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editorial

Ageing in changing social contexts: Challenges and opportunities for Health Psychology

Catrinel Craciun
Co-editor
Konstadina Griva
Co-editor

Demographic changes over the last decades give rise to new challenges of social adjustment to the needs of an increasing ageing population but also represent opportunities for growth at a social and individual level. On the one hand, the increase in older population has been described as a "silver tsunami", threatening the functioning of health and pension systems (van Leuven, 2012). On the other hand, old persons are seen as a resource to society and their active engagement and contribution is encouraged (Lassen & Moreira, 2014). Longer lives do not automatically mean more years to enjoy, but might imply more years of disability and dependence on family or care systems. An ageing population does increase the demand for health care services for chronic illnesses, elderly care and adjustment of preventive services to the unique needs of the old and very old. However, it also creates the opportunity for intergenerational communication, wisdom and spiritual growth. Health psychologists may play a relevant role in designing research and interventions to help people enjoy health and well-being in old age.

From a life span perspective, development is the result of dynamic lifelong process that is embedded in historical time and place and is influenced by the social context (Stowe & Cooney, 2015). Social or environmental changes such as in restructuring of health systems, functioning of social networks (Ajrouch, Akiyama, & Antonucci, 2007), changes in family structures or technological advances leave their mark on how people age. For instance, the baby boomer generation (i.e. people born between 1946 and 1964, who have reached retirement age around 2014) is often referred to in the literature as the generation that has witnessed several social changes across their lifespan and inspired changes in policy and research on ageing. Baby boomers have experienced times of economic upheaval but also went through financial crisis that affected their pension plans and thus stimulated thought on changing retirement policies. Furthermore, with the ageing if the baby boomers, such concepts as successful ageing emerged, to be criticized and replaced by active ageing, positive ageing (Lassen & Moreira, 2014) or harmonious ageing (Liang & Luo, 2012) and new ideas about elderly care were put forward in order to promote their independence in old age (Breheny & Stephens, 2012).

The present special issue is brought together to address some of these concerns that rise from changing social circumstances and their implications for health and well-being outcomes in old age. The contributions to this issue raise several questions and propose some answers that may stimulate further thought and collaborations for designing research and interventions to promote healthy aging.

The current issue

One challenge that an ageing population raises for policy is dealing with the *care of older citizens*. The contribution by Lai and Ishikava (2015, this issue) brings insight from the experience of Japan, a country with the highest ageing rate in the world. The authors offer thought provoking suggestions on how health psychology may be used to inform practice in elderly care by using practical examples of what is being already implemented in Japan. They

also highlight the relevance of cultural and social norms and how these may influence elderly care services.

We are said to live in a youth oriented culture, where health, beauty and productivity are associated with youth and this is reflected in negative mass media representations of the old (Rozanova, 2010). Furthermore, even research on ageing has been criticized for promoting "agelessness" instead of positive ageing (Andrews, 2000). Thus, the question on *how to invest old age with positive meaning and/or emphasize the resources that elderly people may bring to society* become particular pertinent to informed balances discussion. Positive images of ageing need to be developed and social roles created for older persons so that they can enjoy good health and well-being in old age. The contribution by Yap (2015, this issue) discusses the concept of successful ageing in a critical way and the importance of spirituality as a resource for positive ageing. Moreover, in order that old persons are valued in society, they have to be seen in a positive light by the young generation and have a healthy intergenerational exchange. Lucacel (2015, this issue) addresses the issue of how older persons are perceived by the young and how negative stereotypes should be changed and how may communication between generations be stimulated.

A key challenge for the ageing generations today is represented by the demands of rapidly evolving technology in everyday life. For example, the health literacy of the elderly depends more and more on their ability to include technological novelty in their lives since modern health systems require online communication and elderly care services integrate technical innovations. Using social media channels (e.g. Facebook), seeking health advice online or being member of patient/ health forums, using emails to communicate with health care providers, or partaking in online behavior change programs. Disease management or behavior change are becoming part of everyday life for all, including the elderly. The article by Paech and Lippke (2015, this issue) deals with the questions why the older generation does not use technology as much as younger people and how can we help them increase the use of technology to their advantage? Health literacy might provide a solution. The authors describe the EU initiative on studying health literacy in several European countries, addressing the needs of the older population and entries for intervention.

Retirement is associated with old age and for an increasing numbers of retirees the transition from occupational arena to retired life is also marked by migration to different countries. Whatever the reasons behind the migration (e.g. Seeking a better job, joining one's family, moving to another country to spend retirement years etc.) migration and *aging* generate diverse challenges for individuals and health systems alike. Simpson, Triliva, Thomas, Chatzidamianos, and Murray (2015, this issue) discuss the experiences of post retirement migration and their interaction with health care systems as shared by a group of British elderly living in Crete.

The successful ageing paradigm has been mostly criticized for those whom it excludes (Katz & Calasanti, 2015). Thus, research and intervention needs to include vulnerable groups that have lower chances for positive ageing and may experience health inequalities in their old age. Craciun, Gellert, and Flick (2015, this issue) tackle the subject of preparation for positive ageing in Germans who age in precarious circumstances (i.e. they have low paid employment or temporary job contracts without reliable pension plans). The difference between low SES and precariousness lies in the fact that the latter category may have good salaries, but these are limited to a time period. Living in an age of uncertainty (Bauman, 2007) may influence how these people plan and actively prepare for their healthy old age.

Several articles have identified planning as a relevant resource for positive ageing. Nevertheless, sometimes we deal with several goals at the same time and need to successfully manage the conflict that emerges from conflicting aims. Tomasik and Freund (2015, this issue) explore goal conflict and its

implications within research and practice with the elderly. Moreover, especially in old age, people may need to deal with not being able to implement their plans as they would like to. Backup plans might serve as a motivating factor and support for goal pursuit. Napolitano and Freund (2015, this issue) report on their work about the use of backup plans as self-regulatory strategies in old age and the implications of their findings for further research and practice.

We hope you enjoy this issue!

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Catrinel Craciun

Babes-Bolyai University, Cluj Napoca, Romania

Jacobs University Bremen, Center of Lifelong Learning, Bremen, Germany

Freie Universität Berlin, Berlin, Germany

craciunic@zedat.fu-berlin.de, catrinelcraciun@yahoo.com

Konstadina Griva

Department of Psychology, National University of Singapore, Singapore

psygk@nus.edu.sg

original article

How can behavioural science contribute to elderly care? Lessons from Japan

Alden Lai
National Healthcare Group, Singapore
Yoshiki Ishikawa
Cancer Scan Inc., Tokyo

Estimated to be 26.9% in 2015, Japan has the highest ageing rate in the world (Organisation for Economic Co-operation and Development [OECD], 2009). Not only is Japan grappling with economic and social issues surrounding the greying baby boomers, it further faces the problem of plummeting fertility rates. As the ageing phenomenon is unprecedented, health systems in the world lack historical references to tackle the challenges that lie ahead and therefore can only adapt to needs as they arise. In this vein, Japan has been a platform for academics, practitioners and policy-makers alike to generate innovative measures for elderly care while providing valuable lessons for the world. Simultaneously, this also creates opportunities for the behavioural scientific community to shape the ways we deal with ageing. This article aims to describe the current measures Japan is undertaking to mitigate the challenges of ageing, and in the process offer suggestions on how behavioural science research can contribute to these initiatives.

Discourse on ageing in Japan cannot exclude the long-term care insurance (LTCI), which is the flagship intervention designed by the government to mitigate the needs of the Japanese elderly on a national level. Implemented in 2000, the LTCI represents a social insurance system funded equally by tax and employer contributions to allow the elderly to afford the care services they require. Japan's LTCI closely resembles that of Germany's, except for the absence of cash allowances for family caregivers. A paper by Campbell, Ikegami, and Gibson (2010) documented Japan to be providing public benefits to 13.5% of its population that are above 65 years of age, whilst figures for Germany and the United States stand at 10.5% and 4.5% respectively (also see article for a comprehensive comparison between Japan and Germany's LTCI systems). Although the LTCI is at its core a fiscal measure, the government has sought input in behavioural science for its improvement in recent years as it looks beyond economic aspects in its LTCI policy. For example, based on a review published in *The Lancet*, the emotional burden on caregivers is clearly flagged as a concern (Tamiya et al., 2011). Considering the abundance of literature underlining the experiences of burnout and depressive symptoms experienced by the caregivers of elderly persons (e.g., Etters, Goodall, & Harrison, 2008), this topic is certainly relevant to the health behavioural science community. The provision of care to frail and older adults has been associated with higher depression and stress, and lower self-efficacy and general subjective wellbeing, in comparison to non-caregivers (Pinquart & Sorensen, 2003). It was also suggested that family caregivers who provide care at home have unmet informational, social and emotional needs that can be mitigated by the formation of local peer support groups (Bee, Barnes, & Luker, 2008; Stoltz, Udén, & Willman, 2004). Furthermore, a series of evidence-based psychosocial interventions, classified into psycho-educational, psychotherapeutic, or multicomponent, have been identified to reduce distress and improve carers' wellbeing (Gallagher-Thompson & Coon, 2007; Pinquart, Sorensen, & Duberstein, 2002). Given the burgeoning amount of evidence, the next step is to apply such evidence in appropriate manners in LTCI to extend its purview to caregivers to alleviate their psycho-emotional burden.

It is, however, instrumental at this stage to highlight the need to consider cultural and societal norms when conducting behavioural science research in caregiver support, especially in the context of home care. Ethnic differences exist in caregiving – White caregivers are more likely to be spouses than Asians and Latinos for example (Janevic, & Connell, 2003). In contrast, in Japan and East Asian countries, daughters-in-law are the main caregivers of older adults due to the strong influence of Confucian teachings (Hashizume, 2000; Koh & Koh, 2008). Tamiya et al. (2011) estimated that 40% of the elderly population in Japan are living with their children, and highlighted how traditional Japanese family values prescribe that a 'self-respecting' daughter-in-law will not allow someone else to provide care on her behalf for her elderly in-laws. Furthermore, a six year retrospective study with 191 Japanese elderly females documented systemic differences in mortality rates according to the type of family caregiver (i.e., spouse, biological daughter or daughter-in-law) (Nishi et al., 2010). Having mentioned this, given the percolation of Western values in recent years, and recognition of the elderly care burden being imposed on family caregivers by the Japanese government, such traditional perspectives are evolving. In short, as elderly care can be considered an intimate family affair, and has implications on care arrangements, we recommend that any form of psychosocial interventions designed to enhance support for the caregiver should be culturally tailored for outcome optimisation.

Exciting work on the application of health psychology theories for elderly care is underway in Japan. In 2014, the Japanese parliament approved the Health Data Plan for a systematic identification of older adults that are at risk of developing chronic disease complications for targeted psychosocial interventions. Part of the National Revitalisation Strategy, a pilot programme will focus on disease self-management and prevention of diabetes in 180,000 elderly in a local community. Adapting from the Theory of Planned Behaviour, information from annual health screenings and health insurance claims are first analysed at the municipal level to identify a specific subset of the population that meets the following criteria – at risk of developing diabetes complications, requiring medication, and exhibiting poor medication adherence. Secondly, an algorithm is applied to further segregate this subset into two groups; one with high behavioural intentions of taking their medication, and the other with low intentions. Third, health messages tailored to each level of intentions are disseminated with the aim of increasing their medication adherence. Older adults at the pre-diabetes stage are also identified as part of the process; for this borderline at-risk group, lifestyle counseling will be conducted as part of disease prevention. It is encouraging that health authorities are taking theoretically-informed and systematic steps in the design of this intervention, as previous literature has established the use of theory, or explicitly described theoretical constructs, to enhance the effectiveness of public health interventions (Glanz & Bishop, 2010). In fact, the inception of the Health Data Plan was informed by a successful trial conducted to examine the effectiveness of tailored print reminders for the uptake of breast cancer screening in Japanese women (Ishikawa et al., 2012). Scheduled to be implemented from 2015, the scope of this new initiative will also be expanded to other diseases should preliminary evaluations yield successful outcomes. It is hoped that this blend of big data analysis, health psychology and health communication will result in a new and effective framework of examining chronic disease management and prevention for elderly care in Japan.

In an article by National Institutes of Health's Office of Behavioural and Social Sciences Research in the United States, an integration of the three disciplinary domains of 'the largely biomedical sciences, the largely individual behavioural sciences, and the largely group or population sciences of the ecologic world view' was being advocated (Mabry, Olster, Morgan, & Abrams, 2008). Mabry and colleagues called for the vertical integration of these

traditionally disparate domains to generate breakthroughs in the ways we tackle complex health issues, such as elderly care, chronic disease management, and social inequality in our society. Coincidentally, the same paper presented a conceptual model for diabetes by Jones et al. (2006) as a system comprising both elements of individual behaviours and ecological determinants of diabetes management, which is similar to the Health Data Plan mentioned above. It may thus be argued that the application of behavioral science in elderly care will require an inherent paradigm shift in the way we perceive and use our current knowledge. Forefront thinkers have asserted the need for behavioural scientists to be more creative, consider culture and context, and most importantly, inculcate interdisciplinary perspectives in the design and implementation of interventions to better meet our society's health needs at a system level (Glanz & Bishop, 2010; Mabry, Olster, Morgan, & Abrams, 2008).

This article had two aims – to introduce examples from Japan on current efforts in the mitigating of elderly care needs, and suggest ways in which behavioural science can contribute to these initiatives. We hope that by describing Japan's flagship elderly care intervention, the psycho-emotional burden of caregivers, and the use of behavioural theory for diabetes management and prevention in the elderly, we have provided some form of inspiration for readers to contemplate about the ways we can apply our knowledge and findings in health psychology for an upcoming and unprecedented challenge the world will face – ageing.

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Alden Lai
National Healthcare Group, Singapore
alden.lai.yuanhong@gmail.com

Yoshiki Ishikawa
Cancer Scan Inc., Tokyo, Japan
ishikawa@cancerscan.jp

original article

What constitutes successful ageing?

Philip Yap
Khoo Teck Puat Hospital

Population ageing is taking place the world over especially in more developed first world countries. Given the hackneyed negative stereotypes surrounding ageing societies, there is a move towards reframing ageing in a more positive light. Today, the buzz words "active" or "successful" ageing have come to the fore. The goals are to keep seniors engaged physically, mentally and socially so as to maintain independence and a good quality of life. The WHO movement, "Global Embrace", refers to seniors as "human treasure" and "precious capital" (World Health Organisation [WHO], 2001). In essence, successful ageing entails harnessing seniors' instrumental value for their own good and the good of society at large.

Much of our understanding of successful ageing comes from the seminal work of Rowe and Kahn (1997) who studied what distinguished seniors who aged better than others. They identified 3 main characteristics of successful ageing: 1) avoiding or minimising disease 2) maximising physical and mental faculties 3) active social engagement. There is also research to support the premise that remaining active despite old age is the key to preserving wellness, independence and longevity. Today, more elements have been added to successful ageing. In Singapore, for example, it encompasses life-long learning and employability (Ministry of Health Singapore, 2014).

Attractive and useful as it may be, the idea of successful ageing can be construed an oxymoron. Ageing, no matter how active or successful is inevitably characterised by decline and eventual death, albeit the rate of deterioration varying from person to person. Does ageing remain successful when decline sets in? While personal responsibility is implicated in determining how one ages, many also suffer from the ills of age related diseases due to factors beyond their control. Is successful ageing then beyond reach for those stricken by chronic disabling illnesses such as dementia or stroke?

Today's perspective on successful ageing has its beginnings in Victorian times when mid-life was deemed crucial to one's salvation. Such an ideology, together with modern scientific rationalism, has resulted in seniors being evaluated on mid-life standards of autonomy and health (Cole, 1997). Some aspects of active ageing may indirectly reinforce such mind-sets by promoting traits associated with physical and mental vitality, and a senior is assessed by his instrumental worth. However, few can function optimally at their prime right to the final days of their lives. Even for those who enjoy the good fortune of active ageing, it cannot last forever.

Hence, success in ageing must move beyond the material to embrace decline and to recognise the value of the elderly beyond the physical and tangible. Acceptance of decline is essential for the elderly to cope with losses, which may be physical, social and personal. The intrinsic value of seniors should be emphasised and it goes beyond personal attributes. As enunciated by William Thomas, founder of Eden Alternative, "elders are the glue that bind us together" (Thomas, 2004); this remains real even if they lose all their utilitarian worth.

Embracing losses in ageing can help seniors resolve Erickson's (Erikson, 1994) final stage of growth in ego integrity versus despair. Seniors who continue to combat ageing find themselves at the losing end ultimately and end up despondent and in despair.

Conversely, those who are able to transcend the losses in old age through acceptance, lowered self-expectations and finding new meaning, gain integrity. Crowther, Parker, Achenbaum, Larimore and Koenig (2002) posit a fourth dimension of positive spirituality to Rowe and Kahn's model for successful ageing, which may well be the final piece of the puzzle to ageing successfully.

Spirituality consists of cognitive and experiential dimensions (Edlund, 2014). Cognitively, it involves finding provisional and ultimate meaning to existential issues. Experientially, it subsists in relationships which may be expressed in concrete human bonding, or in connectedness with the transcendent and beyond the material world. Such connectedness is especially vital for persons who are losing the qualities that define them as unique individuals through illnesses like dementia. For them, personhood consequently becomes more relational. Unlike active ageing which is beyond the frail, spirituality embraces the whole person and is relevant to all, even those chronically ill or disabled. Imbued with spirituality, seniors review their lives to gain new insights from past to make sense of the present, and find hope for the future (MacKinlay & Trevitt, 2007). Such spiritual aspirations bring about inner fulfilment and engender new optimism.

Successful ageing defined in "active" terms has its failings in the unavoidable losses of ageing, even the 'active' elderly must face deterioration and mortality. Success in ageing must hence move into the realm of spirituality to help seniors rise above societal yardsticks of youth and vitality, to finding meaning in the losses and even sufferings of old age. Finding meaning and hope is a choice seniors can make. Such choices express true freedom, and perhaps constitute true success in ageing.

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Philip Yap
Department of Geriatric Medicine, Khoo Teck Puat Hospital, Singapore
yap.philip.lk@alexandrahealth.com.sg

original article

Are young people's views on aging accurate?

Raluca Lucacel
Babes Bolyai University

There is an inevitable increase in the older adult population nowadays due to the dropping birth rates and longer life expectancy (World Health Report, 2010). The rates of the aging population are growing rapidly, from 200 million people aged over 65 years in 1950, to 470 million in 2008 and to 1 billion in 2050 (Population Reference Bureau, 2008). This accelerated increase will be without a doubt related to a series of changes both at an individual and societal level. Despite the fact that many individuals see aging predominantly as problematic they should also keep in mind that there is more to aging and the aging process than problems and negative outcomes. Due to all of this changes, now, more than ever there is an urgent need for people to be educated about aging and the aging process (Cottle & Glover, 2007).

Although there are individuals who consider that aging and the aging process are something bad and should be avoided if possible (Macnicol, 2006), this does not mean that it is also true or that is it right to think that way. People can have different views on different concepts but the value of their truth cannot be that easily established.

People's beliefs about aging and the aging process are formulated mainly on societal knowledge (Lee, 2009). Individuals have a lot of misconceptions and myths about this process. Maybe one of the most common one is that it is best for old people not to engage in any demanding physical activity because their bones might break or other bad things might happen. Actually, studies have shown over and over again that exercises are very helpful for most people, even for the aged ones (Etgen et al., 2010). There are many other myths and misconceptions related to the old people's health, cognitive abilities and behaviors. The majority of them perpetuate themselves from generation to generation and even though there is a considerable larger amount of people who live longer today than it was fifty years ago, they are still the target of negative attitudes. Studies have shown that these negative attitudes are very familiar for other age groups (Rees, King, & Schimtz, 2009).

The way older people are treated is very much related to the way they are seen by others. Children, youngsters, grow-ups and even old people might have negative views on aging and the aging process. These negative views often transform themselves into beliefs like: *old people are senile, they all have health issues, and they are boring, non-interesting, and unattractive*. By being seen as described above old people might feel socially devalued (Levy & Banaji, 2002). If people have these beliefs they will for sure avoid interaction with the aged. Most of the people will not even try to see if that is actually how older people are and behave, they will just avoid them as a safety measure, or so they believe. Now, one might consider that everybody has a negative view about aging and the aging process, but this is for sure not the case. As pointed before there are individuals who consider aging a bad thing, but there are other individuals who can see the positive parts of it.

Studies show that younger persons discriminate more against aging and the aging process when compared to older individuals (Lee, 2009). This happens primarily because young people perceive aging and the aging process as a decline in all aspects of life. Low productivity, low efficiency and lack of independence are amongst the most popular negative effects of the aging process (O'hanlon & Brookore, 2002). Considering that the young people's behaviors

towards the aged are guided by this kind of beliefs it is not difficult to imagine how hard it must be for the aging population. So, based on this, we might say that old people have to face these negative behaviors on a daily basis.

Other studies have shown that undergraduate students have passive and negative views towards the aged (Wurtele, 2009). They simply do not care enough to engage in interactions with older people and see how they really are. They prefer to do nothing about it because it is easier this way. The problem here is that younger individuals are inclined to accept age stereotypes automatically without inquiring their validity (Nelson, 2004). By doing so they are very likely to expand their knowledge base about aging and the aging process with untrue and unverified information.

It is very important to know how these beliefs perpetuate themselves and how they are learned by the young people. Some of the individuals might rely on what they see in the media, others might listen to stories told by different people or read information in different settings (Van Dussen & Weaver, 2009). There are very few courses on gerontology and most of them are taught only at universities for medical science. Education about aging and the aging process is much needed and should be implemented in more general settings.

Equally important are questions related to the development span of the aging beliefs. For instance, when do people start developing or learning about aging or how these beliefs are shaped or change over time. Are these beliefs learnt from birth or are the results of a continuous process over lifespan? Many of these questions are not well understood. There is however evidence that these beliefs do change as people get older. Studies comparing attitudes towards aging and the aging process between younger and older groups show that negative attitudes do change as people grow old (Cummings, Kropf, & DeWeaver, 2000). Even if younger people hold a negative view about aging and the aging process once they get closer to the age of 65 years old they start to see the benefits. But this does not mean that everything changes, that all the negativity just disappeared. We should not forget that people had decades to strengthen their negative attitudes, from the time they were young, until they reached the older age, meaning that by the time these views and stereotypes have become relevant they have already been internalized (Levy & Langer, 1994). For sure, we can say that there is a need for accurate information about aging and the aging process to be taught early in education.

Due to the fact that in the near future the aging population will be double than it is today it is highly recommended to turn our attention to some relevant issues. This relevant issues are mainly represented by the negative behaviors young people can exhibit towards the aged and their negative attitudes. We also have to consider that from now on we will need more and more people who will have to work with the aged, but working with them seems to be the less attractive career choice among the youngsters (Ferrario, Freeman, Nellett, & Scheel, 2008). If youngsters will maintain the same negative attitudes about the aging population it will be very difficult to train new professionals for working with this population. Therefor it is important to begin promoting accurate information about aging and planning proper guidance and training services according to the identified needs. No one is saying that getting older has only benefits, but what is important to emphasize here is that it does not have only disadvantages either. That is why accurate and documented information is needed.

Besides early education there is one more thing that can be done in order to change those negative attitudes. Interacting with older people has great impact on the views individuals have about aging and the aging process. By interaction we understand: *spending time with older people, discussing ideas with them, getting involved in different activities together and enjoying daily moments*.

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Raluca Lucacel

School of Psychology, Babes Bolyai University, Cluj Napoca, Romania

ralucalucacel@psychology.ro

original article

Health literacy as a key to healthy ageing in Europe

Juliane Paech
Jacobs University
Sonia Lippke
Jacobs University

In the face of *demographic change* the older population represents an important group to look at: What helps them to remain or recover their health, how can they participate in society and age successfully? We currently also face a strong rise of *information technology*. These technologies are full of challenges, and responding to them becomes more difficult with increasing age and health demands (Himanen, 2004; International Telecommunication Union [ITU], 2005). While *mobile technology* and *the Internet* offer different benefits also for frail older people, this group also tends to become marginalized as they do not use these technologies appropriately for the benefit of their health and social participation (ITU, 2005). The question is: Why do older people not use these technologies? How can the use of these technologies be increased in the aging population?

Literacy can give an answer as it plays a crucial role in health and well-being. It is the key resource in handling the amount of information and making use of it. The concept of *health literacy* has gained importance in the field of health research (Kickbusch, Pelikan, Apfel, & Tsouros, 2013; Ownby, Waldrop-Valverde, & Taha, 2012). Health literacy describes "the degree to which people are able to access, understand, appraise and communicate information to engage with the demands of different health contexts in order to promote and maintain good health across the life-course" (Kwan et al., 2006, p.80). However, little is known about how health literacy can be promoted effectively especially in context of mobile technology and the Internet. Therefore, this was investigated in the IROHLA project (cf. www.irohla.eu).

The IROHLA project and the intervention model

The complex interplay of health literacy involves components both at the individual and the system level. At the *individual level*, social-cognitive factors, such as self-efficacy and intention, and *contextual determinants*, such as social support, play a crucial role in the initiation or maintenance of health behaviors (Schwarzer, 2008; Schwarzer, Lippke, & Luszczynska, 2011). When considering health literacy, apart from the health sector, the *social sector* should also be taken into consideration as fertile ground for interventions (Batterham et al., 2014). Social factors and their impact on the use of health care services are widely discussed: Addressing social issues can be a cost-effective strategy in the health care system (Valtora & Hanratty, 2012) as empirical evidence suggests that social aspects can determine physician visits, re-hospitalization, and length of hospital stays (Newall, McArthur, & Menec, 2014). Such a comprehensive approach, accounting for synergistic effects of different sectors, is adopted by the IROHLA (Intervention Research on Health Literacy among Ageing Population) project.

The EU-funded initiative aims to improve health literacy for older people in Europe by providing evidence-based *guidelines for policy and practice*. IROHLA identifies and evaluates existing health literacy programs and policies, also including knowledge from private and social sectors applicable to the health sector. *The IROHLA model for health literacy interventions in the ageing population*

(IROHLA Consortium, 2013; see Figure 1) serves as a basis of the research undertaken in the project. This model explicitly takes contextual support into account thus leveraging the social sector for improving well-being and (health) literacy levels in older people.

The IROHLA model was developed to facilitate the understanding and improvement of health literacy in different European contexts, addressing the needs of older adults in various settings and identifying entry points for interventions. Demands and capacities of the individual, their context and the health system must be harmonized to achieve better health literacy outcomes. Health promotion and preventive actions should take the interaction between individuals and the health system into account (Nutbeam, 2000). Healthy ageing is considered the main outcome of the IROHLA research model accounting for intermediate outcomes, such as motivation, participation or health behavior change, which can be determined by health literacy (IROHLA Consortium, 2013; see Figure 1).

In the course of the IROHLA enquiries prevailing good practices in the field of interventions enhancing *social participation* were identified. Social participation refers to the concept of social engagement (Bath & Gardiner, 2005) and comprises different kinds of activities that fulfil social purposes, e.g. meeting friends, joining a club or going to the theatre. Thus social participation depicts a strategy to active and healthy ageing (for a review, see Adams, Leibbrandt, & Moon, 2011). The *social sector* typically includes non-profit, non-governmental organizations

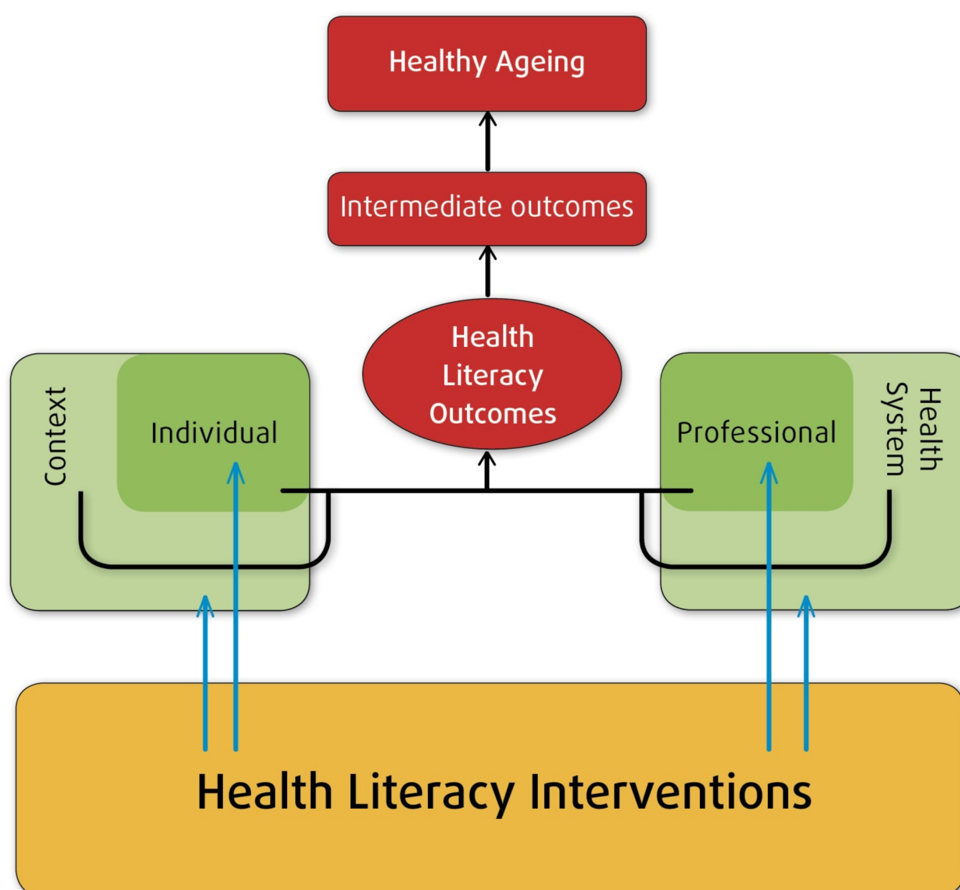

Figure 1. IROHLA intervention model (IROHLA Consortium, 2013).

or initiatives, aiming for social involvement and activation of citizens, and is much broader than the classical health sector (Evers & Laville, 2004). Programs targeting social participation from the social sector might be applied to the health sector and replenish health literacy interventions. Two promising initiatives from the social sector are to be described in more detail here.

Social isolation and loneliness are a growing problem among vulnerable groups, such as frail older people and people with low education (Nicaise, 2012). However, there exist some initiatives that search for creative and low-threshold solutions to foster social participation. Much can be learned from those programs and transferred to the field of health literacy research and practice. In the following, two best-practice examples will be described.

NALA

The fact that 1 in 6 Irish people has literacy difficulties brought the National Adult Literacy Agency (NALA) on to the scene. This was the call for action to improve literacy and numeracy difficulties in the Irish population and, in particular, the well-being of older adults. NALA opens new perspectives for social participation and adult education.

While older adults often feel discouraged to study at their age or even talk about literacy deficits, NALA is running campaigns to change such attitudes. For this, a free phone support line is set up for people looking for help or more information. Around 4000 volunteers are now active at NALA to help as tutors. Long distance courses via the Internet are provided to people from different social and economic backgrounds.

NALA also approaches the government to facilitate political changes. Government policies need to be targeted in order to achieve long-term benefits for society. This course of action is based on research results to provide an evidence base for the best approaches to deal with literacy and life skills.

For further information see http://www.nala.ie/

KOVE

Imagine you are waiting at a crossing: When the green light appears you will probably hurry across the street. But what would you do at the age of 70 or with a broken leg? Sometimes you have only 5 seconds to cross the street before the stop sign appears again for the pedestrians. This is only one of the obstacles older people from Kilburn High Road face. The KOVE (Kilburn Older Voices Exchange) project wants to draw everybody's attention to this. You can join them on- and offline, follow their steps and lives, see London from the angle of older and vulnerable individuals and recognize the barriers they are facing in everyday life. The project website (http://www.kove.org.uk/) contains all project descriptions and shows video recordings filmed by the older people themselves.

KOVE is an outstanding social project with the aim of improving the quality of life for older people in London. Since 2001, this project gives them a voice to raise problematic issues and makes barriers for older and other vulnerable people visible. The community group works in a network with other local groups and has partnerships with several agencies to make sure the improvements will be put into practice. Sometimes those are little things, such as lowering the platforms when boarding a bus, which still make a difference. Furthermore, KOVE also helps to improve home care standards and provides training films with care staff. The community group is actively involved in a number of projects and always welcomes new members to join their work.

KOVE works with vulnerable and older people, helping them to remain independent and socially integrated by engaging and consulting them on needs and community initiatives. The projects carried on by KOVE derive from concerns and suggestions that older people arise, e.g., tackling the fear of crime, campaigning for a community toilet scheme or raising

awareness of road safety. Have a look at the documented actions. Maybe you change your point of view to some daily routines and comforting habits?

Next steps of IROHLA

After developing a theoretical framework for the analysis of promising interventions in the health literacy context and systematic reviews of publications from the health, private and social sectors, further steps have to be taken towards the production of evidence-based guidelines for policy and practice. The health literacy concept has to be established in European research, policy, and practice as the majority of the health literacy interventions and policy documents is still coming from North America. The IROHLA project will contribute to this vision: A list of best-practices will be compiled and an evidence-based guideline will be developed comprising the determinants of effective national or regional health literacy approaches and determinants of the organizational context for implementing interventions.

What can health psychologists learn from IROHLA?

In times of demographic change the understanding and improvement of healthy ageing and the role of technology is imperative. On the one side, health psychology can help to understand the relationship among psychological factors, behavior and physical health and thus inform interventions in the preventive or rehabilitative setting also with making use of technology. On the other side, health literacy interventions can contain more than the classical health psychology interventions. It is useful to broaden the scope of the current research and practice by including social aspects of active and healthy ageing. Moreover, the IROHLA project will have impact on policy building, introducing a comprehensive, evidence-based guideline for future health literacy research and practice which is important for translating evidence into action.

Further information on IROHLA and the reviewed interventions can be found here http://www.irohla.eu/

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Juliane Paech
Jacobs Center on Lifelong Learning and Institutional Development (JCLL), Jacobs University, Bremen, Germany
j.paech@jacobs-university.de

Sonia Lippke
Jacobs Center on Lifelong Learning and Institutional Development (JCLL), Jacobs University, Bremen, Germany
s.lippke@jacobs-university.de

original article

Living with a long term physical health condition: Psychological experiences of older lifestyle migrants

Jane Simpson
Lancaster University
Sofia Triliva
University of Crete
Carol Thomas
Lancaster University
Gerasimos Chatzidamianos
Lancaster University
Craig Murray
Lancaster University

An increasing number of people are living with at least one long term health condition or chronic illness (Ham, 2006). One concept within chronic illness research increasingly regarded as important is psychological adjustment. In this study this is understood as the result of a series of adaptations to maintain a positive view of the self and the world in the face of a health problem' (Sharpe & Curran, 2006, p. 1161). One example of when successful psychological adjustment to a long term condition faces a number of additional challenges is when it is experienced in a different social context – for example as an expatriate or migrant living in a different country from that of birth and early life.

One area of migration which is of particular interest given its increase and relative lack of research is 'lifestyle' migration (Benson & O'Reilly, 2009). This type of migration is 'the very antithesis of being economically motivated, and [is] undertaken by those who prioritise quality-of-life and aesthetic concerns over income' (King, 2002, p. 100). Many lifestyle migrants tend to be older (e.g., retirees) (Huete & Mantecon, 2011) and many relocate from northern Europe to Southern Europe which, through the search for sunnier climates, has also been referred to as 'heliotropic migration' (King, Warnes, & Williams, 2000). Although figures are difficult to determine given the lack of data on specific types of migration within Europe, it is generally accepted that lifestyle migration in older north European citizens to southern Europe is on the rise (e.g., King, 2002). Indeed, in a study looking at the number of foreign nationals in one part of Spain, the Costa Blanca, 78% of the inhabitants of one town are foreign nationals and 92% of those are from the EU. Consequently, the aim of the study was to provide an in-depth idiographic account of the psychological processes involved in the adjustment of older UK citizens with a long term physical health condition currently living in Crete, the largest of the Greek islands.

Method

Participants

Participants were 50 or over and had been born in the UK and spent a substantial part of their adult life there (see Table 1); ten participants (age range: 50-70; M = 62.3 years) were interviewed. All participants received health care on the IKA system, which is the public social security system. Many of the services covered by this system can be administered in private facilities. A large sector of people living in the country is insured under its auspices. There is recognized reciprocity with the British public insurance system and the costs incurred for procedures either within the IKA facilities or by private physicians are fully or partially reimbursed.

Procedure

The study received ethical approval from both universities involved in the research (universities of Lancaster and Crete). Participants were recruited from adverts in various fora set up for the expatriate community – newsletters, adverts in cafes etc. All

Table 1

Participant clinical and demographic details

Pseudonym	Age (years)	Long term condition/s	Time since onset of symptoms (years)	Time living in Crete (years)	Living situation	Care received in UK	Work status
Rory	60s	Musculo-skeletal, cardiovascular	15	3	Alone	GP appointments	Retired
Tina	50s	Cancer	2	8	With partner	Some surgery/chemotherapy received in UK	Part-time work
Mark	60s	Neurological disorder	3	7	With partner	None	Retired
Andrea	50s	Cancer	7	8	Alone	Surgical complications only	Retired
Thomas	70s	Neurological disorder/cancer	12	13	With partner	Neurological liaison	Involved in family business
Margaret	60s	Cancer	20	10	With partner	None	Retired
Lisa	50s	Cardiovascular / skin complaint	2	9	With partner	Outpatient consultations	Own businesses
Tricia	50s	Cancer	1	8	With partner	None	Retired
John	70s	Musculo-skeletal	20	10	With partner	None	Retired
Anne	70s	Cardiovascular, musculo-skeletal	6	20	Alone	None	Retired

participants were interviewed face to face in English by interviewers who had English as their first language. The interviews were all conducted individually - no spouses or partners were present - and ranged from 45 to 92 minutes in length (M = 68 minutes). Interviews were transcribed verbatim. Data collection occurred between April and June 2013. Interview data underwent an inductive, phenomenologically informed thematic analysis (see Braun & Clarke, 2006, for further details).

Results

Three themes were constructed from the data and are detailed below.

1. Reasons for migration inform coping strategies and adjustment

Participants had made the active decision to move to Crete for a number of 'pull' reasons –for example, the warmer weather, the physical beauty of the island, and the perceived characteristics of Cretans (friendly, direct, having more traditional family

values, more informal, less hierarchical). For most participants, these 'pull' factors helped efforts to cope and manage their illness.

> *"I mean I've come to the terms with the fact that, unless somebody comes up with bloody miracle cure in the next few years, I'm just gonna get worse, so make hay while the bloody sun shines and to hell with it." (Mark)*

In addition to the physical features of the environment, the perceived characteristics of Cretan people were also important in the management of the illness. Health professionals were generally described as caring, efficient, "saintly" (Mark) and "brilliant" (Andrea). They were also, however, seen by the participants as being direct and not concerned with adhering to the rules when more flexible options might be better for the patient – in other words more patient-centric than rule-based in their care decisions. Indeed this reflected another common perception of Cretan society ('and there's a sense of we only obey the rules that make sense': Mark). For example, John, who as part of an operation had another procedure performed which he had not explicitly given consent for (but which had helped his condition), said:

> *"You know, when you ask them why they did something, they tell you why they did it, because it was better or… like, say, with this ankle, they'd chopped the small bone in my leg here, chopped it off here and did it there but didn't ask me or tell me, they just did it."*

There is certainly 'continuity' in comparing the 'pull' factors behind migration with the coping strategies used by participants to manage their illness and this raises issues about the relevance of Bury's (1982) work in this particular context. For example, Bury's emphasis on chronic illness as 'biographical disruption' has been supported as a concept in many studies, although not without its critics (see Williams, 2000). However, maybe its opposite, biographical continuity is more relevant here as participants in this study were determined not to let the advent or previous existence of a chronic illness impact in any meaningful way on their chosen lifestyle (Carricaburu & Pierret, 1995).

2. Differences in health care provision positively contributed to psychological adjustment.

All participants agreed that there were differences in the provision of health care between the UK and Greece but many of the experiences reported were positive, e.g., shorter waiting times. However, other examples of the differences cited were less obviously positive and, consequently, the psychological reaction to them more complex. One example cited by all participants was the difference in nursing care. In Greece, nurses were considered less visible on the wards and did not carry out personal care. However, this difference was usually commented on positively in that nurses were given a higher status and described as 'technicians' or 'mini-doctors'. Where nursing care was appraised negatively ('appalling', 'non-existent'), it was also described as not needed by those participants, so did not impact on their more global (and mostly positive) impression of the quality of health care they had received.

Another example of a difference which could have been more negatively appraised was the need for health care in Greece to be directed more by the individual (or their close family) as opposed to the health care system. However, this was mainly seen as a positive and a benefit psychologically. The participants stated that they find the control they need to take in order to get treatment for their medical problems contributes to a proactive stance and empowers them. The fact that they literally carry their medical records from one service provider to another and that they take specimens or test results from one specialist to another impacts the level of control they possess and makes them feel in charge of their lives and their illness. This aspect of the system which may be thought at negative in that it does not

buffer the patient from the stress of running about was paradoxically viewed and experienced as providing the participants with a push to taking an active or proactive stance and pushing them to engage actively, as one participant stated:

> *"… maybe you do have to fight more if you're somewhere like this where you're not in that, you're not cushioned by that system…… maybe that is a good thing because maybe that makes you a little bit more positive about stuff, that you've got to go forward and you can't just relax back into it."*

Clearly the need to find a positive angle on the more unusual health experiences could be seen as an example of 'benefit finding', the psychological need to find positives from traumatic experiences (Tennen & Affleck, 2002) and which has been argued to reduce anxiety (Tomich & Helgeson, 2004). Tedeschi and Calhoun (2004) also argue that benefit finding is more likely with people with particular personality characteristics such as hardiness and optimism and these have been argued to typify lifestyle migrants (e.g., Warnes, King, Williams, & Patterson, 1999). For some participants, their insistence on the positives was difficult to accept uncritically as highlighted by contradictions in their accounts. For example, Margaret was very complimentary about her surgeon and described her surgery scars as 'fabulous'; however, she also later on in the interview talked about how her operation had left her 'mutilated'. It seems that the need to maintain a positive outlook is supported by a number of psychological processes which reduce any dissonance between conflicting cognitions (e.g., Festinger, 1957).

3. Health care decisions as a reflection of commitment to integration

Participants differed as to whether they received all their health care in Crete or had received some in Crete and some in the UK (e.g., one participant had had the operation in the UK but chemotherapy in Crete). However, all participants expressed either their 'trust' or 'total confidence' in the Greek health care system and did not appreciate negative comments from friends and family in the UK. Decisions about where to have their health care reflected participants' commitment to their integration with their host nation and society to which they had chosen to immigrate. For John, despite the fact that aspects of his health care had been problematic, and even objectively potentially traumatising, he was completely positive about his experiences. This seemed tied up with his take on the need for integration:

> *"there's some Brits in that taverna and some [Greeks] in that taverna, in that like it happens in our village. I come along, I'll sit with the [Greeks] initially to have a cup of coffee, have a cup of coffee, and you see Brits, they'll come along, they won't go there... And that's what they are, you know… they alienate themselves, you know, which is… wrong."*

He then interprets his decision not to seek health care in the UK as consistent with the need to integrate, to demonstrate his identity as an authentic and committed member of Cretan society. His illness experience had made him 'more integrated and more… yeah, more part of them, yeah. More part of the local society… yeah'.

In general the participants – none of whom considered themselves fluent in Greek - did not view their lack of command of Greek as problematic in navigating the health care system or as contributing negatively to their health care experience. Most commented how they managed using a mixture of Greek and English or emphasised that the doctors tended to speak English well. Indeed it is more likely that the fact that lack of language was not problematic bolstered their feelings of control and confidence in their own coping abilities but also reflected their trust in the health care system. For example, Margaret signed her surgical consent form (written in Greek) even though she could not

understand it.

The social psychological concept of ‘ingroup-outgroup’ categorisation is particularly relevant here (Social Identity Theory: Tajfel, 1982). This concept refers to the differences in behaviours and attitudes which are attributed to the preferred group (the ingroup) and the non-preferred or actively disliked (the outgroup). All participants in this study identified themselves with their local Cretan community. Some additionally also identified with a specific type of expatriate; this was one who wanted to integrate and was not just a ‘Brit abroad’ (cf. O'Reilly, 2000, for different motivations in UK lifestyle migrants to Southern Spain). Consequently for this latter group, their group norms reflected those of both ingroups - e.g., directness, care and a willingness to ‘say what needs to be said’ from the Cretan ingroup and a non-complaining, positive regard for their new way of life in Crete from the expat ingroup. The adoption of an outlook which closely conforms to the norms of a favoured group (or. in this study, favoured groups) has been argued to be one way of reducing stress (Kruglanski, 2004). It is also likely that dealing with the uncertainties and vagaries of a new healthcare system is made easier by a psychological process which has a net effect of reducing uncertainty and doubt.

Conclusion

This study has been the first to describe the psychological processes involved in older UK lifestyle migrants’ successful adaption to living with a long term health condition. Understandings from such research endeavours can be useful for healthcare practitioners working with lifestyle migrants or in medical tourism settings.

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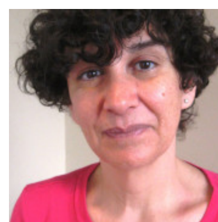
Jane Simpson
Education Division of Health Research Faculty of Health & Medicine, Lancaster University, Bailrigg, Lancaster, United Kingdom
j.simpson2@lancaster.ac.uk



Sofia Triliva
Department of Psychology, University of Crete, Rethymno, Crete, Greece
triliva@uoc.gr

Carol Thomas

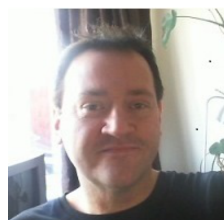
Centre for Disability Research (CeDR), Centre for Gender and Women's Studies, Health Research, Centre for Ageing Research, International Observatory on End of Life Care, Lancaster University, Lancaster, United Kingdom

cedr@lancaster.ac.uk

Gerasimos Chatzidamianos

Spectrum Centre, Lancaster University, Lancaster, United Kingdom

g.chatzidamianos@lancaster.ac.uk



Craig Murray

Department of Health Research, Lancaster University, Lancaster, United Kingdom

c.murray@lancaster.ac.uk

original article

Is healthy ageing for all? The role of positive views on ageing in preparing for a healthy old age in a precarious context

Catrinel Craciun
Babes Bolyai University
Jacobs University Bremen
Paul Gellert
Charité – Universitätsmedizin Berlin
Uwe Flick
Freie Universität Berlin

Demographic changes during the last decades constitute a challenge for ensuring better and not just longer lives for ageing individuals. Active or positive ageing policy sets this as a goal and encourages individual and collective strategies to optimize economic, social, cultural participation over the life course (Lassen & Moreira, 2014). Hence, preparation for old age and identification of psychosocial resources for ensuring a positive old age becomes a relevant issue for both research and intervention.

Among the most cherished psychological resources that may be used in preparation for old age are positive views on aging (Levy, 2003), meaning that one perceives more gains than losses associated with ageing, invests one's future with positive meaning and continues to set goals for old age. They were shown to stimulate involvement in preventive behaviour (Levy & Myers, 2004) like physical activity (Wurm, Tesch-Römer, Tomasik, 2007) or have a direct physiological effect on health (Levy, Hausdorff, Hencke, & Wei, 2000). Since views on ageing become increasingly connected with actual experiences during adult years (Levy, 2009) it becomes relevant to know how middle-aged individuals manage their experiences and resources for shaping their positive views on aging. Moreover, these emerge in a social context, and therefore might differ depending on education or social status and indirectly lead to experiencing health inequalities in old age or even during the preparation process. For instance, it was shown that people with lower education level hold more negative views on ageing (Wurm, Berner, & Tesch-Römer, 2013). Thus, one may ask if all people can imagine a positive old age and ultimately, is positive aging possible for all?

Social inequalities were shown in previous studies to accumulate over the lifespan and result in health disparities in old age (Brandt, Deindl, & Hank, 2012). Besides low income or education, the type of profession or work one had was associated with poorer health and greater functional limitations in older adults (Corna, 2013). For instance, sociological studies pointed out the interesting situation of precarious workers, who are sometimes well-educated individuals who may also earn a good income, however with the drawback that their work contract is temporary and they lack a good pension insurance (Portacolone, 2013). Precariousness means living in "an age of uncertainty" where the State lacks resources and personal initiative for care is required (Bauman, 2007). More than missing financial resources as a low social-economic status (SES) would imply (Corna, 2013) or having a low education level, it refers to having to deal with the daily hassles of an uncertain future perspective, triggered by the instability of a temporary job or lack of retirement benefits. Thus, job and factual as well as perceived pension insecurity rather than low income or low education level itself determine bad health (Marmot & Wilkinson, 2005). Moreover, the uncertainty is said to be associated with the collapse of long-term thinking and planning and the social structures that sustain these. Thus, individuals are considered to live a fragmented life, filled with short-term projects where flexibility rather than long-term planning is required (Bauman, 2007).

Precariousness is not a phenomenon restricted to

developing countries, but affects well-developed states around the world like the USA, France or Italy (Portacolone, 2013). For instance, in Germany the rising number of mini jobs (i.e., jobs paid with 400 Euro) make saving for old age or engaging in health behaviours less probable. The prospect of poverty in old age becomes reality especially for freelancers, unemployed, or single mothers (Börsch- Supan, Gasche, & Lamla, 2013).The frequent change in career paths (i.e., part time jobs) and the increasing importance of private insurance contribute to the growing risk for poverty in old age (Schmäl, 2008). Nevertheless, perceiving positive aspects of growing old might stimulate one to identify resources to age in a good way, while negative perspectives on aging may hinder preparations as one could consider these unnecessary. Moreover, for individuals with an uncertain future perspective, imagining a positive old age and taking preparatory actions might be more difficult compared to financially secured individuals who can make plans for their retirement years. Thus, it becomes relevant to ask if precarious individuals have positive views on ageing and if so, if they are connected with preparatory actions for old age?

Methods

Data are part of a larger research project on resources for positive ageing (see Craciun & Flick, 2014). For the present contribution, we chose to report findings based on the analysis of interviews with 10 persons with a precarious background (5 men and 5 women, living in Berlin, Germany). The *episodic interviews* (Flick, 2014) were used for data collection, since it allows both an investigation of semantic knowledge (concepts such as positive aging) and episodic knowledge (i.e., in which contexts or situations people think about positive aging). The original interview guide comprised several questions on preparing for positive aging. However, for the present study we selected questions about positive views on aging (e.g., "*What does positive aging mean to you? Can you give me some examples?*"). Interviews were analysed following the principles of case specific thematic coding (Flick, 2014).

Results

We distinguished four main themes related to the positive views on ageing held by individuals living in precarious circumstances.

The wise self

For most interviewed individuals, the source of positive meaning in old age is that "*one has a lot of experiences to share*" (MW, m). However, the best way to enjoy wisdom in old age is by "*Living in the moment…children are doing it and young people also, but in old age it has another quality, because there are more stories there…it is important not to be troubled by the stories from one's past or by one's biographies, but to live in the present with all your knowledge of the world*" (MW, m). Planning too much what should happen in the future can lead to experiencing fears of not achieving it or can set unrealistic standards and thus lead to frustration.

The autonomous self

Since physical health, mental fitness, and the ability to decide independently are important qualities for the daily lives of precarious persons, they project these as desired characteristics for a positive old age "*you never know, but I wish that, no matter how old I get, I will stay independent...*" (SK, m). Being engaged in several different activities gives positive meaning to old age and keeps a person fit and healthy. Since activities convey meaning in life, one participant highlighted the relevance of engaging in activities outside work. Otherwise, once you cannot work as before, your source of meaning in life disappears: "*it is important to distance yourself from your work a bit and do other things….because if you identify with work completely than you end up with a*

feeling of meaninglessness when the work is not there anymore" (CZ, m).

Chameleon self

The chameleon self represents the ability to constantly adapt to changing circumstances: "*I invent myself every year…in my line of work (freelance translator) I am obliged to do this every year anyway…*" (AL, f). Moreover, change is perceived as something positive and the challenge is to be open to accept it as one participant expressed: "*everything can be a new beginning…I just let it surprise me…I do not have such a clear image, I do not have a plan…but it does not bother me, it is too much work to always think about it, always worry, to plan…I don't care*" (CS, m). Another participant placed the self in the social context of constant change, characteristic of modern times: "*People invent themselves and reinvent themselves, they invent their jobs, this is the requirement, this is the reality today*" (JS, m). Far from being perceived as stressful, the idea of change is seen as something desirable and an opportunity of growth and development in old age: "*I hope that I will always discover new things. You learn new things and you want to...some people think that if someone is old then they do not learn anymore from the young...*" (MW, m). Thus, the requirement of flexibility may have been incorporated in the concept of self and redefined in positive terms in order to cope with the stress of being constantly "*on the move*".

The social activist self

All interviewed individuals said that a social self is representative for positive old age. Being part of a social network, either of friends or family members is considered relevant as a source of positive meaning in old age. Mostly, interviewed middle-aged imagine living in a community apartment with friends in their old age, sharing expenses and doing activities together: "*when we are over 65 we can do things together…concerts, theatre, opera. Having fun together and when the money is not there we can help each other just like in a family*" (MS, f). "*I imagine myself living with friends in a shared apartment, because of money issues…where we can cook together, we can share our rent and survive on little money but do many beautiful things…*" (CB, f). Some mentioned spending time with their families or enjoy being grandparents: "*it is also a lot of fun to take care of such a small individual; it opens up new horizons and perspectives*" (AL, f). Being socially active protects one from loneliness in old age and provides the very meaning of being human: "*…very important are human relations, that you have a social network, it does not have to be the family…but I guess the family is still very important despite all post-modern debates. I believe it is important…we are not virtual beings, we are social beings…*" (JS, m). Being part of a social network links one with younger generations and access to culture and new ideas: "*my image of positive aging would be that I walk slowly through Berlin with a walking stick but not a walker frame, no a beautiful walking stick and that I go in the evening to the concert at the philharmonic where also many young people go...take part in cultural life, if I could not do that it would be very sad...*" (MW, m).

Discussion

This paper aimed at providing a better understanding of positive views on aging in an emerging precarious context (i.e., Lack of a secure job or pension plan combined with a perceived insecure future). Findings show that individuals in precarious circumstances tend to value wisdom and autonomy, lending support to previous studies on positive views on ageing (Jolanki, 2009; Yang, 2013). However, for these individuals, wisdom is mainly defined as "*living in the moment with all your acquired knowledge*". They place emphasis on adaptability and flexibility more than on stability and long term planning, proving they have adjusted to their precarious living conditions. Even if the future does not take the form

of clear stages and transitions, interviewed precarious persons perceive a future for their old age and invest it with positive meanings. They aim to remain autonomous and make plans on how to achieve this in their old age, thus confirming the existence of positive views on ageing, as defined in previous literature (Wurm et al., 2007). The emerging positive view on ageing in precarious circumstances shares a number of similarities with the positive views on ageing as previously defined (Wurm et al., 2007). The wisdom and autonomy components match the development aspect of positive views on ageing. The desire for autonomy corresponds to a prevention of physical losses that might directly interfere with independence, while the social activist implies the prevention of social losses. The difference lies in the emphasis placed on flexibility, namely the flexible adjustment to situations, and less on long-term planning and future directed thinking, which are important components of the positive view on ageing as described before. Planning and long-term thinking may characterize the positive views of people with secure pension plans as shown by Craciun and Flick (2014). Moreover, positive views on ageing of precarious individuals comprise concrete preparatory actions such as social engagement, but less for health behaviours such as physical activity (Klusmann, Evers, Schwarzer, & Heuser, 2012) which may affect their health and functionality in old age.

Conclusions and practical implications

The study raised the issue of investigating precariousness in addition to only looking at the SES of persons, when exploring their views on ageing. It sought to stimulate further thought regarding how to plan behaviour change interventions for individuals ageing in precarious circumstances, who may value flexibility over structured planning and social activities over engagement in health behaviours. For individuals who are in a precarious situation, a positive view on ageing might mean social engagement and flexibility in dealing with choices rather than the ability to set goals and make plans to engage in health behaviours, as described in previous definitions of positive views on ageing. As an implication for practice, interventions that integrate goal flexibility and social engagement in promoting health behaviour might be more successful that those focusing on planning and goal setting or action control. In this sense, positive ageing is there to be achieved by all, only the positive views people hold regarding their old age differ according to their present work circumstances and pension plans. Since changing precarious circumstances may not constitute the direct target of health psychologists, the latter may focus on adjusting interventions to the positive views of ageing of precarious individuals rather than attempt to change the views of ageing that these people hold and make them more positive than they already are.

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Catrinel Craciun

Babes Bolyai University, Cluj Napoca, Romania

Jacobs University Bremen, Center of Lifelong Learning, Bremen, Germany

craciunic@zedat.fu-berlin.de, catrinelcraciun@yahoo.com

Paul Gellert
Charité – Universitätsmedizin Berlin, Institute of Medical Sociology, Berlin, Germany
paul.gellert@charite.de

Uwe Flick
Department of Education and Psychology, Division Qualitative Social and Education Research, Freie Universität Berlin, Berlin, Germany
uwe.flick@fu-berlin.de

original article

You cannot spend the same dollar twice: A series of studies on resolving goal conflicts

Martin J. Tomasik
University of Zurich
Alexandra M. Freund
University of Zurich

Most of us pursue multiple goals in different domains of life at the same time. Some of these goals can have facilitative associations with each other, either because of instrumental goal relations or because of overlapping goal attainment strategies (Riediger, Freund, & Baltes, 2005). For instance, the goal of earning more money is probably furthered by the goal of graduating in a MBA program, because an MBA degree is instrumental for earning more money. Similarly, the goal of practicing a foreign language in a conversation club is highly compatible with the goal of getting to know new people, because the strategies of attaining both goals overlap substantially. Previous research on goal relations has demonstrated that such facilitative relations in a person's goal system are associated with the actual engagement in goal pursuit in everyday life as well as with goal achievement (Riediger & Freund, 2004). This is an important insight, especially for researchers who develop interventions that further goal pursuit and achievement.

However, goals can also conflict with each other (Riediger, Freund, & Baltes, 2005). Conflicts between goals are mostly due to resource limitations or incompatible goal attainment strategies. Time constraints are a case in point for resource-based conflicts. For instance, the goal to learn a new music instrument and to increase one's physical fitness to the degree that one is able to run the marathon conflict with each other as time for pursuing both goals is limited. For time (similar as for money) it is true that we "cannot spend the same hour (or dollar, respectively) twice." Similarly, the goal of losing weight and winning the cheeseburger eating contest conflict with each other as the goal attainment strategies of eating less (in order to lose weight) and eating a lot (during the contest) are highly incompatible. Previous research has shown that goal conflicts affect goal engagement much less than goal facilitation does. However, goal conflicts can be a source of lower psychological well-being (Riediger, Freund, & Baltes, 2005) and more psychosomatic complaints (Freund, Knecht, & Wiese, 2014). Furthermore, the likelihood of goal attainment is lower when goals conflict with each other (Boudreaux & Ozer, 2013), presumably because people have to invest valuable resources into resolving the conflict that are thus not available for pursuing the goals.

The starting point of our current research on goal conflicts is the observation that older people usually experience more intergoal facilitation and fewer goal conflicts (Riediger, Freund, & Baltes, 2005). Why this is the case is not yet well understood and it seems that some of the "simple explanations" do not apply (see Riediger & Freund, 2008). For instance, age differences in conflict experience are not due to the fact that older adults have more time and fewer obligations to pursue their personal goals than younger adults. Age differences in the conflict experience occurred both during the week and on weekends, so that the daily constraints for working adults did not seem to play a role. Moreover, although older adults have fewer goals than younger adult do, the restriction of the number of goals was not associated with the experience of goal conflict.

Why, then, do older people experience less conflict than younger adults? We tested in a series of three studies (Freund & Tomasik, 2015; Tomasik & Freund, 2015) whether older adults manage goal conflicts by

prioritizing one conflicting goal over the other more readily than younger adults. In other words, we expected that when older people experience goal conflict, they invest more time and effort into pursuing one of the goals and, at the same time, disengage from the other. As an example let us consider person who has only time on three evenings per week to pursue the two goals of learning new musical instrument and of running the marathon. The person might either try to accomplish both goals by practicing the piano twice a week and training for the marathon once a week, but is likely to neither learn to play the piano very well nor be ever able to succeed the entire marathon distance. Instead, the person might decide to give up the goal of learning to play the piano but instead focus on the marathon by running three times a week. This form of prioritizing requires abandoning the piano learning goal in favor of the marathon goal. This should lead to experiencing less conflict and an increase in the likelihood of achieving at least one of the goals to one's satisfaction. Given that resources sharply decrease with increasing age (Baltes, Lindenberger, & Staudinger, 2006), older adults might more often follow the motto that "one can do anything but not everything" and thus be "experts" in prioritization compared to younger adults who might believe that they have sufficient resources "to do it all."

In order to test our hypothesis of age-related differences in prioritization, we developed an empirical paradigm using two comparable tasks that conflict with each other to a similar degree for younger and older participants. Furthermore, we needed to make sure that both tasks were similarly attractive for the two age groups and that both the young and the older adults perform similarly well on them. This has been a particularly crucial stage in preparing the study materials, as we wanted to exclude the possible alternative explanation that age-related differences in prioritization could be due to age-related differences in task performance. After careful pretesting, we identified two tasks that met these criteria. The one task is an *item-sorting task* where participants sort small pictures of items (e.g., animals) on a given dimension (e.g., life expectancy in the wild). This task taps into general knowledge, an area of cognition where younger and older adults perform similarly well. The other task was a *word riddle* in which participants have to descramble a scrambled sentence by swapping letters between words. This task taps into verbal abilities, which again is a cognitive domain that shows few if any age-related differences.

We induced a conflict between these two tasks by asking participants to solve both of them within a limited period of time (4 minutes) that is not sufficient for most of the participants. Participants were asked to solve five consecutive sets of these tasks. Between the sets, we assessed perceived task conflict and the mood of the participants.

Both studies showed that older people prioritize more by allocating more time into one task than into the other (just like the person in the example above who focuses on jogging three times a week rather than trying to accomplish learning a new musical instrument in addition). However, contrary to our expectations we did not find that prioritization was associated with experiencing less conflict. In fact, the opposite was true. Younger and older people who prioritized more also perceived more conflict between the two tasks. This finding might reflect that even when spending more time on one of the two tasks, participants might not have been able to disengage from the other but felt that they ought to have worked on both. In our example, this would be similar to the person feeling guilty and conflicted whenever she or he goes jogging for not spending any time on practicing the piano. In this sense, prioritization might in the short term come with "psychological costs."

To test this explanation, we conducted a third study (Tomasik & Freund, 2015) in which we extended the temporal scope from about one hour to five consecutive days and measured perceived conflict both concurrently and retrospectively. In other words, we did not only ask about the currently perceived

conflict when people were working on the tasks, but also asked them to judge how much conflict they had perceived the day before. With the retrospective measurement, we hoped to avoid that current frustration of not being able to solve both tasks might lead to experiencing goal conflict.

By extending the study design from five rounds to five days, we also had to adapt the tasks to be more meaningful and involving. We decided to employ a learning task in which participants were asked to collect and learn information that was presented on 40 different flash cards each day. 20 flash cards contained information on "poverty in the world" and 20 flash cards were about "healthy nutrition." These two topics are similarly interesting for both younger and older adults. Conflict was again created by limiting the amount of time that participants were allowed to study the cards. After time was over, participants took a short quiz on the topics related to "poverty in the world" and "healthy nutrition." The number of correct answers directly translated into a monetary donation for a charity related to either poverty or nutrition.

As we had expected, prioritization was again related to experiencing more conflict in the situation when participants tried to solve both tasks. However, when asked retrospectively about the conflict they had perceived on preceding day, higher prioritization was related to *less* perceived conflict. Hence, the benefits of prioritization seem to need some time to develop and people experience these benefits only from a temporal distance.

Taken together our three studies suggest the following dynamics: When people are confronted with two conflicting tasks, they prioritize more, and the more they do this, the more conflict they experience. This is true for both the young and the older adults but older people seem to be particularly good at prioritizing. Interestingly, prioritization is associated with the "psychological cost" of not being able to meet all goals, at least in the short run. However, with increasing time from the conflict situation, prioritization leads to lower perceived conflict. Given that older adults prioritize more than younger adults do, they might have an advantage in solving goal conflicts.

Although the current studies did not involve engagement and disengagement from conflicting health-related goals, one could speculate about the conclusions that can be drawn for from a health psychology perspective. First, time seems to play a crucial role in disengagement from conflicting or unattainable goals. Second, the ability to effectively solve goal conflicts – and thus to mitigate the health-related consequences that result from it – might turn out as an important developmental gain on which interventions targeting health-related behaviors in older adults could focus.

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Martin J. Tomasik

Department of Psychology, University of Zurich, Switzerland

tomasik@psychologie.uzh.ch

Alexandra M. Freund

Department of Psychology, University of Zurich, Switzerland

freund@psychologie.uzh.ch

original article

Backup plans as a motivational construct

Christopher M. Napolitano
University of Zurich
Alexandra M. Freund
University of Zurich

Imagine that you are a cardiologist consulting a patient about his high levels of cholesterol. First, you present the ideal treatment: changes in diet and exercise. However, you also offer a backup plan. "If diet and exercise don't reduce your cholesterol by your next visit," you say, "then I will prescribe statin medication."

In this example, medication represents a backup plan, which we define as an *alternative means to achieve an end that is developed, but not initially (or ever) used*. In many cases, having backup plans can be an effective approach for managing uncertainty. However, as the central premise of a new program of research that we are conducting at the University of Zurich, we posit that backup plans can change the way a person pursues a goal, even if they are not currently or even ever used. We expect that these changes occur as the result of decreased resource availability as well as changes in goal-related motivation. Returning to our example, the patient's diet change may be compromised if he knows that the prescription is forthcoming, he may "ease off" on his diet and exercise in the weeks leading to the follow-up appointment.

The central question of our research is: Do backup plans serve as a safety net supporting goal pursuit, or are they an expense that compromises goal striving? In other words: Do backup plans support or undermine self-regulation? Here, we begin by describing the theoretical underpinnings of our conceptualization of backup plans. We next describe current and future research projects that test the use and usefulness of backup plans. Finally, we conclude by summarizing and providing an outlook for the role of backup plans in the study of aging and health.

Introducing backup plans

What are backup plans and what are the processes that underlie their use? We consider backup plans to be equifinal (e.g., von Bertalanffy, 1968) means held back for potential later use to achieve ends. We posit that backup planning involves three processes: a person (1) develops a backup plan from the set of means that equifinally lead to a goal. These backup plans are then (2) reserved, or held back for potential later use. Finally, should a person's first-choice plan prove unsuitable, backup plans (3) replace Plan A. For example, an older adult has the goal of maintaining fitness. Her first-choice plan is hiking, but she develops swimming as a backup plan in case her knees become sore. She reserves the swimming backup plan and begins her hiking routine. Later, she replaces hiking with the swimming after knee discomfort.

Contingent and redundant backup plans

People develop and reserve backup plans because they may later prove useful in goal pursuit. The potential utility of backup plans can be described in two different ways - *contingency* and *redundancy*. Contingent backup plans address specific anticipated losses resulting from or pertinent to the first-choice plan. In the above example, the older adult developed a contingent backup plan: anticipating that her knees

may ache, she reserves the backup means of swimming. At first glance, contingent backup plans may resemble *implementation intentions* (e.g., Gollwitzer, 1999), which are specific goal-related behavioral responses to support means in anticipated situations. However, contingent backup plans wholly replace one's first-choice means, whereas implementation intentions are instead used to continue supporting first choice means. Because of this difference, replacing with contingent backup plans is an intentional process that may be motivationally challenging. Replacing with the above backup plan to go swimming involves allocating additional resources (e.g., buying swim goggles), and if this older adult views the swimming as inferior to hiking, she could decide to disregard the pain in her knees and continue hiking.

Not every backup plan is developed with a specific marker of when it may be beneficial to replace a first-choice plan. Redundant backup plans are instead reserved because they may later prove more useful than one's first choice plan. To compare whether a reserved redundant backup plan is more advantageous than a one's first-choice plan, we argue that redundant backup plans remain activated to various degrees. This activation can distract resources from a first-choice plan, and implies that reserved redundant backup plans can expend one's resources even if they are not being used. Thus, similar to situations where a person is concurrently using multiple means (Kruglanski, Pierro, & Sheveland, 2011), reserving redundant backup plans can decrease one's commitment to the first-choice plan, and invite unnecessary, distracting, and even demotivating deliberations about which means to use. For an example of a redundant backup plan, imagine wanting to take a perfect sunset photograph. Your first-choice plan involves using a zoom lens, but you pack backup lenses in case they might prove better for the conditions. Carrying the additional lenses (reserving) slows your walk to the vantage point, and deliberating about which lens best suits the photograph (replacing) could result in you missing the perfect moment entirely.

Understanding the use and usefulness of backup plans: The role of simplicity costs

We posit that in order to understand whether backup plans support or impair goal pursuit, one must compare costs and benefits of pursuing a goal with a backup plan against the nested option of pursuing the same goal with the first-choice plan alone. In other words, do the *potential* benefits of having a backup plan (e.g., being able to efficiently replace a first-choice means) outweigh the *certain* costs of developing, reserving, and replacing with it? We term the difference between the benefit/cost ratio of a single-means approach and the benefit/cost ratio of a backup plan *simplicity* costs. In contrast to opportunity costs, which refer to the value of opportunities forgone after the selection of an alternative goal, simplicity costs are the value lost by forgoing the simplicity of pursuing the goal with a single means.

Simplicity costs change across the course of goal pursuit. For example, the benefits of increased confidence for achieving the goal at its onset ("I'll definitely get this photo because I have all my lenses") might outweigh the costs of developing a backup plan (i.e., packing the lenses). However, later in the goal pursuit, this calculus can shift. Goal achievement may be impaired when deliberating whether or not to take a backup plan out of reserve and use it to replace a first-choice plan. In addition, replacing with a backup plan may be aversive, akin to admitting failure of the first-choice plan.

Changes in simplicity costs across goal pursuit underlie the use and utility of backup plans. We hypothesize that people decide to develop backup plans using a heuristic involving projected simplicity costs. Broadly consistent with expectancy-value models (e.g., Eccles & Wigfield, 2002), we expect that

people tend to develop backup plans if their *projected simplicity costs at the end of the goal pursuit* are within their subjectively-defined acceptable threshold of decreased efficiency for increased likelihood of success. In other words, people make backup plans when they anticipate that the value of their additional investments will "be worth it in the end."

Using this heuristic can be problematic because people may overlook the simplicity costs incurred during the reserving and replacing processes. For example, our hapless photographer did not account for the delays incurred from carrying a lens-filled bag, nor did he account for the time spent deliberating whether or not to replace with his backup lenses. Given these often-overlooked costs, we hypothesize that a person's approach to regulating simplicity costs is key for understanding variations in the usefulness of backup plans. On the one hand, accepting too few simplicity costs may result in ineffective backup plans that provide little support in the case of a first-choice plans' shortcomings. On the other hand, allowing simplicity costs to escalate can undermine the motivation to pursue a goal, or exhaust the resources required to achieve a goal.

Current and future research involving backup plans

We are currently testing our hypotheses regarding the use and usefulness of backup plans across several studies. Here we briefly describe an ongoing study that tests our hypothesis regarding the basic processes underlying backup plans (the "ball-throwing" study), as well as a soon-to-be-launched study that tests the effect of reserved backup plans on the motivation to pursue physical fitness goals (the "exercise study"). The central premise for these studies, as well as our research program in general, is that backup plans can change the way a person pursues a goal, even if they are not currently or even ever used.

In the ongoing ball-throwing study, we ask participants to throw balls underhanded into a trashcan from a seated position three meters away. There are two conditions. In the control condition, participants only throw ping-pong balls. Participants in the control condition have five practice throws, and then ten "official" throws. In the experimental condition, participants have access to ping-pong *and* tennis balls and decide how many of each ball they throw for the five practice throws, but most begin the "official" throws using ping-pong balls. They may switch balls at any time. For these participants, the tennis balls represent the backup plan. Our hypothesis is that participants in the control condition will have the highest average score, and that participants in the experimental condition will have the lowest average score, given the additional simplicity costs they accrue during the developing (not practicing ping-pong throws enough), reserving (deliberating about which ball is best) and replacing (recalibrating for the heavier tennis ball) processes. We also predict that the average score of the participants in the experimental condition who do not replace with tennis balls should fall somewhere in between these two poles, reflecting the effect of purely psychological simplicity costs.

In the upcoming exercise study, we again have two conditions. Participants in the control condition are provided a YouTube link to a single aerobic workout video, calibrated to their age, and instructed to workout to this video every day for one week. Experimental participants are given the option of three videos, and can "develop" backup plans by watching short clips of each video. In the experimental condition, we instruct participants that if they wish to switch to a backup video, they may only do so after the fourth day of the study. We hypothesize that the participants in the control condition will average a higher number of days exercised. In contrast, we expect participants in the experimental condition to work out less, especially in the days leading up to the fourth day, consistent with the motivational challenges that backup plans can

introduce, as described in our first example of the patient with high cholesterol.

Summary and Outlook

Backup plans are not currently described by existing motivational theories, despite their being a potentially-commonplace self-regulatory approach for managing uncertainty. Promoting efficient backup planning may be particularly important for older adults in the years to come, because as the life expectancy increases across much of the world, older adults may be tasked with self-regulating greater shares of their development (Wrosch & Freund, 2001). Research on aging and health could focus on the role of backup plans for retirement planning, physical fitness, medical messaging, medication compliance, and other related issues.

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Note

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Christopher M. Napolitano

Department of Psychology, University of Zurich, Switzerland

napolitano@psychologie.uzh.ch

Alexandra M. Freund

Department of Psychology, University of Zurich, Switzerland

University Research Priority Program Dynamics of Healthy Aging, University of Zurich, Switzerland

freund@psychologie.uzh.ch

report

Paving the way for mental health and wellbeing

A New United Nations Sustainable Development Goal - The 65th Annual United Nations DPI/NGO Conference

Lisa M. Wu
Icahn School of Medicine at Mount Sinai

With the forthcoming establishment of new UN sustainable development goals for 2015, themes of the 65th Annual UN DPI/NGO conference (held from 27-29 August, 2014 in New York) paved the way for dialogue regarding issues that included sustainable management of our natural resources, climate change, human rights, and mental health and wellbeing. Though many of the UN's goals may seem, on the surface to be cursory to the goals of psychologists in research and practice, the UN's recent conference brought to the fore the relevance of our field to the salient and urgent goals affecting our planet. Indeed, as was frequently reported in workshop sessions, the World Health Organization (WHO) has indicated that depression will be the leading global disease by 2030; an alarming prediction that highlights the need for psychologists' involvement in achieving UN objectives. For the first time, the promotion of mental health and wellbeing will be included in the UN's sustainable development agenda for 2015 to 2030.

The numerous workshops and symposia illustrated the diversity of issues as well as the interconnected nature of the challenges affecting us. One workshop that was led by psychologists was entitled, "Promoting mental health and wellbeing for youth in the new post-2015 sustainable development agenda: Psychological principles, science and practices" (sponsored by the International Association of Applied Psychology, the World Council for Psychotherapy, the Psychology Coalition of NGOs at the UN, and the Manhattan Multicultural Counseling Center). Dr. Judy Kuriansky, clinical psychologist and chair of the Psychology Coalition of NGOs, spoke at length about the escalating stresses and mental health problems facing youth today, including the aforementioned alarming statistic by the WHO regarding depression. She alerted the audience to the fact that a billion young people in the world have mental health problems with only about 20% of them getting the help that they need. Importantly, she emphasized that the world cannot be sustainable unless people's wellbeing is also embraced. It has only been through Drs. Kuriansky and Caleb Otto's (Ambassador to Palau) advocacy that mental health and wellbeing is now included in the UN's sustainable development agenda. Ambassadors the world over, from New Zealand to Costa Rica to the Philippines, have endorsed this need for governments and policy makers to take this goal seriously, emphasizing its direct impact on economic development.

The terrible plight of youth in refugee camps was hailed as an example of a vulnerable group prone to mental health problems. Maria Pia Belloni and Amber Eriksson of Organisation Mondial pour l'Education Prescolaire (OMEP) presented on their work with refugee children. They described a disheartening statistic – every 4 seconds someone in the world is forced to flee their home, many of them children, and often due to war. Such children may be forced to move from their home into a tent, their playground becoming the desert of a refugee camp. Such refugee camps include Za'atari Refugee Camp in Jordan (housing 150,000 refugees) and one of the largest in Dadaab in Kenya (housing 500,000 refugees). In the Dadaab camp, 51% are female and 58% are younger than 18 years of age. These camps save lives in the emergency phase, but extended residence can lead to extremes of behavior in children. Trapped in a "legal limbo," such camps deprive them of the "right to have rights" despite the presence of international

humanitarian actors and entitlements enshrined in international law. Both pre-migration and post-migration stressors severely affect the mental health of children. Often these children have witnessed unspeakable atrocities. They have seen their homes bombed, they have witnessed members of their family or friends killed, and/or they have been brought close to death during their journey to the camp (e.g., the boat people who travel to Australia). Even during their time in the camps, these children may be plagued by feelings of sadness and isolation behind the bars. On Christmas Island, children's drawings often feature bars and locks. Belloni emphasized the importance of education in emergency situations due to its ability to provide psychological, physical, emotional, and cognitive protection. Unfortunately, a majority of children in refugee camps are not enrolled in school. And, when such schools exist, there may be 80 to 100 students per teacher, often poorly trained. Sometimes the classroom may literally exist under a tree. There are a million children under 6 years old living in refugee camps who are deprived of the opportunity to develop their potential – a situation intolerable from humanitarian, human rights, and sustainability perspectives. Erikkson explained that although children are extremely resilient – indeed some take on the role of caregiver for prolonged periods – the harsh conditions that bring them to the camps and camp life itself can lead children to deal with what she termed a "complex compound trauma." She described imaging studies that have shown that early exposure to traumatic events can change brain structure in children as young as 3 to 6 months of age, and these brain changes are associated with cognitive deficits. Hence, she emphasized that even if a child cannot communicate their grief, it does not mean they do not experience it. Psychosocial health is as important as physical health. Without early intervention and treatment, these children may experience personality and behavioral disorders that persist into adulthood. The OMEP is endeavoring to train people to go into the camps to provide age-appropriate support to these children. They also hope to train people in these communities, perhaps via Skype or video chat, in order to provide them with the tools to help their own.

The importance of youth was also emphasized in the Right to Not be Left Behind symposium. Ahmad Alhendawi, the UN Secretary General's envoy on youth highlighted that youth engagement in politics is exceedingly small with fewer than 1% of MPs in the world under the age of 30. The youth don't have a voice, yet they are the demographic most likely to be affected by climate change. During my conversations with other conference attendees in the UN cafeteria, I learned that climate change is a likely stress not just on our physical environment, but on the physical and mental well-being of our communities. And yet, the interdependence of our world requires us to educate our youth so that global changes can occur in the future. Courtney White representing the NGO Committee on Education brought this issue to the fore. She talked about the importance of climate change and intergenerational solutions. Different bioregions of the world experience climate change differently. That is, climate change is not going to affect everyone everywhere. Hence, White explained that how we work with youth has to be differentiated. She described a constructive approach that links climate change to everyday emotions and concerns, such as through the use of a new app called "Habitat the game." In this app, youth become engaged in real world behaviors over which they have self-efficacy and that enhance their understanding of how their lives impact the environment. Apps like these highlight the small changes in behavior that make a difference and help youth to process the negative experiences of other youth around the world.

A second psychology-focused workshop was entitled "Global mental health crisis and a replicable, sustainable intervention," presented by the team from the Institute for Multicultural Counseling and Education Services (IMCES) and the International Council of Psychologists. The aim of the workshop was to present their cross-cultural research as well as the

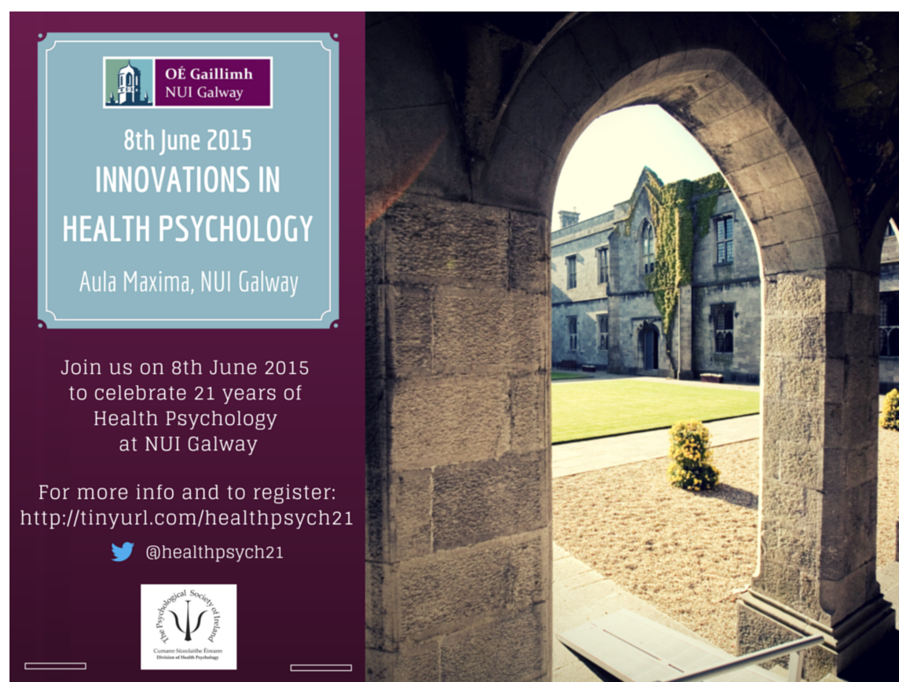
development of an intervention that could be transferred to different culturally-diverse communities. Their research has primarily focused on investigating depression around the world by identifying the concept of depression in different communities and the best practices to treat it. Dr. Tara Pir, founder and director of the IMCES stated that there is a "need to support interventions that are not necessarily "evidence-based practices," but have worked in different communities outside the Western world." Dr. Marc Borkheim of the IMCES argued that it is "impossible to replicate unique socio-cultural factors of the population of any given mental health clinic in sampling methodologies." He described the importance of understanding the mental health needs of a particular clinic population through performance evaluation studies. The IMCES team presented some of the findings from their work across the world. One notable study involved the development of the Cultural Stigma Survey by Dr. Pir for research and engagement to bridge direct service and research. Dr. Katrin Malakuti indicated that stigma associated with going to psychotherapy can often be more destructive than mental illness itself. Their goal is to understand the basis of psychotherapy, as well as the desire for a "quick fix."

Dr. Pir went on to discuss their "Wraparound Program" which is a community-based program that addresses high risk families on multiple levels using a holistic approach that works with the family as a whole, in their homes and natural communities. She described the program as sustainable, because the act of going in to the communities and using members of that community to assist families toward health and wellness is replicable and culturally sensitive. Such principles can be taken to any community in the world.

Consistent with the theme of working with diverse communities, in the aforementioned "Right to not be left behind" symposium, Ignacio Saiz, Executive Director for the Center for Economic and Social Rights, talked about the UN's Millenium Declaration that reiterated its focus on human rights for women, minorities and disadvantaged groups. Apparently the goals and targets set in 2001 fell short. The aim of the new sustainable development goals has been to remedy those short falls. From reproductive rights to the rights of the disabled to the rights to have access to justice to women's rights; numerous speakers spoke about the work that was still needed to ensure human rights are not compromised. It is evident that much work needs to be done and that psychologists have an important role to play, particularly with groups who are most vulnerable to being "left behind."

As health psychologists, we understand the impact of external factors on physical and psychological health and wellbeing. Thus, despite the diversity of issues present in the UN's sustainable development goals, the relevance of our discipline to obtaining these goals is only growing. The conference highlighted for me new avenues for involvement by our professional community to improve lives on a global scale.

Lisa M. Wu
Division of Cancer Prevention and Control, Department of Oncological Sciences, Icahn School of Medicine at Mount Sinai, New York, NY, USA
lisa.wu@mssm.edu



Innovations in Health Psychology: Celebrating 21 years of Health Psychology
National University of Ireland, Galway
8th June 2015

In 2015, NUI Galway's MSc in Health Psychology programme (founded in 1994) celebrates its 21st birthday. Inrecognition of this achievement, the School of Psychology at NUI Galway and the Psychological Society of Ireland Division of Health Psychology invite past graduates, researchers, practitioners and policy makers to a daylong celebration of Innovations in Health Psychology in Ireland.

The event will:

- Showcase existing work by Health Psychologists, nationally and internationally
- Promote discussion on advancing the role of Health Psychology in health related practice, policy and research
- Provide a collegial setting for graduates of our programmes and a broader community to come together and discuss the future of Health Psychology in Ireland

Attendance is FREE but you must register at: Conference website. Spaces at the event are limited, so early registration is strongly recommended.

Deadline for registration: 27th May

If you would like to present your work as a poster at the event, under the theme of 'Innovations in Health Psychology', you can submit an abstract at: Abstract submission website.

Deadline for abstract submission: 20th April.

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