As Researchers and Clinicians, We Must Carefully Balance Our Tendencies toward Both Skepticism and Zeal

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Lazarus outlines four reasons why he believes it will be difficult to demonstrate convincing empirical evidence for psychosocial influences on health. We found his argument provocative, and we agree that there are difficult methodological challenges to be met in this field. However, we feel that his major points are relevant only to some of the many ways in which psychosocial factors may influence health. Contrary to his presentation, we do not see these difficulties as intrinsic problems or as all-encompassing methodological barriers to empirical evidence in the field.

In his first point, Lazarus argues that because health is affected by numerous uncontrollable factors, psychosocial influences exert a modest influence on health, at best. Before considering this point directly, we note that it is curious that Lazarus considers the use of nicotine and alcohol as examples of such uncontrollable factors. Rather, while we accept the evidence showing neurobiological and genetic influences on craving and addictive processes, we simultaneously hold that these “uncontrollable” behaviors are affected by psychosocial factors and are amenable to change via behavioral methods (Baker 1988). Moreover, stress alters these behaviors as well.

Beyond this, we agree with Lazarus’ contention that health is multiply determined and that under particular circumstances psychosocial factors may account for negligible portions of the variance in well-being. However, we feel that Lazarus neglects circumstances where behavioral factors are of primary importance in health. For instance, consider an important and contemporary example in which exposure to the pathogen may in many cases be regulated solely by behavioral factors—exposure to the HIV virus via high-risk sexual behavior. Health change is more than a passive, singular transition from a disease-free to a diseased state. It often involves generative behavior, including but not limited to engaging in high-risk activity that exposes one to pathogens or that alters susceptibility. It involves the perceptual, cognitive-affective, and behavioral processes of symptom detection, recognition, and reporting (Leventhal 1986). It also involves the complex decision to seek assessment and treatment in a timely fashion. And it involves effective compliance with treatment regimens (Meyer, Leventhal & Gutmann 1985). Thus, viewing health as multidimensional (Lazarus’ fourth point and one with which we are in agreement) and dynamic illustrates arenas in which psychosocial factors may influence health—ones, we believe, that are fruitful of empirical examination.

Adopting a multidimensional and dynamic view of health and health change also speaks to the second and third points made by Lazarus. In these points, Lazarus contends that demonstrating the influence of psychosocial factors on health is hampered by the stability of health and the necessity of taking repeated measures of psychosocial factors across the extensive period of time that may be necessary for a transition from health to illness. These two points are predicated on one model in which psychosocial influences on health are studied by waiting for an organism to move from a nondiseased to a diseased state, requiring that the researcher fortuitously capture naturally occurring and perhaps infrequent events (Kasl 1985). We agree that prospective methodologies are critical contributors to the empirical literature and that they represent one of the most effective ways of drawing clearly interpretable conclusions about the influence of psychosocial factors on health. However, they are not the whole picture. Ignored here are other processes in which psychosocial factors may operate—such as recovery from illness, development of secondary complications, and rate of disease progression. Further, Lazarus’ view ignores conceptual distinctions between causal, maintaining, and mitigating factors.

We also differ from Lazarus in our belief that a number of processes that are reasonably stable or representative of the person are extremely useful for longitudinal studies. In particular, in well-designed prospective epidemiological studies, personal relationships appear to have strong causal ties to mortality, with the effect “rivaling the effects of well-established risk factors such as cigarette smoking, blood pressure, blood lipids, obesity, and physical activity” (House, Landis & Umberson 1988, p. 542).

Lazarus raises the issue of how health is defined, a very important and particularly thorny issue. One of the criteria he suggests is social functioning. In this regard, Wells and colleagues (1989), reporting on 11,242 outpatients from the Medical Outcomes Study, showed that patients with either a current
depressive disorder or depressive symptoms in the absence of disorder had worse physical, social, and role function, worse perceived current health, and greater bodily pain than patients with no chronic conditions. In particular, the researchers noted that the poorer functioning that was uniquely associated with depressive symptoms was comparable to, or even worse than, the poor functioning uniquely associated with the eight chronic medical conditions they studied (hypertension, diabetes, current coronary artery disease, current angina, current arthritis, current GI problems, current lung problems, or current back problems).

Depression interacted with the medical conditions in an additive fashion. For instance, patients with current advanced coronary artery disease and depressive symptoms had twice the reduction in social functioning associated with either of the conditions alone. Among the chronic conditions they studied, the only one associated with greater functional problems than depression was current heart conditions. The authors emphasized that even in the absence of a syndromal depressive disorder, depressive symptoms were associated with considerably poorer functioning and had clear clinical significance. Recent evidence also indicates that the long-term outcome of depressive episodes may be much less favorable than had been previously assumed, with many depressed individuals either failing to recover or frequently relapsing (Alexopoulos et al. 1989).

Relevant to our discussion of the health impact of personal relationships is the fact that impaired social relationships are characteristic of both currently depressed individuals and remitted depressives (George et al. 1989). Size of social network and subjective social support are both significant predictors of follow-up depressive symptoms, after controlling for initial depressive symptoms (George et al. 1989).

Finally, and perhaps most importantly, we question what appears to be Lazarus’ implicit assumption that prospective studies are the best or only way to demonstrate causal influences on health. To the contrary, controlled clinical trials in which treatment or risk factors are experimentally varied may represent our strongest method for testing the causal influence of psychosocial factors (Kiecolt-Glaser & Glaser in press; Kasl 1985). We noted Cohen et al. (1991) and Spiegel et al. (1989) as recent promising examples. In the end, converging evidence from prospective and experimental designs will make the strongest case for psychosocial influences on health.

In sum, we agree with Lazarus that conclusions about psychosocial influences on health must be cautiously and thoughtfully drawn. As researchers and clinicians, we must carefully balance our tendencies toward both skepticism and zeal. Unwarranted conclusions as to the “unequivocal” nature of results may prematurely terminate pursuit of an important line of research just as zealousness for equivocal findings may lead researchers down an unfruitful path. As clinicians, the demands of the immediate situation may undermine our caution and cause us to feel an imminent need to intervene, whereas undue skepticism may inhibit intervention. Both processes raise important ethical issues. Reading Lazarus’ points caused us to step back and reflect on some of our implicit assumptions about the promise of a psychosocial approach to health. Having done so, we are encouraged about the prospects of this approach, and we feel that we can continue our work while adopting an attitude of healthy skepticism.

REFERENCES


