from dedicated journals (*Journal of Behavioral Medicine*, *Behavioral Medicine Abstracts*, etc.), 1982 alone has seen the publication of two special issues on behavioural medicine in British journals (*British Journal of Clinical Psychology*, *Journal of Psychosomatic Research*) and several books (e.g. Eiser, 1982; Pinkerton *et al.*, 1982; Surwit *et al.*, 1982). It is clear that proponents of behavioural medicine are striving hard to establish a separate discipline. But is the attempt succeeding?

Definitions of behavioural medicine tend to be prolix (e.g. Schwartz and Weiss, 1978) but, broadly speaking, the term describes applications of the behavioural sciences to clinical problems outside a psychiatric domain. It is broader in scope than psychosomatic medicine, with its traditional emphasis on personality and intrapsychic phenomena in the aetiology and treatment of non-psychiatric disorders. It also differs from medical psychology, both through its emphasis on empirical relationships between observable behaviour and medical disorders, and by the inclusion of behavioural sciences other than psychology in its theoretical base. On the other hand, it is clear that much of behavioural medicine has arisen from simple re-labelling, and that many investigators have jumped on the bandwagon without any fundamental shift in orientation or practice. Thus a recent survey of behavioural medicine programmes in the U.S.A. indicated that referrals were accepted not only for medical problems (hypertension, haemophilia, dietary compliance in dialysis patients, etc.), but for conditions such as phobias, anorexia and insomnia that might be managed in more conventional settings (Behavioural Medicine Update, 1981). The title behavioural medicine is also unfortunate in its reference to medicine rather than health, and its endorsement of a narrow behaviourist orientation.

What then is to be gained from the promotion of behavioural medicine as a distinct entity? It has certainly been valuable in demonstrating to the medical profession that behavioural sciences are relevant to health care and clinical problems in general, and that the distinction between physical or somatic and psychological medicine is inappropriate. The term may also reassure patients by removing the connotations of psychiatric disturbance that sometimes

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hinder the work of psychologists in general medical settings. But at present, behavioural medicine cannot be considered a coherent discipline. Although it is beginning to provide a framework for the understanding of health related behaviours (for example the health belief model described by Becker) the techniques employed in management are entirely derivative. It has no unique theoretical foundations, but draws procedures piecemeal from psychophysiology, social psychology and clinical psychological practice. Interventions are largely administered pragmatically, with little hypothesis testing or understanding of why different methods produce the responses they do.

Tension headache serves as one example of the apparently successful application of behavioural methods (E.M.G. feedback) to a physical problem. It has become increasingly clear however, that the original rationale (control of excessive E.M.G. levels) is probably irrelevant to aetiology or treatment mechanism, since headache intensity does not directly relate to muscle tension. A better understanding will require a more careful analysis of the way in which psychological factors can influence pain behaviour and experience (Phillips, 1980).

Another well-researched area, psychological preparation for surgery, also reveals an excess of pragmatic intervention studies, with little or no attempt to understand the mechanisms involved. It still remains unclear why advance information often facilitates physical recovery and why it should sometimes fail to do so. Recent comparative studies indicate that cognitive-behavioural coping methods can be superior to information alone, but whether this is attributable to greater anxiety reduction or some other mediating influence and how these are translated into physical benefit, remains obscure (Ridgeway and Mathews, 1982).

The fact that so little is known about these relatively successful interventions indicates how far behavioural medicine has to go before it is more than a ragbag of interventions imported from other areas. This is not necessarily a serious cause for concern, given that the same could be said in the past of the whole of behaviour therapy. While some of the concepts and methods of behaviour therapy will undoubtedly continue to be used in behavioural medicine, the field will have come of age only when new principles have been developed that are specific to the understanding and treatment of physical disorders by psychological methods.

ANDREW STEPTOE
and ANDREW MATHEWS

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