Salud Pública de México
ISSN: 0036-3634
spm@insp.mx
Instituto Nacional de Salud Pública
México

Cabieses, Baltica
At the edge of individual cognitive-behavioural policies: how to walk the public health path to effectively improve population health?
Salud Pública de México, vol. 55, núm. 4, julio-agosto, 2013, pp. 421-426
Instituto Nacional de Salud Pública
Cuernavaca, México

At the edge of individual cognitive-behavioural policies: how to walk the public health path to effectively improve population health?

Baltica Cabieses, PhD.[1,2]

Cabieses B.
At the edge of individual cognitive-behavioural policies: how to walk the public health path to effectively improve population health?
Salud Publica Mex 2013;55:421-426.

Abstract

Most countries worldwide have recognised the significance of contextual social determinants of health (SDH) on population health. This essay challenges current public health views focused on individual risk-factors and motivates an evidence-informed debate in this matter. I argue that despite both international consensus and a growing body of evidence to support the relevance of addressing such more distant SDH through public policies, most governments remain focused on the modification of individual health-risk behaviours like smoking, excessive alcohol consumption, heavily fatted diets and lack of physical exercise. Decades after following this same policy path, many countries have not achieved the expected reduction in rates of health-risk behaviours, and some have even experienced an increase in these risky behaviours over time. Policies addressing contextual SDH might take longer to implement, but could be more effective in the long-run, as structural modifications promote more sustainable changes to a larger proportion of the population.

Key words: public health; risk factors; therapeutics; social medicine; health inequalities

Cabieses B.
Al límite de políticas individuales cognitivo-conductuales: ¿hacia dónde ir en salud pública para mejorar de manera efectiva la salud poblacional?
Salud Publica Mex 2013;55:421-426.

Resumen

La mayoría de los países del mundo han reconocido la importancia de los determinantes sociales en la salud de la población. Este ensayo cuestiona las perspectivas actuales de salud pública que se centran exclusivamente en factores de riesgo individuales. Pese al consenso internacional y la creciente evidencia que apoya la importancia de hacer frente a determinantes sociales estructurales, la mayoría de los gobiernos siguen centrados en la modificación de los comportamientos de riesgo individuales para la salud (tabaquismo, alcohol y ejercicio físico). Décadas después de seguir el mismo foco en salud pública, muchos países no han logrado la reducción esperada en las tasas de comportamientos riesgosos para la salud, y algunos incluso han experimentado un aumento de éstos en el tiempo. Políticas dirigidas a aspectos estructurales que afectan la salud de la población pueden tomar más tiempo, pero podrían ser más eficaces al promover cambios más sustentables a largo plazo.

Palabras clave: salud pública; factores de riesgo; terapéutica; medicina social; desigualdades en salud

(1) Facultad de Medicina, Universidad del Desarrollo, Clínica Alemana. Chile.
(2) Department of Health Sciences, University of York. Heslington, York, UK.

Received on: October 16, 2012 • **Accepted on:** May 28, 2013
Corresponding author: Baltica Cabieses, PhD. Av. Las Condes 12.348 La Barnechea, Santiago, Chile.
E-mail: bcabieses@udd.cl; bbcv500@york.ac.uk

Most countries worldwide have at some point in time recognised the significance of broad contextual factors influencing population health.[1] This has been stated by researchers and public health practitioners since the 19th century[2] and consented at international declarations on human rights to health since the end of the Second World War.[3] It has also received growing attention among stakeholders and governments reaching, at least in paper, almost every continent and country.[4] Robust research evidence mostly in high and, to some degree, in low and middle income countries (LMICs) have informed societies about the importance and benefits of addressing both structural and social contextual determinants of health (SDH). Nevertheless, in most countries research evidence is not of public domain and this knowledge belongs to academicians and not public health stakeholders. Structural contextual determinants of health ("hard" factors according to McIntyre[5]) include those physical, social, cultural, organizational, community, economic, legal, or policy aspects of the environment that impede or facilitate good health in a population.[6] These are frequently represented by occupational class, income and wealth. Social contextual factors ("soft" factors according to McIntyre[5]) include the conditions that influence the health of people and communities as a whole, and include conditions for early childhood development, education, employment, income and job security, food security, health services, and access to services, housing, social exclusion, and stigma. Contextual determinants of health are considered "distant" factors to population health, whereas material living conditions, genes and behaviours are considered "proximal" factors to population health.[7] This proximity is explained by the evident and strong individual-level relationship between them and different health outcomes,[8] but requires the inclusion of contextual (structural and social) factors to a full understanding of what and how population health is patterned in a society.[9,10]

Despite both international consensus and a growing body of evidence to support the relevance of addressing broad structural SDH through social and health policies,[9] most governments and private healthcare systems remain focused on the modification of individual health-risk behaviours like smoking, excessive alcohol consumption, heavily fatted diets and lack of physical exercise.[11] However, decades after following this same policy path, many countries have not achieved the expected change in rates of health-risk behaviours, or have even experienced an increase in these behaviours over time.[12,13] This is more evident in socioeconomically deprived groups within societies.[14] Moreover, those countries that have achieved a reduction of individual-risk behaviours have not experienced a similar reduction in morbidity and mortality rates.[15] Why is this happening? Should we "walk" a different path in our public health agendas? Have we lost our track? This essay aims to promote a discussion on this issue. The central notion is that more effort should be aimed at the modification of the structural and social, contextual factors such as everyday living conditions, rather than to creating and promoting therapeutic approaches and programs that focus on individual level strategies to change behaviors and cognitions, such as Cognitive Behavioral Therapies (CBTs) and related therapies. It should be noted that this essay does not intend to provide simple solutions to this complex topic. Contextualized solutions cannot be imposed, and there seems to be great variation of what works in different settings. The purpose of this essay is, therefore, to start with what current evidence tells us about public health and how a focus on "proximal" determinants only could be limiting our ability to effectively improve population health.

Population health status and life expectancy have consistently increased in the last 100 years in almost every country worldwide.[16,17] In most cases, these improvements can be causally linked to drastic public health policies that took place since the 1940s that were focused on "nature"; contextual dimensions affecting health like clean water, sewage food supply, and social protection for children and the poor.[18-20] Preventing and treating acute infections improved mothers' and infants' health, reduced mortality rates and increased life expectancy. Countries level of development and related economic and political stability also had a key role to play,[21] as it does nowadays.[22,23] But there was a relevant downside to these apparent positive results, which became evident through groundbreaking reports the early 1980s.[24] While global indicators showed the improvement of population health, there were growing gaps in health status by socioeconomic groups.[25] In most countries, global improvements in health status and life expectancy can be largely explained by an increase in these indicators among those in the top of the socioeconomic ladder.[26] They represent a small proportion of the population and yet capture most of populations' good health, not to mention more effective use of healthcare services.[27,28] The rest of the population do not experience the same level of good health and wellbeing and also tend to consistently report higher rates of individual health-risk behaviours.[9]

The described concentration of health-risk behaviours among the less privileged socioeconomic groups in most countries, with few exceptions in those in epidemiologic transition, is the most salient reason why most stakeholders, public health practitioners and

some groups of researchers might have advocated for the installation of healthcare policies that aim to reduce the global burden of individual health-risk behaviours.[29] They hope to promote a change in behaviour that would allow individuals to effectively lead a healthier lifestyle.[30] The reduction of current rates of smoking, poor diet, sedentary life and excessive alcohol drinking has been expected to improve global health indicators, prevent future diseases closely related to such individual risk factors, and ideally reduce the gap in good health between those in the bottom and top socioeconomic position (i.e. an equity-centered aim).[31] Besides, individual risky behaviours are usually expected to change within a short period of time (i.e. a single presidential period of 4 to 6 years) and as a result their reduction could lead to a positive assessment of a political party. Unfortunately, changes in individual behaviours are not easy to achieve[32] and the link between them and the reduction of the gap in ill-health between the worse-off and the better-off is not as clear and direct as initially thought.[33,34]

Many decades have passed since individually-focused therapies took a central role in the policy scenario in high-income countries, and later on in LMICs. Even nowadays it is frequent to find sanitary objectives for the coming decade focused on individual risk behaviours.[11] Cognitive behavioural therapies (CBTs) and related therapies tend to group such individual-level strategies to promote behavioural change.[35] CBTs are psychotherapeutic approaches that address dysfunctional emotions, behaviors, and cognitions through goal-oriented, systematic processes.[36] They include several types of therapies and counseling scenarios that frequently overlap in their aim, individual-level focus, and some of their components or processes (e.g. behavioural activation, motivational interviewing, person-centered counseling, etc.).[37] They have proven to be effective in different mental health conditions,[38,39] especially when they are held in concomitance with other strategies that support individual's change, such as financial incentives, family involvement and health practitioners' follow-up.[40,41] However, what appears to work in one particular group might not be easily translated to another. In some cases, CBTs have not been able to prove their efficacy or cost-effectiveness, even under controlled scenarios like randomized controlled trials.[42,43]

There are several recognised limitations of CBTs,[44,45] but beyond those it seems that the individual-level focus of these therapies is simply not enough to effectively improve health or even reduce health-risk behaviours. CBTs might improve attitudes and empower individuals to change their bahaviours to healthier ones, they might feel ready to do it, and even might initiate such change, but they still might not be able to maintain it when other, broader contextual factors, are not in the right place. In turn, there is the risk that failure in maintenance of behavioural change might have more detrimental consequences than having left the person without any intervention at all. It could be the case that guilt, failure and shame might emerge when the person does not achieve expected goals as a result of poor adaptation of the context in which behavioural change was supposed to take place. In these cases of 'withdrawal', repetition of CBTs might become incredibly difficult and complex. Unfortunately, most of the literature on CBTs reports satisfactory results only and less is described and debated when these individual-level approaches fail. Moreover, it is surprising what little awareness CBT practitioners from the US and Europe have demonstrated when I have directly asked them about the effect of broad contextual factors on the degree of success of their therapies in the past.

It might be reasonable then to question whether we are walking the right path in terms of public health when focusing on CBTs mostly. In many countries, millions are invested every year in the implementation of CBTs and less effort is aimed into modifying broader contextual determinants of health. These are not simple decisions to make. Budgets are always restricted and only a pool of strategies has to be chosen over thousands of possibilities. Alternative policies like improving public education since pre-school; regulations on a fair minimum wage for a healthy lifestyle and a debate on a potential upper wage bound; strong social protection measures for families in poverty; the creation of green and safe areas in every community; and other measures that should be raised by communities themselves, have little consideration in many countries. They tend to be observed as hard to implement, long-term and 'less fashionable' strategies, and yet could have a wider stronger impact on population's health than individual changes in behaviours.[1,4] Broader contextual policies might take longer to achieve such improvement in health and wellbeing,[46] but could be more effective in the long-run,[47] as changes in the context might promote individual change in a larger proportion of the population.[26,48]

There are many examples of changes in individuals through changes in the context, as described in the first paragraph, but I would like to add a particularly striking one. Every person would generally accept that Nelson Mandela led a period of great suffering and conflict in South Africa.[49] And yet his optimism, critical thought and conscious leadership led him to make many right decisions for his population. And in a time of great fear, anxiety and oppression, he created a social

ambience for change.[50] Instead of focusing his policies on individual approaches to change, he implemented strategies that allowed people to work together, to collaborate, to learn more about the world and themselves, to respect and trust each other and, as a consequence, to improve their health and wellbeing.[51,52] It is not my intention to advocate for the eradication of CBTs or any other individual-level public health intervention. Public health certainly needs both individual and broad contextual approaches for effective success. Instead, I am challenging current views and motivating a debate in which those in policy power —and everyone else— are better informed of the most likely consequences of their decisions on population health. I believe we are, in many countries, walking the public health path looking at our feet and the closest stones (individual-level approach) and policies are trying to help us skip a few stones so we don't fall to the ground. And yet we should be, at least occasionally, looking at the horizon and what is around us, and whether we are on the right direction (contextual approach). Our horizon should define our goals and is inevitably shaped by our values and principles. Any public health that ignores the horizon is likely to lose track, money and time. Those living in socioeconomic deprivation, particularly the children and vulnerable ones, will get sick and die while we let our stones become our horizon.

I suggest two possible courses of action. First, that those devoted to CBTs and individual-approach to lifestyle change in public health, challenge current theoretical and practical frameworks, creating clear and explicit links between the person and their context. The critical assumption that changes in the individual´s beliefs, attitudes, and ultimately behaviours, will necessarily have a positive effect on the context (family and broader) to sustain the desired change in lifestyle over time, needs to be further questioned. There are some interesting advances in this matter and the "third wave"[53] or "contextual CBTs"[54] methods emphasize the context and function of psychological events more so than their validity, frequency, or form. However, these methods remain focused on the individual and the concept of 'context' paradoxically remains within the person. That is, contextual CBT focuses more on what the authors call a "trans-diagnostic approach to mental health" in which rather than treat specific diagnoses (e.g., generalized anxiety disorder), contextual CBT therapists focus more on processes like emotion regulation.[53] A better description of how individuals relate to their social, cultural, and socio-political environment (distant contextual SDH) and how that in turn determines their choice in behaviours(proximal individual SDH) should be the necessary future steps in CBTs. Improved description of failures of CBTs in the scientific literature could shed some new light on this particular dimension. Besides, great knowledge has been gained so far in the social epidemiology field to inform such process and a multi-disciplinary approach could be the key to success in this matter. Second, stakeholders might need to develop strategies for action beyond the individual-level approach. Structural public, social and health policies that are explicitly linked to existing individually-focussed interventions might be the ticket to lasting, sustainable, equitable improvement of population health and wellbeing.

To conclude, this essay challenges current public health views focused on individual risk-factors and motivates an evidence-informed debate in this matter. Broader contextual policies might take longer to implement, but could be more effective in the long-run, as such lasting structural modifications might promote more sustainable and effective changes to a larger proportion of the population. Also, research evidence needs to be better considered at the policy level. Quite often politicians do not see the link between structural, social contextual factors and health status. They do not inform society about this, nor the media or other stakeholders, because they tend not to read research findings. Research translation and social appropriation of knowledge become important factors to inform societies about the relevance of social determinants of health. Furthermore, solutions to this problem cannot be imposed, as there is great variation in their effectiveness based on the context. Public health policies should combine bottom-up and top-down policy strategies in order to legitimate any policy decision made by the society they serve. Hopefully, those who read this paper and further consult the references used may continue to think about the importance of distal contextual/structural social determinants of health. Future research could use this manuscript and the recommendations made here in order to continue developing *what* concrete strategies could take place in *which* settings to improve current "proximal" and "individual-based" public health approach towards a "distant" and "contextualized" one to effectively improve population health.

References

1. Irwin A, *et al*. The commission on social determinants of health: tackling the social roots of health inequities. PLoS Med 2006; 3(6):e106.
2. Hamlin C. Could you starve to death in England in 1839? The Chadwick-Farr controversy and the loss of the "social" in public health. Am J Public Health 1995; 85(6):856-866.
3. Krieger N. Latin American social medicine: the quest for social justice and public health. Am J Public Health 2003;93(12):1989-1991.

4. Solar O, Irwin A. Social determinants, political contexts and civil society action: a historical perspective on the Commission on Social Determinants of Health. Health Promot J Austr 2006;17(3):180-185.
5. MacIntyre S. The Black Report and beyond: What are the issues? Soc Sci Med 1997;44(6):723-745.
6. Marmot M. Closing the health gap in a generation: the work of the Commission on Social Determinants of Health and its recommendations. Glob Health Promot 2009; Suppl 1:23-27.
7. Krieger N. Proximal, distal, and the politics of causation: what's level got to do with it? Am J Public Health 2008; 98(2): 221-230.
8. Marmot M, Friel S, Bell R, Houweling TAJ, Taylor S. Closing the gap in a generation: health equity through action on the social determinants of health. Lancet 2008; 372(9650):1661-1669.
9. Marmot M. Fair Society, Healthy Lives. London: The Marmot Review, 2010.
10. Irwin A, Scali E. Action on the social determinants of health: a historical perspective. Glob Public Health 2007; 2(3): 235-256.
11. Chilean Ministry of Health, Estrategia Nacional de Salud. Para el cumplimiento de los Objetivos Sanitarios de la Década 2011-2020, G.d. Chile, ed. Santiago: Chilean Ministry of Health, 2011.
12. Najman JM, Toloo G, Siskind V. Socioeconomic disadvantage and changes in health risk behaviours in Australia: 1989-90 to 2001. Bull World Health Organ 2006;84(12): 976-984.
13. Cornaz S, Taffe P, Santos-Eggimann B. Life-course socioeconomic environment and health risk behaviours. A multilevel small-area analysis of young-old persons in an urban neighbourhood in Lausanne, Switzerland. Health & Place 2009;15(1):273-283.
14. Fukuda Y, Nakamura K, Takano T. Accumulation of health risk behaviours is associated with lower socioeconomic status and women's urban residence: a multilevel analysis in Japan. Bmc Public Health 2005; 5:53.
15. Lantz PM, Golberstein E, House J, Morenoff J. Socioeconomic disparities in health change in a longitudinal study of US adults: the role of health-risk behaviors. Soc Sci Med 2001;53(1):29-40.
16. United Nations. World Population Prospects: The 2010 Revision. UN Department of Economic and Social Affairs. [Accesed on 12th January 2013]. Available from: http://esa.un.org/wpp/
17. United Nations, World Urbanization Prospects: The 2011 Revision, U.N.P. Division, Editor. 2012: New York. [Accesed on 13th January 2013]. Available from: http://esa.un.org/unup/
18. Susser M. A personal history: social medicine in a South African setting, 1952-5. Part 1: The shape of ideas forged in the second world war. J Epidemiol Community Health 2006;60(7): 554-557.
19. Porter D. Changing disciplines: John Ryle and the making of social medicine in Britain in the 1940s. Hist Sci 1992;30(88 pt 2):137-164.
20. Dingemans, G. [Social medicine in Latin America]. Presse Medicale 1953;61(59):1203-1204.
21. The World Bank, World Development Indicators 2012. 2012, The World Bank: Washington, D.C. [Accesed on 17th January of 2013] Available from: [http://data.worldbank.org/data-catalog/world-development-indicators]
22. Bishai D, O'Neil J. Economic growth and better health: the UK's surprising progress. Lancet 2012; 380(9842): 649.
23. Borowy I. Global Health and Development: Conceptualizing Health between Economic Growth and Environmental Sustainability. J Hist Med Allied Sci 2012;1-35.
24. DHSS, ed. Inequalities in Health: Black Report. A report of a research working group. London: DHSS, 1980.
25. Vinson S, Graham NA, Gold MS. Socioeconomic inequities often translate into health inequalities. J Natl Med Assoc 2006; 98(5):816-817.
26. Graham H. Where is the future in public health? Milbank Q 2010;88(2):149-68.
27. Wagstaff A, Paci P, van Doorslaer E. On the measurement of inequalities in health. Soc Sci Med 1991;33(5):545-557.
28. Wagstaff A, van Doorslaer E, Paci P.On the measurement of horizontal inequity in the delivery of health care. J Health Econ 1991;10(2):169-205; discussion 247-249, 251-256.
29. Vallgarda S. Addressing individual behaviours and living conditions: four Nordic public health policies. Scand J Public Health 2011;39(6 Suppl): 6-10.
30. Gaudiano BA. Cognitive-behavioural therapies: achievements and challenges. Evid Based Ment Health 2008;11(1): 5-7.
31. Molster C, Kyne G, O'Leary P. Motivating intentions to adopt risk-reducing behaviours for chronic diseases: impact of a public health tool for collecting family health histories. Health Promot J Austr 2011;22(1): 57-62.
32. Blacconiere MJ, Oleckno WA. Health-promoting behaviours in public health: testing the health promotion model. J R Soc Promot Health 1999; 119(1): 11-16.
33. Frohlich K. Psycho-social correlates of health and health behaviours: what does the term psycho-social mean for public health? Int J Public Health 2007;52(1):2-3.
34. von Lengerke T, Vinck J, Rütten A, Reitmer P, Abel T, Annas L. Health policy perception and health behaviours: a multilevel analysis and implications for public health psychology. J Health Psychol 2004;9(1):157-175.
35. Rachman S. The evolution of cognitive behaviour therapy, in Science and practice of cognitive behaviour therap. Clark D, Fairburn CG, Gelder MG, eds. Oxford: Oxford University Press, 1997:1-26.
36. Lambert M, Bergin A, Garfield S. Introduction and Historical Overview, in Bergin and Garfield's Handbook of Psychotherapy and Behavior Change. Lambert M, ed. New York: John Wiley & Sons, 2004:3-15.
37. Hofmann S. An Introduction to Modern CBT, in Psychological Solutions to Mental Health Problems. Hofmann S, ed. West Sussex, England: Wiley-Blackwell, 2011.
38. Butler AC, Chapman JE, Forman EM, Beck AT. The empirical status of cognitive-behavioral therapy: a review of meta-analyses. Clin Psych Rev 2006; 26(1):17-31.
39. Hoifodt RS, *et al.* Effectiveness of cognitive behavioural therapy in primary health care: a review. Fam Pract 2011; 28(5):489-504.
40. Kohler S, *et al.* Effectiveness of Cognitive-Behavioural Therapy Plus Pharmacotherapy in Inpatient Treatment of Depressive Disorders. Clin Psychol Psychother, 2011.
41. Welschen LM, Van Oppen P, Dekker J, Bouter L, Stalman W, Nijpels G. The effectiveness of adding cognitive behavioural therapy aimed at changing lifestyle to managed diabetes care for patients with type 2 diabetes: design of a randomised controlled trial. Bmc Public Health 2007;7:74.
42. Morley S, Williams A, Hussain S. Estimating the clinical effectiveness of cognitive behavioural therapy in the clinic: evaluation of a CBT informed pain management programme. Pain 2008;137(3): 670-680.
43. de Graaf LE, Gerhards SAH, Evens S, Arntz A, Riper H, Severens J. Clinical and cost-effectiveness of computerised cognitive behavioural therapy for depression in primary care: design of a randomised trial. Bmc Public Health 2008; 8:224.
44. Prakash O. Limitations of cognitive behavioural therapy for sleep disorders in older adults. Br J Psychiatry 2007;191: 266; author reply 266.
45. Hutton JM. Issues to consider in cognitive-behavioural therapy for irritable bowel syndrome. Eur J Gastroenterol Hepatol 2008;20(4):249-251.
46. Brennan VM. Structural inequalities among social groups continue to result in unequal rates of health and mortality, and these inequalities increasingly disfavor middle-income as well as low-income people. A note from the editor. J Health Care Poor Underserved 2008;19(3):vii-xi.
47. Manderbacka K, Lahelma E, Rahkonen O. Structural changes and social inequalities in health in Finland, 1986-1994. Scand J Public Health Suppl 2001;55: 41-54.
48. Costa G, Marinacci C, Caiazzo A, Spadea T. Individual and contextual determinants of inequalities in health: the Italian case. Int J Health Serv 2003;33(4):635-667; discussion 743-749.

49. Pirro R. Nelson Mandela and the ordinary uses of tragedy in private and political life. Soundings 2002;85(1-2):81-106.
50. Mathibe LJ, Maharaj B. Implementation of the principles of holistic patient care at the Nelson R. Mandela School of Medicine: medical students' perspectives. Med Teach 2006;28(8):744-745.
51. Bolton K. The proposed Nelson Mandela Children's Hospital, Johannesburg: providing the best care for children in the developing world. World Hosp Health Serv 2011;47(4):21-23.
52. Cliffe L. Mandela, Nelson - the Struggle Is My Life - Int-Def-+-Aid-Fund-So-Africa. Third World Quarterly 1987;9(2):728-731.
53. Hayes SC, *et al.* Open, Aware, and Active: Contextual Approaches as an Emerging Trend in the Behavioral and Cognitive Therapies. Ann Rev Clin Psychol 2011;7: 141-168.
54. Hofmann SG, Sawyer AT, Fang A. The Empirical Status of the "New Wave" of Cognitive Behavioral Therapy. Psychiatr Clin North Am 2010;33(3):701.