

EDITORIAL

Redefining health psychology: From pathogenesis to the science of human flourishing

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In 1946, the World Health Organization defined health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.”¹ Eighty years later, we must ask whether health psychology has fulfilled this vision. We argue that the field has yet to fully realize this vision. The field has devoted substantial attention to the illness end of the health continuum, examining how stress triggers cardiovascular disease, how depression disrupts immune function, and how unhealthy behaviors elevate morbidity risk, while the study of health promotion and optimal wellbeing has received comparatively less attention. We suggest that the discipline should now more fully embrace what its name implies.

We propose the following definition: Health psychology is the scientific study of the multilevel mechanisms, spanning biological, psychological, social, and technological systems, through which individuals and populations acquire, sustain, and optimize health, with human flourishing as its defining outcome. This formulation places health generation, rather than disease mitigation, at the center of the discipline.

For much of the twentieth century, the biomedical model treated mind and body as separate domains. Even the psychosomatic tradition, though innovative, remained anchored in pathology. A decisive shift came when Engel proposed the biopsychosocial model, arguing that illness arises from interactions among biological vulnerabilities, psychological states, and social contexts.² This framework established that psychology was indispensable to understanding health, not merely a supplement to medicine.

Matarazzo³ subsequently formalized the discipline in his Association of American Psychological Association presidential address. His definition placed “promotion and maintenance of health” first among the field’s objectives³, yet in the decades that followed, prevention and treatment research received greater empirical emphasis. However, accumulating evidence has begun to correct this imbalance. Steptoe and colleagues⁴ demonstrated through large-scale epidemiological data that subjective wellbeing independently predicts health and longevity, while Huber and colleagues⁵ argued that the very definition of health must move beyond the absence of disease toward the capacity to adapt and flourish. These developments laid the groundwork for the paradigm shift

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we now advocate. Table 1 summarizes the key distinctions between illness-oriented and health-oriented paradigms within health psychology.

Five converging developments point toward the need for a fundamental reorientation of health psychology.

- (i) Interdisciplinary integration: Health psychologists can no longer afford ignorance of neighboring disciplines. The neural circuits governing stress reactivity, the epigenetic embedding of psychosocial adversity, the gut-brain connection's modulation of emotion, the immune system's sensitivity to psychological states, and cognitive neural imaging all require fluency in the languages of neuroscience, genomics, microbiology, and immunology. The mechanisms of health are inherently multilevel; our research frameworks must reflect this complexity.
- (ii) Artificial intelligence and digital phenotyping: Smartphones and wearables now generate continuous, passive streams of behavioral and physiological data, including sleep patterns, physical activity, social engagement, speech characteristics, and heart rate variability, forming individuals' digital behavioral profiles. Machine learning algorithms can detect early warning signals of health decline and identify personalized moments when preventive intervention is most effective. Large language models show promise for extending the reach of evidence-based behavioral strategies, though their current limitations warrant caution. These include factual unreliability, the potential for amplifying biases, and the absence of genuine clinical judgment. These advances also raise urgent questions about privacy, algorithmic fairness, data security, informed consent for passive monitoring, and the appropriate boundaries of human-machine interaction in health care.
- (iii) Brain-computer interfaces and neurotechnology: From electroencephalogram-based neurofeedback to closed-loop deep brain stimulation, technologies

that directly modulate neural activity are beginning to blur the traditional boundary between psychological and physical intervention. Health psychology must engage with these tools critically. While their potential applications, including meditation enhancement, stress management, sleep regulation, resilience promotion, anxiety regulation, addiction intervention, and cognitive enhancement, are generating considerable research interest, most remain at early investigative stages with limited evidence of real-world efficacy. Moreover, significant challenges remain, including device accessibility, long-term safety data, the risk of widening health disparities through unequal access, and unresolved questions about mental privacy and cognitive liberty. Ensuring that rigorous evidence and ethical frameworks keep pace with technological development is essential.

- (iv) Precision health psychology: Genetic variation, neural profiles, personality traits, and sociocultural contexts jointly determine who benefits from which intervention. Building models that match individuals to optimal strategies, specifying what works for whom, under what conditions, and through what mechanisms, will define the next generation of health psychology research.
- (v) Cultural diversity and global reach: Health psychology's theories and tools have been shaped primarily by research conducted in a narrow range of cultural settings. Diverse traditions, including East Asian mind-body frameworks, Indigenous healing practices, and community-based approaches from the Global South, offer underexplored resources for understanding and promoting health. A mature discipline must accommodate multiple frameworks of wellbeing rather than exporting a single model.

Health psychology stands at a crossroads. One path continues the familiar trajectory: refining disease models, optimizing clinical interventions, deepening our

Table 1. Contrasting orientations within health psychology

Dimension	Illness-oriented paradigm	Health-oriented paradigm
Core question	What causes disease?	What generates and sustains health?
Theoretical foundation	Pathogenesis	Salutogenesis
Primary outcome	Symptom reduction, diagnostic remission	Flourishing, vitality, adaptive capacity
Target population	Clinical and at-risk groups	Universal, across the full health continuum
Intervention logic	Remediate dysfunction after onset	Build protective resources before decline
Disciplinary scope	Single-discipline	Cross-discipline
Causal model	Psychological as secondary	Equal contributors

understanding of pathology, all valuable contributions. The other path, more demanding but truer to the discipline's founding aspirations, reorients inquiry toward health itself. The World Health Organization's 1946 definition was not merely a slogan; it was a mandate. Eighty years on, we believe it is time for health psychology to become what its name has always promised: not the psychology of disease, but the science of health.

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Conflict of interest

Both Yanping Bao and Yibo Wu serve on the editorial board of this journal as Editor-in-Chief and Executive Editor-in-Chief, respectively. They were not involved in the peer review or editorial decision-making process for this manuscript.

Further disclosure

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