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Special Issue on Health Psychology Practice in Europe

367 Anne Marie Plass, Ewa Gruszczynska, Sven Ingmar Andersson & Angelos P Kassianos
Health Psychology Practice in Europe and other countries represented in EHPS: A first step to Moving Forward Together

375 Jenny Mc Sharry, Angel Marie Chater, Jasminka Despot Lucanin, Stefan Höfer, Antonia Paschali & Lisa Marie Warner
Health Psychology Education and Training in Countries Represented in the EHPS

382 Kyra Hamilton, Massimo Miglioretti & Anne Marie Plass
Employability of Health Psychologists: Reflections on Career Identity and Role Perceptions

390 Nadine Berndt, Stefan Höfer, Jelena Kolesnikova & Noa Vilchinsky
Legal regulation of Health Psychology as a profession

395 Wim Nieuwenboom & Sven Ingmar Andersson
Health psychologists cooperating – challenges and opportunities

400 Angelos P. Kassianos, Ewa Gruszczynska, Sven Ingmar Andersson & Anne Marie Plass
Future directions in Health Psychology Practice in Europe and other countries represented in the EHPS: Moving Forward Together

405 Reem Talhouk, Chaza Akik, Yasmine Koukaz, Hala Ghattas, Madeline Balaam, Kyle Montague, Tom Bartindale, Kyle Montague, Tom Bartindale, Patrick Olivier & Vera Araujo-Soares
Improving the Implementation of UN Sustainable Development Goal 3: Enhancing Access to Healthcare by Syrian Refugees Through Community Health Shows

409 Sarah Goodman, Vera Araujo-Soares & Nihal Mohamed
The 10th Annual Psychology Day at the United Nations, Promoting Well-Being in the 21st Century: Psychological Contributions for Social, Economic, and Environmental Challenges

special issue

Health Psychology Practice in Europe and other countries represented in the EHPS: A first step to Moving Forward Together

Anne Marie Plass
University Medical Center Göttingen, Germany
Ewa Gruszczynska
University of Social Sciences and Humanities, Poland
Sven Ingmar Andersson
Lund University, Sweden
Angelos P Kassianos
University College London, UK

Since 1978, Health Psychology has officially been established as a field within psychology, as Division 38 within the American Psychological Society (APA) (Schwarzer & Gutiérrez-Doña, 2000). Since then, this specialist field in psychology has flourished, with many more professional Health Psychology organisations (e.g., The British Psychological Society Division of Health Psychology, the Australian Psychological Society College of Health Psychologists, the European Health Psychology Society), peer reviewed journals (e.g, Health Psychology Review, Health Psychology, Journal of Health Psychology), Health Psychology training programs and Health Psychology departments in medical schools or at universities. As such, Health Psychology has met the necessary conditions to gain recognition as an independent specialist field within psychology (Matarazzo, 1987). Yet, the exact disciplinary boundaries that define Health Psychology, and the roles and identities held by Health Psychologists in the different settings, remain unclear (Thielke, Thompson, & Stuart, 2011).

One of the first to define Health Psychology was Matarazzo (1987), who defined Health Psychology as "an aggregate field in psychology, involving educational, scientific, and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, and the identification of etiologic and diagnostic correlates of health, illness, and related dysfunction." (Matarazzo, 1980, p.815). Since then, there are many works describing this specialist field of psychology (e.g., Cohen, McChargue, & Collins, 2003; Johnston, 1994; Matarazzo, 1980; Michie & Abraham, 2004; Morrison & Bennett, 2016; Ogden, 2007; Taylor, 1990). Yet, a global consensus on what Health Psychology practice is, and who Health Psychologists are, as well as internationally recognised standards, is lacking. This lacking of global consensus is mirrored by Health Psychologists working in a wide variety of settings: alongside (other) healthcare professionals, in hospitals, clinics, public health departments, etc. on a small-scale basis working with individual patients or on large-scale behavior change and health promotion programs. Consequently, there is much variation in how teaching and training in Health Psychology is delivered (Byrne, Gethin & Swanson, 2017). This might result in a variation in competencies, hindering (future) global mobility and employability of Health Psychologists and the exchange of expertise and knowledge on an international level. Moreover, in being a specialised and unique field of psychology, it would be helpful to develop a framework of standardized Health Psychology skills and competencies (e.g. see Crossier & Parveva, 2013, regarding the Bologna Process). Such standardisation would contribute to promoting the international recognition of Health Psychology curricula within Europe and beyond, warranting the unique identity of Health Psychology, improving global mobility of Health

Psychologists, securing its 'unique selling point', and increasing visibility of the profession.

Health Psychology is a very broad and diverse field, sharing fuzzy borders with several other fields (Freedland, 2017). Health Psychology overlaps with clinical psychology, medical psychology, and behavioral medicine, and can be divided in the following four subdomains: clinical health psychology, public health psychology, community health psychology, and critical health psychology (Thielke et al., 2011), see box 1.1. The difference between Health Psychology and Behavioral Medicine might be the most blurred. Behavioral Medicine, historically based on learning theory, has become a broad interdisciplinary collaborative effort to study all kinds of health- and illness related phenomena (Schwarzer & Gutiérrez-Doña, 2000). Schwarzer and Gutiérrez-Doña (2000) argued that the major difference between Behavioral Medicine and Health Psychology is that the former is interdisciplinary, whereas the latter is a field within psychology. Following this, French, Vedara, Kaptein and Weinman (2010), distinguish between Health Psychology and Behavioral Medicine, by locating Health Psychology in the field of psychology, and Behavioural Medicine in the field of the medical sciences. However, in a recent editorial of Health Psychology, the official journal of the Society for Health Psychology of the American Psychological Association, the new Editor-in-Chief, Kenneth E. Freedland defined Health Psychology as a part of Behavioral Medicine, which in turn is a part of medicine and public health sciences and services, rather than a part of psychology (Freedland, 2017). Although both Behavioral Medicine and Health Psychology have in common that they mainly focus on physical health (French et al., 2010), the medical profession still largely adheres to the biomedical model, whereas Health Psychologists take a biopsychosocial approach, that regards health and illness as resulting from an interplay of biological processes, psychological, behavioral, and social processes (Schwarzer & Gutiérrez-Doña, 2000). This raises the question as to whether the EHPS-member countries agree to defining Health Psychology as being part of medicine rather than a specialist field of psychology consistent with its long tradition (Johnston, 1994; Ogden, 2007 Weinman, 1990), and urges the need for a European consensus about what Health Psychology is.

This leads to wondering what the definition of Health Psychology is across Europe, and other countries represented in the EHPS. In addition, Byrne and colleagues (2017) have encouraged the EHPS to take the lead in promoting a more coordinated approach and standardized international regulation of Health Psychology at a European and international level. This is especially of importance to guiding training and careers, and improving the further building of Health Psychology at an international level. As a starting point to further enabling this, this special issue of the European Health Psychologist (EHP) will present an overview of the status of Health Psychology in the countries respresented in the EHPS with regard to: Health Psychology education, Health Psychology as an applied profession, legislation around Health Psychology and cooperation of Health Psychologists with other professionals.

The articles contained within this special issue are informed by a short online survey that collected information on Health Psychology education, legislation with regard to Health Psychology, the profession of Health Psychology, and cooperation of Health Psychologists with other professionals. The online survey was sent to the National Delegates (NDs) of the EHPS (for survey questions, see box 1.2). The EHPS National Delegates are the national representatives in EHPS member countries that have ten or more EHPS members. Of the 29 NDs that opened the link to the survey, 27 responded. The topics addressed were regarded the most important issues in

Clinical health psychology is the application of scientific knowledge, derived from the field of health psychology, to clinical questions that may arise across the spectrum of health care. Clinical Health Psychology is one of many specialty practice areas for clinical psychologists. It is also a major contributor to the prevention-focused field of *behavioral health* and the treatment-oriented field of *behavioral medicine*. Clinical practice includes education, the techniques of *behavior change*, and *psychotherapy*. In some countries, a clinical health psychologist, with additional training, can become a *medical psychologist*, thereby, obtain prescription privileges.

Public health psychology is population oriented. A major aim of PHP is to investigate potential causal links between psychosocial factors and health at the population level. Public health psychologists present research results to educators, policy makers, and health care providers in order to promote better public health. PHP is allied to other public health disciplines including *epidemiology, nutrition, genetics, and biostatistics*. Some Public Health Psychology interventions are targeted toward at-risk population groups (e.g., undereducated, single pregnant women who smoke) and not the population as a whole (e.g., all pregnant women).

Community health psychology investigates community factors that contribute to the health and well-being of individuals who live in communities. Community Health Psychology also develops community-level interventions that are designed to combat disease and promote physical and mental health. The community often serves as the level of analysis, and is frequently sought as a partner in health-related interventions.

Critical health psychology is concerned with the distribution of power and the impact of power differentials on health experience and behavior, health care systems, and health policy. Critical Health Psychology prioritizes social justice and the universal right to health for people of all races, genders, ages, and socioeconomic positions. A major concern is health inequalities. The critical health psychologist is an agent of change, not simply an analyst or cataloguer.

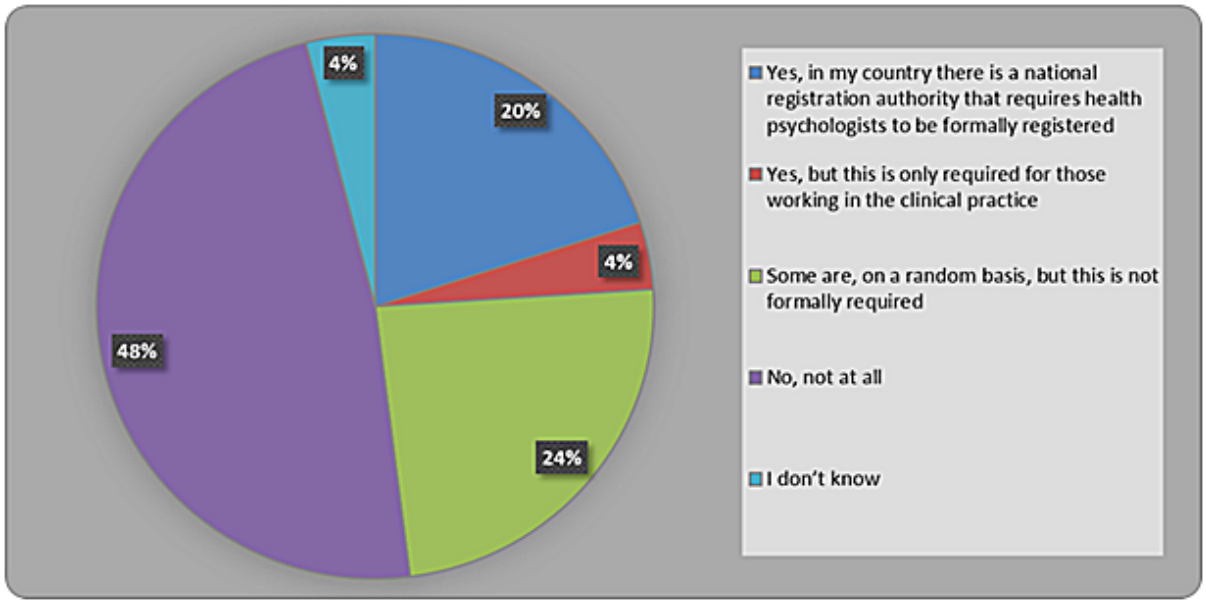
Box 1.1 Definitions of the four domains that can be identified within Health Psychology (https://en.wikipedia.org/wiki/Health_psychology)

Box 1.2 *Online Survey on the current status of Health Psychology in the EHPS-member countries*

General
How is health psychology defined in your country? Please provide the most used definition. *(open ended)*

Education	
Are there separate and full programs dedicated only to health psychology in your country at the following levels of education: 1. Undergraduate (BA/ BSc)/ 2. Masters Level (MA/ MSc)/ 3. PhD/ 4. Other programs (please provide details for other programs))? *(yes/ no)*	
How many colleges or universities in your country offer health psychology programmes? Please indicate for each level of education(Undergraduate (BA/ BSc)/ Masters Level (MA/ MSc)/ PhD/ other programs (please provide details for other programs)) both the number of colleges/universities offering such programmes and the total number of colleges/universities in your country (if known)	
Do... a. undergraduate level (BA/BSc) .. b. masters level (MA/MSc) .. c. PhD .. d. other health psychology programmes in your country include:	0. *A combination of both academic and applied training?* 1. *Solely academic training (e.g. research methods, theories, etc.)* 2. *Solely applied training/practitioner skills (e.g. communication skills, motivational interviewing etc.)* 3. *Not applicable*
Is there a requirement or need for continued education in health psychology in your country once you are qualified as a health psychologist? *(Yes/ no). Please provide details (open ended)*	
Do you see a need for the development of European-level standards for health psychology training? *(yes/ no). Justify your answer choice (open ended).*	
What needs do you perceive within your country for future health psychology education / training / continued education programs? *(open ended)*	

Box 1.2.1 *Survey questions concerning the organization of education of health psychology in the EHPS member countries*



Box 1.2.2 *Survey questions concerning legislation regarding health psychology in the EHPS member countries*

Box 1.2.3 *Survey questions concerning the profession of health psychology in the EHPS member countries*

Employability	
Is a professional title of 'health psychologist' legally protected in your country? *(yes/ no)*	
Are health psychologists being registered in your country?	0. *No, not at all* 1. *Yes, in my country there is a national registration authority that requires health psychologists to be officially registered* 2. *Some are, on a random basis, but this is not officially required* 3. *Yes, but this is only required for those working in the clinical practice* 4. *I don't know* 5. *Other, namely….*
In your country, what are the requirements to work as a health psychologist?	0. *In my country, one has to have training in health psychology in order to work as a* health psychologist; 1. *In my country, only those working in clinical practice have to have an official training in health psychology to be working as a health psychologist;* 2. *In my country, everyone can work as a health psychologist regardless their training;* 3. *Other, namely….*
Is it known where most health psychologists end up working in your country? Please rank: 1 is the highest value.	0. *They end up working in the clinical practice (hospital, primary care);* 1. *They end up working in the non-profit sector (universities, research institutions etc.); They end up working in the Industry;* 2. *They end up as being self-employed;* 3. *This is completely unknown*);
What are the main work roles that health psychologists undertake in your country? Please rank: 1 is the highest value.	0. *Clinical health psychologist;* 1. *Expert of health promotion/ disease prevention interventions;* 2. *Occupational health psychologist;* 3. *Academic/ Teacher;* 4. *Researcher.*

General
Requirements might differ between countries. Could you list below what are the mandatory requirements in your country to obtain the title of health psychologist? (Please think of education, legislation, work etc.) *(open ended)*

Cooperation with other professions	
What professions do health psychologists cooperate with in your country? More than one answer allowed.	0. *Other psychologists* 1. *Nurses* 2. *Pharmacologists* 3. *Physicians* 4. *Psychotherapists* 5. *Public healthcare workers* 6. *Social workers* 7. *Sociologists* 8. *Other, please specify…*
In which domains do health psychologists cooperate with other professions in your country? More than one answer is allowed.	0. *Research* 1. *Supervision* 2. *Teaching* 3. *Training* 4. *Other, please specify….*
What are the barriers for cooperation with other professions? Please rank: 1 is the highest values	0. *Lack of funding* 1. *Competition between professors* 2. *Different scientific approaches*
What can be done to stimulate cooperation with other professions?	0. *Changes in grant rules* 1. *Funds for interdisciplinary projects only* 2. *Rewards for cooperation* 3. *Other, please specify…*

General
Additional comments
What country are you a national delegate for?

Box 1.2.4 *Survey questions concerning the coordination of health psychologists with other professions in the EHPS member countries*

investigating the status of Health Psychology in the EHPS-member countries, following Byrne et al (2017). Two NDs did not participate leaving a final sample of 27 participants representing 27 countries (response rate = 93%). For countries represented in this study, see table 1.1. The first question in this survey was for NDs to provide the most used definition of Health Psychology in their country. Although definitions used varied widely, from no definition, to Health Psychology being exchangeable to medical psychology or clinical psychology, all NDs described Health Psychology as belonging to psychology. Further, health promotion, and disease prevention were utilized in describing the uniqueness of Health Psychology, as was the case for health behavior, and health behavior change, see figure 1.1.

To define Health Psychology more globally, and

Figure 1.1: Key issues to defining Health Psychology as mentioned by NDs

highlight its unique characteristics, more insight is needed into the educational standards, the possible legal regulations concerning Health Psychology, and to what is needed to work as a Health Psychologist in the various countries represented in the EHPS. These questions will be addressed in this special issue of the EHP on Health Psychology across Europe and Beyond: 'Who are we, and what do we do?' as a first step to moving forward together.

ANONYMUS	GERMANY	LITHUANIA	SLOVAKIA
AUSTRALIA	GREECE	LUXEMBOURG	SWEDEN
AUSTRIA	IRELAND	NETHERLANDS	SWITZERLAND
CROATIA	ISRAEL	POLAND	TURKEY
CYPRUS	ITALY	PORTUGAL	UK
CZECH REPUBLIC	JAPAN	ROMANIA	UKRAINE
FINLAND	LATVIA	RUSSIA	

Table 1.1: Countries that participated in the online survey

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Anne Marie Plass
EHPS National Delegate of the Netherlands, University Medical Center Göttingen (UMG)/ Georg-August-University, Institute of Medical Psychology and Medical Sociology, Göttingen, Germany
annemarie.plass@med.uni-goettingen.de

Ewa Gruszczynska
EHPS National Delegate of Poland, SWPS University of Social Sciences and Humanities, Department of Health Psychology, Warsaw, Poland
egruszczynska@swps.edu.pl

Sven Ingmar Andersson
EHPS National Delegate of Sweden, , Lund University, Department of Psychology Sweden
sven_ingmar.andersson@psy.lu.se

Angelos P Kassianos
EHPS National Delegate of Cyprus, University College London (UCL), Department of Applied Health Research, UK
angelos.kassianos@ucl.ac.uk

special issue

Health Psychology Education and Training in Countries Represented in the EHPS

Jenny Mc Sharry
ND for Ireland,
National University of Ireland, Ireland
Angel Marie Chater
ND for UK,
University of Bedfordshire, UK
Jasminka Despot Lucanin
ND for Croatia,
University of Zagreb, Croatia
Stefan Höfer
ND for Austria,
Medical University Innsbruck, Austria
Antonia Paschali
ND for Greece,
National & Kapodistrian University of Athens, Greece
Lisa Marie Warner
ND for Germany,
MSB Medical School Berlin, Germany

Introduction

The discussion of training, education and professional practice in Health Psychology has been gaining momentum in the European Health Psychology Society (EHPS) in recent years. At the 29th Conference of the EHPS in Cyprus in 2015, over 100 delegates attended a session to discuss education and training leading to the development of a survey completed by 24 EHPS National Delegates (NDs) to further explore this issue (Byrne et al. 2017). A roundtable discussion at the 30th Conference of the EHPS in Aberdeen Scotland in 2016 provided a forum to discuss the survey results. The findings highlighted the international variation in Health Psychology training and practice across countries represented in the EHPS.

The overall theme of this special issue is the status quo of Health Psychology, and the implementation of Health Psychology in countries represented in the EHPS. Within this theme, we aim to build on the work of Byrne et al. (2017), by discussing results of a second survey that aimed to further describe the status of Health Psychology education and training across countries represented in the EHPS. In addition, we aim to reflect on perceived needs for future development, and to provide two case examples from countries represented in the EHPS to facilitate knowledge sharing across the EHPS.

National Delegates Survey: Education Sub-theme

Five questions (4 close-ended, one open ended) addressing training and education were developed by the education sub-theme group and administered to NDs as part of the ND survey. The online survey link was opened by 29 NDs and 27 responded. All survey questions can be found in Box 1.1.

Numbers and Types of Health Psychology Programmes

NDs provided details of the separate full programmes dedicated only to Health Psychology in each country. As shown in Figure 1, NDs from 6 countries (Germany, Japan, Lithuania, Sweden, Turkey and the UK) reported that separate and full programmes dedicated only to Health Psychology were available in their country at undergraduate level (BA/BSc), representing 22% (6/27) of all included countries. Across countries, NDs reported that a total of 44 universities offer BA/BSc programmes in Health Psychology. At masters level (MA/MSc), 59% (16/27) of countries offer

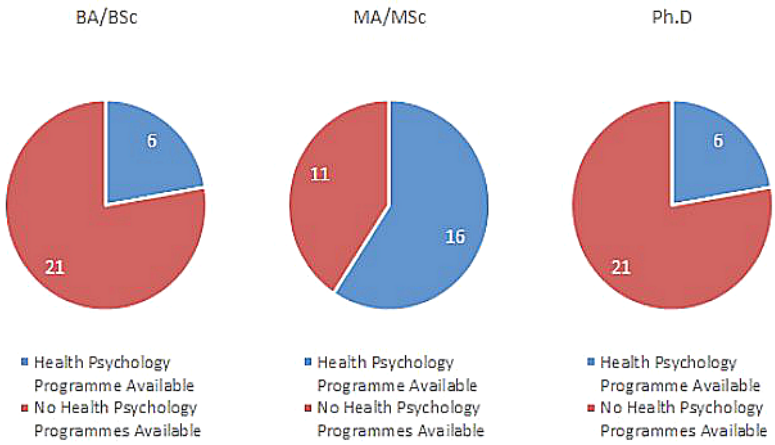

Figure 1: Countries with and without separate and full programmes dedicated to Health Psychology at BA/BSc, MA/MSc and PhD level

programmes dedicated to Health Psychology. Across these 16 countries, 87 universities offer programmes at masters level; the highest number (31) are in the UK. Finally at PhD level, 19% (6/27) of countries have at least one full PhD programme in Health Psychology. Across these six countries, 13 universities in total offer formalised Health Psychology PhD programmes. Again, the highest numbers of these are in the UK, where 7 universities offer specialized and accredited Health Psychology PhD level programmes. Across undergraduate, masters and PhD level programmes NDs reported a focus on a combination of both academic and applied training.

Alongside more formal full courses, Health Psychology was also reported to be either stand-alone post-graduate training or an independent module in undergraduate or masters level courses or as part of other programmes, for example Clinical Psychology (Cyprus) and General Psychology (Slovak Republic).

NDs also reported on the number of programmes dedicated to Health Psychology as a proportion of the total number of psychology programmes in each country. At undergrad level 43 of 599 (7%) universities offer Health Psychology programmes, at masters level 87 of 474 (18%) universities offer Health Psychology programmes and only 13 of 417 universities (3%) offer PhD programmes in Health Psychology. However, it is acknowledged that Health Psychology topics could be studied at many other universities at PhD level, without being a formal PhD/doctorate programme in Health Psychology.

Perceived Needs and Future Developments

The vast majority (26) of NDs supported the development of European-wide standards for Health Psychology training. When asked to describe specific needs for their country in free text responses, seven NDs explicitly linked training requirements to the issue of Health Psychologist certification and regulation. NDs also saw a need to improve links from training to practice and policy and for a clearer articulation of the services that Health Psychologists could provide to increase status and enhance employability. A need for further development of postgraduate programmes was reported by NDs from the countries lacking well-developed Health Psychology education at this level or lacking an applied module at the graduate

level. Additional perceived needs included continued education programs, better coordination with countries' health policies and educational policies, more international cooperation in study programme development, and potential international research exchange.

The immediate needs for education and training in Health Psychology appear to be related to the legal and professional status of Health Psychology in each country. Moreover, all respondents expressed a desire for further development of existing educational programmes and the profession of Health Psychology.

Reflecting on the Findings from the National Delegates Survey

The results of the ND survey highlight the diversity in training and education across countries represented in the EHPS, supporting the previous reports of Byrne et al (2017). However, differences reported may also be the result of differences in the interpretation of questions by NDs. As reported in the other articles included in this special issue, there is no standard definition of Health Psychology used across countries and only one country, Austria, reported the use of a legal definition (see Plass et al., 2018). This ambiguity in definitions and education systems across countries may have impacted on NDs ability to complete the survey accurately, and a number of *Don't Know* responses were received in response to the education sub-theme questions. For example when answering the question *'How many colleges or universities in your country offer health psychology programmes? Please indicate for each level of education both the number of colleges/universities offering such programmes and the total number of colleges/universities in your country (if known)'*, 17 of the 27 NDs included at least one Don't Know response.

Despite variability in terminology used and country-specific requirements, the need for further development of education in Health Psychology was perceived universally by NDs. The specific nature of this development varied, based on the existing level of education in different countries, reflecting differences in the status of Health Psychology practice and employment possibilities across countries. Differences between countries, and variability in the extent of the education and training development, suggest the possibility to better learn from each other across the EHPS.

In the following section we provide examples of case-studies from two countries represented in the EHPS with strong and well-developed training routes to provide inspiration and practical examples to other countries. Examples are provided from the UK where the greatest number of specialised Masters and PhD level programmes exist, and Austria, where there is a formal and standardised Health Psychology training programme in line with legislation.

Case Examples from Countries Represented in the EHPS

United Kingdom

Health Psychology has been established for over 30 years now in the United Kingdom (UK) (Johnston, Weinman & Chater, 2011). To train as a Health Psychologist in the UK, trainees must complete an undergraduate psychology degree (usually 3 years full-time equating to 360 UK credits/ 180 ECTS points) which offers Graduate Basis for Chartership (GBC) with the British Psychological Society (BPS), followed by a 1 year full-time (or part-time equivalent) BPS accredited MSc in Health Psychology (180 UK credits at M level/ 90 ECTS points) leading to Stage 1 Qualification in Health Psychology. Trainees then complete a period of 2 years full time (equating to 37.5/40 hours per week for 46 weeks per year or part-time equivalent) doctoral level supervised

practice in Health Psychology (Stage 2), whereby trainees must show competency in the key areas of generic professional practice, research, teaching/ training, consultancy and psychological interventions/behaviour change. Following completion of Stage 2 training, trainees are eligible to apply for full membership of the Division of Health Psychology (DHP) and Chartered Status with the BPS. This training also meets the Standards of Proficiency (SoPs) needed to register with the Health and Care Professions Council (HCPC), a legal requirement to be able to practice and legally use the term 'Health Psychologist' in the UK. Stage 2 can be achieved through either a university route (Doctorate in Health Psychology [DHealthPsych] or PhD), of which there are 7 BPS accredited university courses in the UK, or via an independent route, whereby the student would be independently supervised by a suitably qualified Health Psychologist to gain the competencies through a BPS-approved training plan. For this, supervisors should be registered on the Register of Applied Practice Psychology Supervisors (RAPPS) and students can study alongside a PhD. Assessment for Stage 2 is via a portfolio of work and an oral viva. Those undergoing the PhD or Doctorate university route will also receive the Dr status; those through the independent route will not, unless they combine with an independent PhD registration.

Austria

Austria has a long tradition of Health Psychology training and education since the first psychology act (1991). In 2014, the second Health Psychology act was implemented, ensuring minimum standards for all Health Psychologists trained in Austria. These minimum standards include a formal degree in psychology (minimum 300 ECTS points) to be eligible to apply for postgraduate Health Psychology education and training. This prior academic training must include a minimum set of 75 ECTS points in the field of Psychopathology, Psychopharmacology, Psychiatry, Neurology, Psychological Diagnostic in particular regarding Health Behaviour, methods of Health Psychology, disease prevention and rehabilitation, psychological interventions in Health Psychology and Clinical Psychology. In addition, the applicant must provide evidence to be physically able (medically attested by a physician) and mentally eligible (attest by a Health Psychologist, Clinical Psychologist or Psychiatrist) and undergo a motivational interview. Only when all criteria are fulfilled, can a candidate sign up for Health Psychology training. In total, the education curriculum contains 1940 hours of education and training. The 1940 hours are broken down into 255 hours of theoretical course work, 1553 hours of internship and 75 hours of case supervision. In addition 57 hours of self-therapy are mandatory. The education training program includes two formal assessments: a written exam, and a final oral state exam. The psychology act 2014 further regulates the details of the content of the educational and training program (e.g. minimum set of hours with different population groups).

Conclusions

Education and training in Health Psychology does not exist in isolation but overlaps with other issues covered within this special issue of the European Psychologist, in particular employability and legislation. The interaction between education, formal registration of Health Psychologists and job opportunities raises an interesting "chicken and egg" question as to which comes first, does offering formal training and registration trigger the job market to open up roles for Health Psychologists or do we need to start by making Health Psychology more visible to help create jobs in this field? For Health Psychology as a discipline to develop, expand and thrive, there is certainly a need for legal regulation and standardised practice of Health Psychology within the healthcare system which will inform the format of education and

training. Equally, in countries without formal education, training or registration, there may be a need for Health Psychology innovators to start by introducing the topic into educational settings, generating research evidence and providing services, in the belief that formal training and legislation will follow. This would be aligned with how Health Psychology began in the UK (Johnston, Weinman & Chater, 2011).

In navigating the complex relationship between training and employability, the EHPS is ideally placed to advocate for the development of international standards of Health Psychology education. The need for the development of European-wide standards for Health Psychology, including an agreed definition of the profession, agreed core competencies and associated training, was endorsed by nearly all NDs and would facilitate mobility among Health Psychologists across Europe. The current article can be viewed as the first step in this direction by providing an opportunity to explore the current status of Health Psychology education and training, to learn from existing case examples in the UK and Austria and to reflect on the potential to work together to develop the future of Health Psychology education, training and practice across Europe.

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Jenny Mc Sharry
Health Behaviour Change Research Group, School of Psychology, National University of Ireland, Galway, Galway, Ireland
jenny.mcsharry@nuigalway.ie

Angel Marie Chater
Centre for Health, Wellbeing and Behaviour Change; University of Bedfordshire, Polhill Avenue, Bedford, UK
Angel.chater@beds.ac.uk

Jasminka Despot Lucanin
Department of Psychology, Croatian Studies, University of Zagreb, Zagreb, Croatia
jdespot@hrstud.hr

Stefan Höfer
Medical University Innsbruck, Innsbruck, Austria
stefan.hoefer@i-med.ac.at

Antonia Paschali
School of Health Sciences, Faculty of Nursing, National & Kapodistrian University of Athens, Greece
anpascha@nurs.uoa.gr

Lisa Marie Warner
MSB Medical School Berlin, Germany
lisa.warner@fu-berlin.de

special issue

Employability of Health Psychologists: Reflections on Career Identity and Role Perceptions

Kyra Hamilton
EHPS ND Australia
Massimo Miglioretti
EHPS ND Italy
Anne Marie Plass
EHPS ND Netherlands

According to Philippot (1998), the term employability is more often used than understood. McArdle, Waters, Briscoe, and Hall (2007) defined employability as a psycho-social construct with three dimensions: (a) *career identity*, that refers to how people define themselves in a particular work context; (b) *adaptability*, the willingness and ability to change personal factors (e.g., behaviours, feelings, thoughts, disposition) in response to environmental demands; and (c) *human and social capital*, with the former referring to a host of personal variables capable of influencing a person's career advancement (e.g., education, work experience, training, skills, knowledge). It is evident from this definition that employability is a multidimensional construct with many facets to consider. This therefore makes investigating the employability of Health Psychologists difficult, and capturing the whole employability picture, especially on a global scale, may be almost impossible. Fueling this difficulty is the wide variety of descriptions for Health Psychology and Health Psychologists.

Although there are many works describing this specialist branch of psychology (e.g., Cohen, McChargue, & Collins, 2003; Johnston, 1994; Matarazzo, 1980; Michie & Abraham, 2004; Morrison & Bennett, 2016; Ogden, 2007; Taylor, 1990) and there exist many professional organisations for the field of Health Psychology (e.g., Division 38 of the American Psychological Association, the British Psychological Society Division of Health Psychology, the Australian Psychological Society College of Health Psychologists, the European Health Psychology Society (EHPS)), confusion remains around the clear boundaries that define Health Psychology (Thielke, Thompson, & Stuart, 2011) and the roles and identities held by Health Psychologists. To understand how Health Psychology is defined, EHPS National Delegates (N=27) were asked to provide the commonly used definition of Health Psychology in their country. Results indicated that responses vary widely between the EHPS member countries. Six countries reported using the definition of Health Psychology based on Matarazzo (1980, 1982), and one country reported using the WHO definition of health (WHO, 1947). Most countries (15/27) defined Health Psychology more broadly, or made use of other definitions (e.g., Bishop, 1994; Johnson, 1994; Weinman, 1990) (See Table 4.1). These descriptions included Health Psychology being defined as research, practice, and science and encompassing biological, social, and psychological factors to understanding wellbeing, health and illness as well as using psychology principals to motivate and intervene to change people's behaviour. However, among these broad definitions, there was much variation in the detail of descriptions of Health Psychology. A few countries (3/27) reported that there was no established definition of Health Psychology, and two countries simply reported Health Psychology being defined as "Medical Psychology" or "Clinical Psychology". These findings indicate that a consensus on a universal definition of Health Psychology may be needed which, in turn, may

Matarazzo 1980, 1982
Health Psychology is an aggregate field in psychology, involving educational, scientific, and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, and the identification of etiologic and diagnostic correlates of health, illness, and related dysfunction. [addition in 1982: …and to the analyses and improvement of the health care system and health policy formation.]
Johnston 1994
Health Psychology is the study of psychological and behavioural processes in health, illness, and healthcare.
Weinman 1990
Health psychology is a disciplinary area of psychology which is concerned with human behavior in the context of health and illness.
WHO 1947
Health is a 'state of complete physical, mental and social well-being and … not merely the absence of disease or infirmity'.

Table 4.1 Examples of Definitions of Health Psychology used in the EHPS member countries

help to establish and solidify the identity of Health Psychologists.

In this article we reflect on the career identity of Health Psychologists in the various EHPS member countries, and how they perceive themselves in their work context. These reflections were drawn from data collected within the larger study that formed the papers in this Special Issue. For details on study methods, see the issue editorial. In addition, three case studies from three different countries (Italy, Netherlands, Australia) are presented that illustrate how Health Psychology is defined in the specific country and the common practice areas Health Psychologists occupy.

Roles and Identities of Health Psychologists

To gain insight into the roles and identities of Health Psychologists, EHPS National Delegates were asked to respond to a series of open and closed questions related to common practice areas Health Psychologists occupy, see box 1.2, p. 371. A range of responses were reported (see Figures 4.1-4.3).

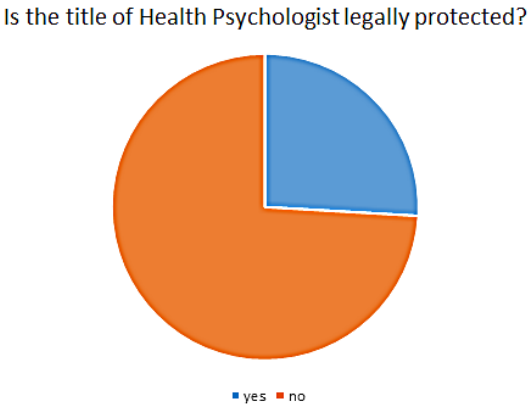

Figure 4.1. *Legal Protection of the Title of Health Psychologist*

Only seven of the 27 countries reported the professional title of 'Health Psychologist' as being legally protected. Six of the 27 countries indicated having a national registration authority that requires Health Psychologists to be formally registered to work. In another six countries, it was reported that registration is possible but not formally required, and in two countries registration was reported as being required only for those working in clinical practice. Twelve of the 27 countries indicated no national registration authority. Only eight of the 27 countries reported having formal requirements to undertake specialist

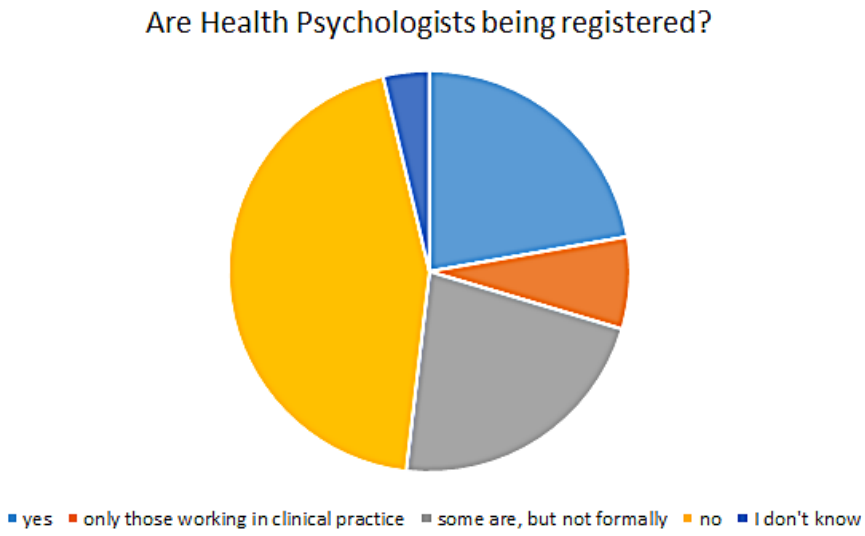

Figure 4.2. *Registration as a Health Psychologist*

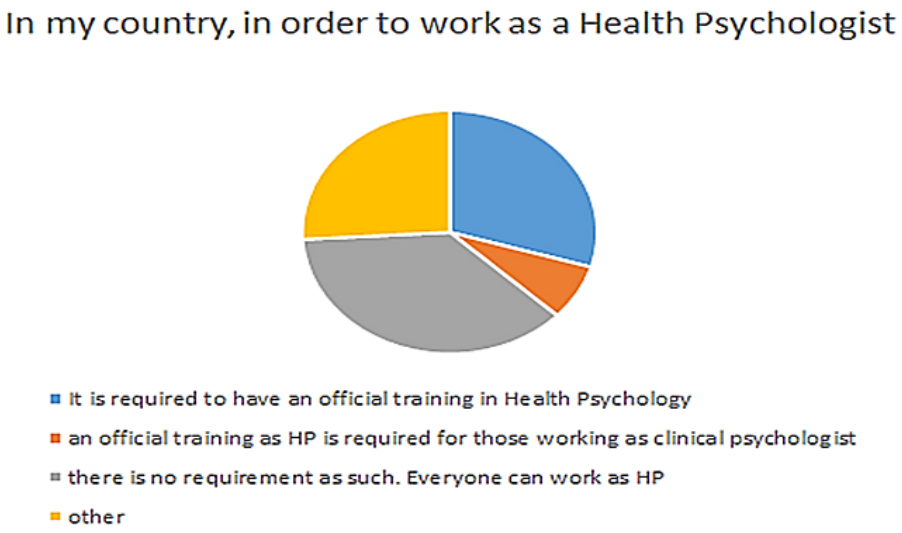

Figure 4.3. *Working as a Health Psychologist*

training in Health Psychology to work as a Health Psychologist, with two countries reporting that training was required only if working in clinical practice. In 10 countries it was reported that everyone can work as a Health Psychologist, regardless of training, and seven countries reported 'other'. In reviewing the data on the roles and contexts where Health Psychologists work, we coded five main work roles (see Figure 4.4). Clinical health psychologist, researcher, and academic/ teacher were the main roles reported as being occupied by Health Psychologists. These data mirrored the context Health Psychologists work in, with clinical practice settings and non-profit/ academic settings being ranked the highest (see Figure 4.5).

Case Studies

1. Health Psychology in Italy. In Italy, a large number of professionals are registered as

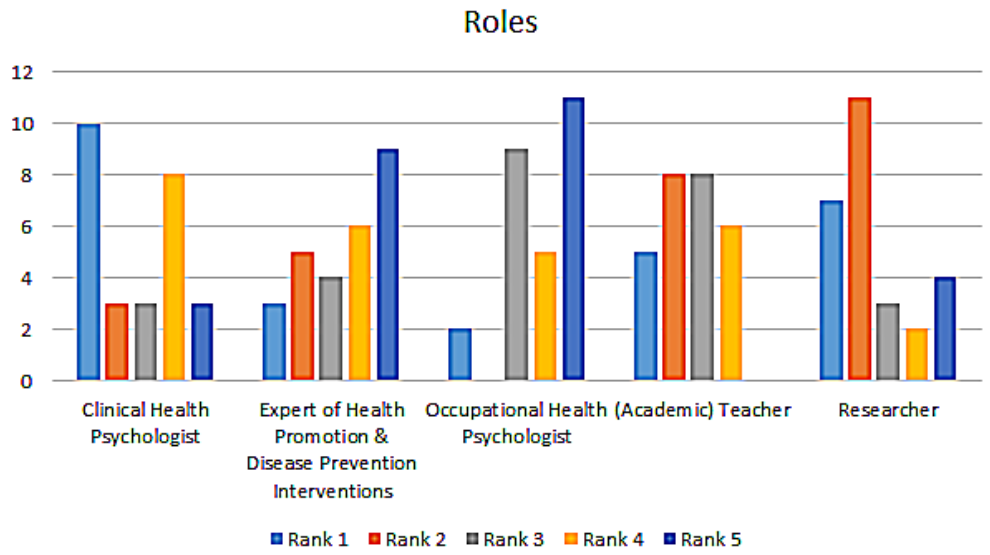

Figure 4.4. *Main Working Roles for those Working in the Field of Health Psychology*

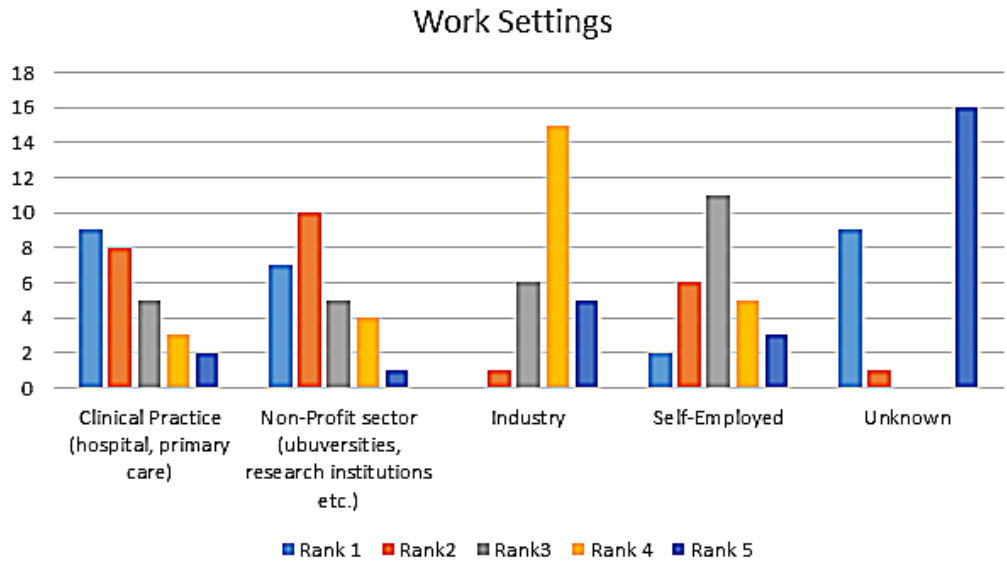

Figure 4.5. *Main Work Settings for those Working as a Health Psychologist*

psychologists (> 100,000), of which many claim to be involved in improving the health and health outcomes of individuals and groups. Only a minority of these, however, would define themselves as a Health Psychologist, as the identity of Health Psychologists and what they do is unclear. There are only two specialized schools in Health Psychology in Italy (University of Rome and University of Turin) that offer professional training that leads to formal recognition of the title of Health Psychologist. As such, many psychologists work as Health Psychologists but under other titles (e.g., Clinical Psychologist). Further, Health Psychologists often assume the role of a Clinical Health Psychologist or the role of researcher. So, in Italy, the integration of health psychology, clinical psychology, positive psychology, occupational health psychology, and community psychology is quite strong with many psychologists holding multiple identities and not a single identity of

'Health Psychologist'. It is the field of research or practice (e.g., healthcare, health promotion, health behaviour change) that the individual works within that defines them as a Health Psychologist.

2. Health Psychology in the Netherlands. In the Netherlands, Health Psychologist, like psychologist in general, is not an officially recognized and/or legally protected title. Four out of 14 universities in the Netherlands offer a Masters program in Health Psychology, after which one has the title of MA (in Health Psychology). Practical training is not part of the curriculum in these Masters programs, and a national registration body for Health Psychology does not exist. The only 'type' of psychologist that needs registration in the so-called BIG registry (BIG is the Dutch abbreviation for professions in healthcare, in Dutch: 'Beroepen in de Gezondheidszorg), are those working in clinical practice, and are given the title of Clinical Psychologist. Health Psychologists are not Clinical Psychologists, consistent with French, Vedhara, Kaptein, and Weinman (2010), but Clinical Psychologists can be Health Psychologists. Thus, in the Netherlands, like in Italy, there is a lack of clarity about who Health Psychologists are and what they do. To improve the visibility of Health Psychologists in the Netherlands (and Belgium), a book showcasing Health Psychology was recently published with the support of ARPH, the Dutch and Belgium organisation for Research in Health Psychology (http://www.arph.nl/images/Health-psychology-showcase_Dutch-version.pdf). In this book, Health Psychologists are defined as behavioural scientists that focus on health behaviour, health behaviour change, and the implementation of health behaviour change interventions. A range of individuals are presented as working as Health Psychologists, though with no formal training in Health Psychology. In the Netherlands the roles and requirements of working as a Health Psychologist are unclear and further understanding of this specialised field of psychology is needed.

3. Health Psychology in Australia. Unlike Italy and Netherlands, in Australia there are very clear regulations on who can officially work under the title of Health Psychologist. Australian undergraduate psychology programs are traditionally a three-year degree, with students competing for entry into an honours/four-year program of study. To register as a psychologist, students need to complete an additional two-year supervised work program, a combination of university coursework as a fifth year and one-year supervised work program, or a Masters or Professional Doctoral program (Littlefield, 2016). Students can then apply to the Australian Health Practitioner Regulation Authority (AHPRA) for registration as a general psychologist. To be eligible to apply for an area of practice endorsement, such as Health Psychologist, a student needs to complete an accredited Masters in one of the approved areas of practice (in this case Health Psychology), and a minimum of two years of approved supervised full-time equivalent practice with a Board approved supervisor. Here lies the issue; currently in Australia there are only two universities that offer an accredited Masters program in Health Psychology (University of Queensland and University of Adelaide). Despite this, the academic field of Health Psychology is strong, and a special issue in Australian Psychologist highlighted this point (Hamilton & Hagger, 2014). Further, the Australian Psychological Society College of Health Psychologists (CHP) recognise the importance of academic members and one can be approved full membership to the specialist college on this basis. According to the CHP (https://groups.psychology.org.au/chp/), Health Psychologists specialise in understanding the relationships between psychological factors (e.g. behaviours, attitudes, beliefs) and health and illness. They highlight that Health Psychologists

practice in two main areas: health promotion (prevention of illness and promotion of healthy lifestyles) and clinical health (application of psychology to illness assessment, treatment, and rehabilitation). In sum, Australia has very clear guidelines and legal regulatory bodies for practicing as a Health Psychologist yet also recognises the importance of academics and researchers working in the field of Health Psychology.

Conclusion

In conclusion, across the 27 EHPS National Delegates who represented 27 countries in this study there appeared to be no global or consistent narrative on who Health Psychologists are and what Health Psychology is. This is clearly demonstrated by the three case studies presented; in Italy Health Psychologists and Clinical Psychologists overlap in roles, in the Netherlands a range of individuals work under the title of Health Psychologist with no specific training in Health Psychology required, in Australia formal professional training and registration is required to work as a Health Psychologist. These case studies and survey findings further highlight that countries also differ in who can practice under the title of Health Psychologist versus working in the field of Health Psychology. In some countries no specialised training in Health Psychology is required to work as a Health Psychologist, while in other countries specialist training is a legal and regulatory requirement. However, where training is available and required in order to work as a Health Psychologist the options appear limited, often to a few universities offering such specialised training. This picture is further complicated by participants' reports that suggest many Health Psychologists end up working as Clinical Psychologists in clinical settings. This has major implications for the professional identity of Health Psychologists and the recognition of Health Psychology as a profession globally. Moreover, the lack of educational pathways potentially threatens the identity of Health Psychology as a discipline and Health Psychologists as specialised professionals. Combating such a threat requires defining and recognising the distinct and unique knowledge and skill sets that Health Psychologists possess and can bring to bear on health problems relative to other psychological disciplines such as clinical and counselling psychology. These issues, however, have not stymied the growth of Health Psychology globally, and there is a critical mass of researchers and practitioners applying Health Psychology theory and principles in diverse contexts. In moving forward and clarifying the roles and identity of Health Psychologists, a global consensus of what Health Psychology is and who Health Psychologists are as well as internationally recognised standards of practice are urgently needed. This will help to improve the global mobility and employability of Health Psychologists and stimulate the exchange of expertise and knowledge on an international level. Health Psychology is a specialised field of psychology, and there is a need to recognise and address the potential identity issue of Health Psychology as a discipline and Health Psychologists as specialised trained professionals. A way forward to instil such an identity may be for Health Psychologists and those adopting identical approaches under different titles (e.g., psycho-oncology, Chambers et al., 2014; behavioural interventions, Plotnikoff et al., 2014) to come together as a collective and into organisations like the EHPS (Hamilton & Hagger, 2014).

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Kyra Hamilton
School of Applied Psychology, Griffith University and Menzies Health Institute Queensland, Australia
kyra.hamilton@griffith.edu.au

Massimo Miglioretti
Department of Psychology, University of Milano Bicocca, Italy
massimo.miglioretti@unimib.it

Anne Marie Plass
Institute for Medical Psychology and Medical Sociology, University Medical Center Göttingen (UMG)/ Georg-August-University, Göttingen, Germany
annemarie.plass@med.uni-goettingen.de

special issue

Legal regulation of Health Psychology as a profession

Nadine Berndt
Ministère de la Santé, Luxembourg
Stefan Höfer
Innsbruck Medical University, Austria
Jelena Kolesnikova
Riga Stradins University, Latvia
Noa Vilchinsky
Bar-Ilan University, Israel

Health Psychology encompasses a broad variety of activities ranging from basic clinical research to education, counseling, and clinical treatment (Kaplan, 2009). A proper regulation of *Health Psychology* as a profession would warrant the provision of high quality, evidence-based interventions performed by educated and supervised health psychologists through defined quality training (Bednar, Lanske, & Schaffenberger, 2004). Regulation further concerns social security and reimbursement of Health Psychology services through private and public insurance schemes, which may foster the access to *Health Psychology* services (DeLeon, Frank, & Wedding, 1995).

Acknowledging the legislative status of the profession around Europe is especially critical for health psychologists who wish to immigrate to other European countries to practice their profession. In addition, health psychologists who are active in countries where no such legislation exists may use this information to facilitate the proper and needed legislation of the profession in their homelands. There are considerable differences concerning the regulation of *Health Psychology* as a profession within Europe. Compared to the more known and regulated profession of Clinical Psychology, for example, the profession of *Health Psychology* is still largely unknown and under- to unregulated. Apparently, a clear distinction between health and clinical psychologists cannot always be drawn. Whereas some kind of regulation of professional activities of psychologists can often be found in the health or healthcare sector, very few European countries have specific regulations in the further specialized field of *Health Psychology* (European Commission, 2016). According to the Austrian Health Institute (Bednar, Lanske, & Schaffenberger, 2004) the profession of health psychologist has been officially recognized since 1989 in only five countries represented in the EHPS, at minimum to the level of specialty area of psychology education (Finland, Italy, the Netherlands), or further regulations (Austria, the UK). Quite exceptionally, the profession of *Health Psychology* has been regulated in Austria as an autonomous liberal profession for more than three decades. The majority of countries represented in the EHPS have indirect regulations for *Health Psychology* as a profession. Most often, a description of the profession and regulations concerning education and training are available, but no official professional titles are awarded (Bednar, Lanske, & Schaffenberger, 2004; European Commission, 2016).

The information provided by the EHPS National Delegates, who participated in the current survey, echo this diverse picture of the profession across countries represented in the EHPS. Not only do regulatory approaches vary, but also the registration and the reimbursement schemes of health psychological services are extremely different. Despite the importance of a clear and secured professional title, as many as 77% (n=21) of all participating National Delegates reported that the title "Health Psychology" is not legally

protected in their country, although a few of these countries have conducted efforts for official recognition. The exceptions apply to Austria, Germany, Switzerland, Latvia, Israel, and Australia (23%).

In Austria, the profession of *Health Psychology* is legally defined and protected; however, legal protection of the profession does not mean that it is exclusive to health psychologists, revealing a weakness in the Austrian law. With regard to Latvia, the law on psychologists was adopted and will enter into force in 2018. The Latvian law on psychologists states that *"psychologists may carry out their professional activities in six fields of work settings including clinical and health psychology"*. Based on the law on psychologists, the Cabinet Regulation on the certification and re-certification is currently under development. According to the Cabinet Regulation, the title "clinical and health psychologist" is included in the so-called Latvian Professions Classifier. Almost half of the participating delegates (n=12), however, reported that there is no registration of *Health Psychology* as a profession in their country at all (see Figure 3.1). According to six delegates (24%), health psychologists are registered on a random basis in their country, but there is no need for formal registration (see also Hamilton et al. in this issue).

In addition, despite the importance of a proper legislation, half of all participating delegates stated that the profession of *Health Psychology* is not legally regulated in their country. Only seven delegates (27%) stated that *Health Psychology* is legally regulated with regard to both training and education requirements (see Figure 3.2). To illustrate, in Slovakia, the profession of health psychologists is neither legally regulated nor even existing. Similarly, Greece encounters an absence of any law regulation or legal protection on the role of a health psychologist. The Ukraine delegate testified that: *"We have no such profession. We have professions of Psychologist and Practical Psychologist"*. Six delegates mentioned that in fact there is a legal regulation of the profession of psychologists, but not specifically for the sub-

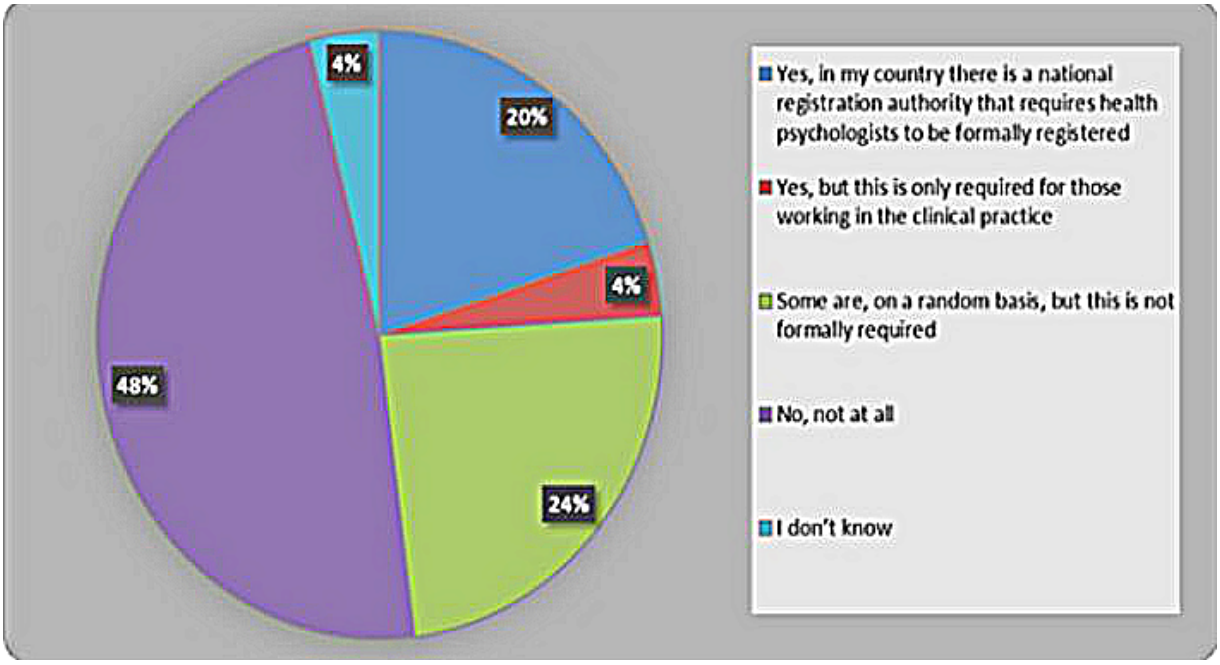

Figure 3.1. Obligatory registration of health psychologists: the National Delegates survey results.

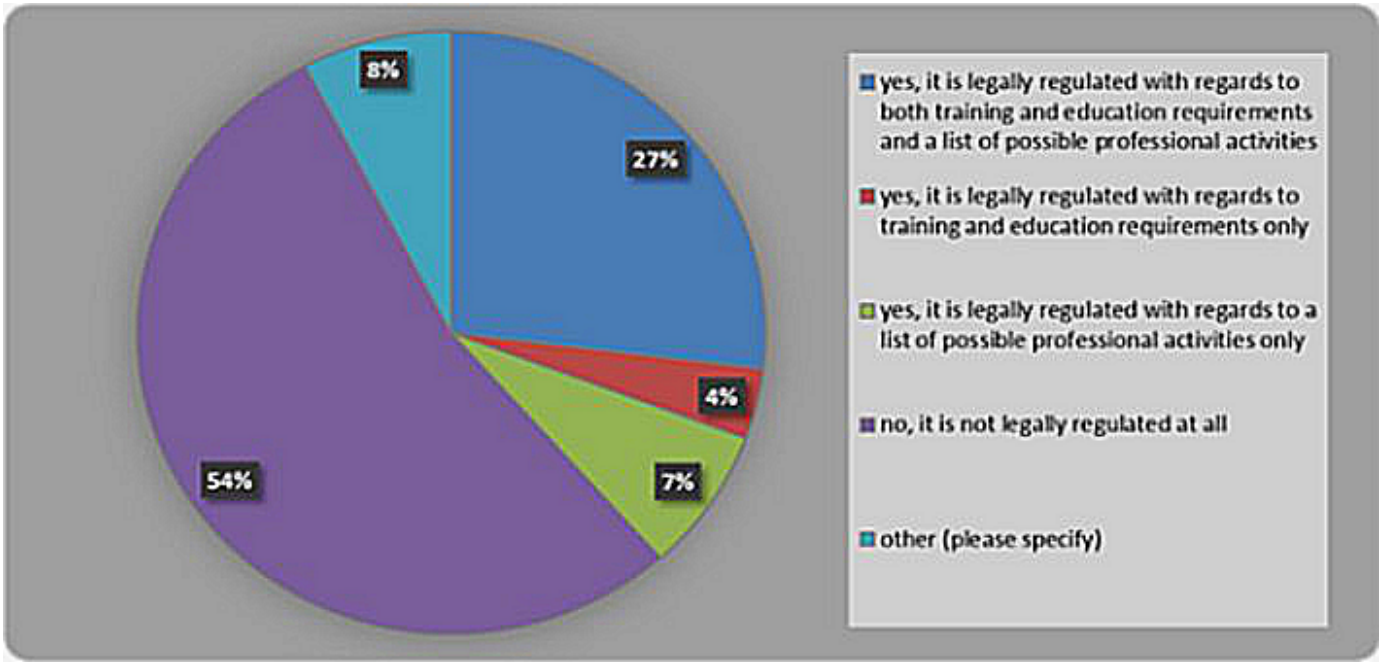

Figure 3.2. Legal regulation of health psychologist as a profession: the National Delegates survey results.

category of health psychologists. This information is in line with the information provided in the report from the European Commission (2016), stating that most countries that regulate "psychologists" generally do not regulate other specialties of psychologists, including health psychologists, separately.

As for insurance issues, in many cases, the national health insurance covers psychological treatment or counseling if treatment is provided by a medical profession (i.e. psychiatrists) or in the context of hospital admission. In the majority of the countries, tariff negotiations with public insurances have failed, or not even started. Given this situation, it is no wonder that almost all (84%) of the National Delegates reported that their country does not offer any public insurance coverage for *Health Psychology* services at all. However, according to a few delegates, coverage may be provided by supplementary insurance or personal private insurance. According to the Croatian National Delegate, *Health Psychology* services are covered in their country, yet only in case the service is included in the list of guaranteed benefits.

When exploring the issue of employment and reimbursement, recent data suggest that health psychologists are mostly employed in third level education in the academic setting, secondary healthcare, or hospitals services and public health, while few health psychologists are employed in primary health care settings (Byrne, Gethin, & Swanson, 2017). The data received from the EHPS National Delegates helped us better understand how *Health Psychology* services vary across countries represented in the EHPS. While more than one single answer option could be applicable, more than half of the delegates (n=15) reported that *Health Psychology* services are accessible, but not reimbursed through self-referral in their country. Seven delegates reported that Health Psychology services are accessible and reimbursed through referral from primary care or other physicians, and only four delegates answered that *Health Psychology* services are accessible and reimbursed through self-referral. For instance, in Germany, *Health Psychology* services are supposed to be accessible and reimbursed through referral of

primary care physicians, but this hardly exists in practice. "*Usually, jobs would be called something with prevention and psychology. Health psychologists are usually employed in academia. In practice, they only appear in few hospitals, rehabilitation centers and health insurance companies*". In contrast, according to the Austrian National Delegate, "*within a hospital setting (including rehabilitation), Health Psychology service is fully covered as the Austrian Hospital Act makes it mandatory for the hospital service provider to offer Health Psychology service for any patient; however outside the hospital setting, only diagnostic parts are covered to some extent with no re-imbursement for therapy or interventions what so ever".*

Conclusions and reflections

This survey aimed to document the level of legal regulation, and registration and reimbursement schemes, for the *Health Psychology* profession within countries represented in the EHPS. In total, 27 countries represented in the EHPS participated in the survey. The results highlight that the scope of legal regulation for the profession as health psychologists is very heterogeneous. In most countries, although health psychologists may be trained and competent to provide health counseling or specific health-related psychological interventions, an insufficient legal scope prohibits them from providing this service in practice (or it is not reimbursed by national health insurances, hence limiting access). It is crucial to resolve the issue that health psychologists may confront when providing health psychology counseling; that is, the risk of running into unpleasant legal concerns when applying "their" particular interventions to patients. Much effort is required in order for *Health Psychology* to be recognized as a unique profession and be legally regulated in each individual European State to begin with. Importantly, there seems to be some inconsistency in a few countries that have officially recognized the profession of *Health Psychology* but not legally protected it, which raises the question as to whether official recognition does not automatically mean legal protection. However, the current survey does not allow us to provide additional clarification on this issue.

Health Psychology appears as a profession of potentially high mobility. However, the current range of regulatory differences may constitute a barrier for mobility and jobs, especially for those health psychologists that intend to move to a country in which the regulated activities are defined differently. In order to improve access to *Health Psychology* services (i.e. health counseling or health-related psychological interventions) and facilitate the mobility of qualified health psychologists within their own countries, as well as the cross-border provision of their services, a flexible and transparent regulatory environment across countries represented in the EHPS is required. Moreover, increased consistency and clarity in the scope of *Health Psychology* regulatory measures are indispensable to foster professional mobility across countries (European Commission, 2016). In this regard, too strict regulations are not necessarily advantageous, since a flexible and transparent regulatory environment may provide a "grey area" for psychologists to work in. Thus, steps toward legislation should be taken cautiously, with much sensitivity to each country's unique requirements and degrees of freedom for psychologists.

Health psychologists and their national associations should reflect upon the effects of their regulatory system and whether potential barriers for mobility are justified, or if they can be alleviated. Moreover, health psychologists are invited to be more actively engaged in political and legal discourse, and seek engagement with decision-makers about the regulation of their professional scope. The countries represented in the EHPS could actively perform a review and facilitate

modernization of their regulations on qualifications governing access to professions or professional titles. Moreover, discussion across countries represented in the EHPS should take place when comparing their systems and work in collaboration when screening their legislation. Changing the existing scope of practice regulations for the *Health Psychology* profession will be a challenging process involving many stakeholders. Yet, this challenge is critical since many patients and their caregivers are in need for professional psychological help, and it is no less than an ethical mission to provide an evidence-based service to support them.

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Nadine Berndt
Service Epidémiologie et Statistique, Direction de la Santé, Ministère de la Santé, Luxembourg
nadine.berndt@ou.nl

Stefan Höfer
Department of Medical Psychology, Innsbruck Medical University, Innsbruck, Austria
stefan.hoefer@i-med.ac.at

Jelena Kolesnikova
Department of Health Psychology and Pedagogy, RigaStradinš University, Latvia
jelena.kolesnikova@rsu.lv

Noa Vilchinsky
Department of Psychology, Bar-Ilan University, Ramat-Gan, Israel
Noa.vilchinsky@biu.ac.il

special issue

Health psychologists cooperating – challenges and opportunities

Wim Nieuwenboom
University of Applied Sciences Northwestern, Switzerland
Sven Ingmar Andersson
Lund University, Sweden

Introduction

For health psychologists, cooperation with other professions is an important part of interdisciplinary work. Such efforts are not without challenge, due at least in part to different scientific approaches characterizing various disciplines involved in the health domain. On the other hand, interdisciplinary cooperation is rich in opportunities for all parties, not least the patients and clients who may have much to gain from such efforts. To elucidate the topic with respect to Health Psychology in the countries represented in the EHPS, questions specifically concerned with cooperation with other professions were included in the questionnaire administered to the EHPS National Delegates (NDs) (see Plass et al., this issue). In this contribution, the cooperation of Health Psychologists with other fields of psychology and with other professions are discussed on the basis of the results the questionnaire study. The article also considers examples from Sweden and Switzerland.

Survey questions on health psychologists cooperating

EHPS NDs were asked with which professions and in which domains HPs were cooperating, which were the barriers that can be identified, as well as what could be done to stimulate cooperation. They were also encouraged to provide additional comments. NDs reported that cooperation with other psychologists and with physicians, nurses and physiotherapists is prevalent (see Figure 1). Health Psychologists are generally seen as cooperating with other professionals in research and teaching and less often in supervision and training (see Figure 2). In several countries (e.g. Cyprus, United Kingdom), service provision was specified as other category. NDs were asked to rank three possible barriers for cooperation (namely *lack of funding, different scientific approaches or competition between professions)*. The highest rank was assigned the number 1, the lowest number 3. On average, the highest barrier to cooperation was considered to be Lack of funding, with a mean rank of 1.42 (see Figure 3), followed by *different scientific approachesand competition between professions*.There are different ways of establishing and stimulating cooperation of Health Psychologists, which also depends on the specific circumstances present in a given country. Thus, the results of this mainly quantitative survey are difficult to interpret without taking the context in the different countries represented in the EHPS into consideration.

Cooperation: examples from two countries

It is the aim of the (present) authors to stimulate further discussions that will lead towards fruitful cooperation between actors in the health sector for the benefit of all parties, patients as well as health care providers. To further such an approach we as authors – one of us from Sweden,

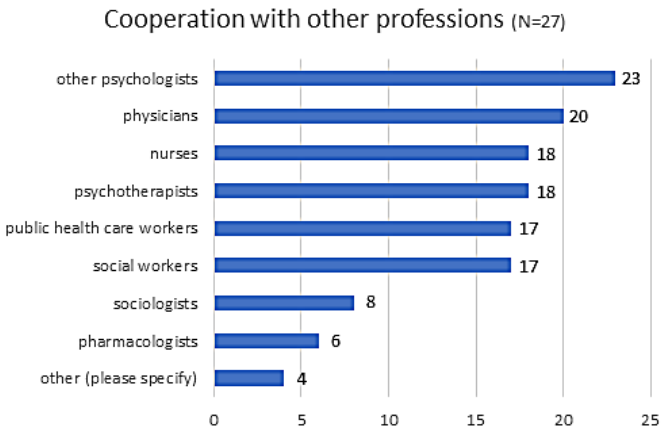

Figure 1. Cooperation with other professions (*n*=27). Absolute numbers are displayed.

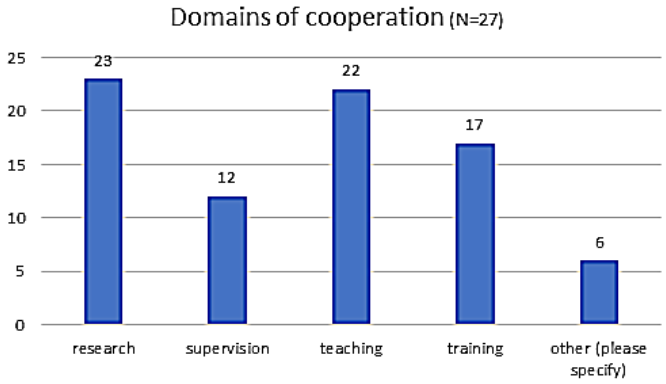

Figure 2. Domains of cooperation (*n*=27). Absolute numbers are displayed.

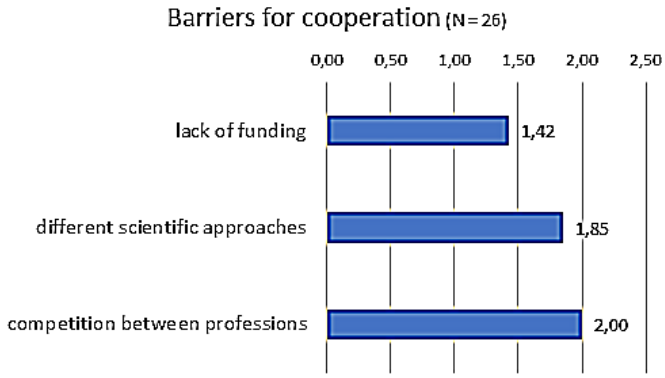

Figure 3. Barriers for cooperation (*n*=26). Mean rankings are displayed.

the other from Switzerland – have chosen to deal with specific situations in our two countries only so far as this leads to a better understanding of the above-mentioned questions on cooperation. Both Switzerland and Sweden are European countries with a very high standard of living. Nevertheless, there are striking differences between the two countries with respect to the health system and the role Health Psychology and Health Psychologists are playing.

Cooperation of HPs in Switzerland

Cooperation with other professionals. One clear indication from this survey is that cooperation in many countries is frequent between Health Psychologists and other professional groups, among them physicians, nurses and physiotherapists, but also teachers and sociologists. This seems to be true despite the fact that in Switzerland Health Psychology is less present in specialized health care centers than in other countries such as Germany, Austria or Sweden. Health Psychologists in Switzerland either have their own practices or are employed in hospitals. The practice of Swiss Health Psychologists consists of working with individual clients and at the level of groups, e.g., in prevention or health promotion projects or networks. In stressing this matter, Swiss Health Psychology is drawing a clear boundary to other psychological areas, such as social and clinical psychology, helping to legitimise its status as a separate discipline within psychology and defining which partners it should cooperate with. This was also politically necessary in order to be recognised by the federal government as a separate area of psychology.

Barriers. Health Psychology is a relatively young discipline in Switzerland and it has taken some effort to establish itself in relation to the others. The fact that Switzerland is a four-language country and that is organized according to regions

contributes to the difficulties. On the other hand, we observe a growing interest in topics and interventions of health psychology, which result both from societal necessity and from increasing specialization. Traditionally, in Switzerland the boundaries between the different professions tend to be clear-cut, a circumstance that stimulates competition rather than cooperation. Fortunately, in recent decades the necessity of cooperation has been feltmore strongly and efforts have been undertaken at different levels to overcome these barriers.

Stimulating cooperation. In order to stimulate cooperation in the different areas between Health Psychologists and other health professionals, it is important that Health Psychology and Health Psychology interventions are embedded in a national health policy. The development of a postgraduate curriculum encourages cooperation at different levels. A postgraduate curriculum including standards for training and supervision exists in both Sweden and Switzerland. In the latter country, standards were defined in a cooperative process in which the federal government, the universities, the professional organizations FSP and SGGPsy and the accreditation commission were involved (cf. Nieuwenboom, 2016). A MAS (Master of Advanced Studies, continued formation) was introduced in the French-speaking part of Switzerland as a joint programme of three universities (Geneve, Lausanne and Fribourg). A logical next step will be the development of a similar programme in the German-speaking part. Health Psychologyhas shown itself to be able to strengthen its identity among other psychological disciplines within the FSP, which facilitates cooperation with those disciplines. What Health Psychology has to offer will become more visible and available in health care centers all over Switzerland.

Cooperation among Health Psychologists in Sweden

In Sweden, involving health psychologists and clinical health psychologists in primary health care has been seen as having many advantages (Andersson, 1989, 2009). A psychologist working in the field of primary prevention can help to bridge the gap that may be evident between existing programmes of health care, social work and education, not the least by means of a generalist approach. The health psychologist can contribute by collaborating with primary health care personnel to the development of new diagnostic and therapeutic methods, considering health and illness as a function of living conditions such as unhealthy eating, insufficient physical activity, use of tobacco and the risk use of alcohol.

Cooperation and education. Cooperation is closely related to the education of psychologists. Encountering primary health care patients rather than patients at typical somatic and psychiatric clinics (which represent a highly selected group of patients) is important, not only for the education of psychologists but also for the recruitment of psychologists within primary health care, and their understanding of the problems that generally confront primary health providers, as such problems often involve less somatic and more psychological and psychosocial (e.g. family, work-place) issues.

Research on cooperation. Within community health care settings, there are broad research possibilities for Health Psychologists to cooperate with other groups in considering what forms of care or social support are most important, including the medicalization of common problems, as well as chronic disease, disability, alcohol and drug abuse, and the prevention of accidents and suicide, for example.

Sveriges Psykologförbund (n.d.), the organization representing professional

psychologists in Sweden, recently documented various similarities and differences in qualifications and responsibilities for psychiatrists, health psychologists and clinical psychologists within general psychiatry in Sweden. The results indicate that cooperation functions reasonably well with mutual respect and understanding of each others competencies and a focus on the patients involved. Cooperation was seen to function less optimally when medical and psychological treatments were not seen as part of the same overall treatment, when roles and responsibilities were not clearly formulated and when the areas of responsibility were not fairly distributed.

Cooperation and Health Psychology - what can be done?

The above-mentioned developments will help to make health psychology and its approach to health problems generally more widely known in society. Intervention projects in the field of public health and health promotion, in which Health Psychologists have the lead or are at least involved, will encourage collaboration at an interprofessional and interdisciplinary level. This is also true regarding research. Grant rules that explicitly mention an interdisciplinary approach as a condition for funding make cooperation necessary and at the same time facilitate a process of creating mutual understanding between the different stakeholders. An experience from Switzerland is that Health Psychologists are active in different networks such as the Mental Health Network Switzerland (Netzwerk Psychische Gesundheit/Réseau Santé Psychique Suisse), which plays an important role in this process.

From the examples above, and also in the process of writing this article, it became clear that even when we compare countries such as Sweden and Switzerland, which at first glance have very much in common, considerable differences exist in the way in which Health Psychologists cooperate with other professionals, depending on the conditions and circumstances involved, on cultural and language considerations, and on other context variables within a specific country. It emphasizes the need to stay in touch and maintain a dialogue that encourages cooperation between the countries represented in the EHPS in exchanging knowledge among Health Psychologists to deal effectively with such matters.

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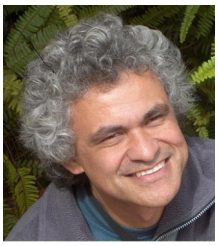

Wim Nieuwenboom
Institute of Social Work and Health, School of Social Work, University of Applied Sciences Northwestern Switzerland, Switzerland
wim.nieuwenboom@fhnw.ch

Sven Ingmar Andersson
Department of Psychology, Lund University, Sweden
sven_ingmar.andersson@psy.lu.se

special issue

Future directions in Health Psychology Practice in Europe and other countries represented in the EHPS: Moving Forward Together

Angelos P. Kassianos
University College London, UK
Ewa Gruszczynska
SWPS University of Social Sciences and Humanities, Poland
Sven Ingmar Andersson
Lund University, Sweden
Anne Marie Plass
University Medical Center Göttingen, Germany

Health Psychology in applied settings

This special issue includes four articles authored by a number of National Delegates (NDs) of the European Health Psychology Society (EHPS) on how Health Psychology is applied in various countries represented in the EHPS. In order to attain an accurate and holistic picture, 27 EHPS NDs completed a survey. The survey focused on four issues related to the status quo of Health Psychology so as to suggest directions for the future: education, legislation, employability and cooperation with other disciplines (see Box 6.1). What are prominent in the articles in this special issue are both the diversity and the communality characterizing Health Psychology across the various countries represented in the EHPS. In some countries, for example, research, education and clinical work in Health Psychology are better described, protected and visible than in others. Matters of legislation and cooperation with other disciplines also vary greatly from one country to another.

It is a fact that Health Psychology as one of the newer disciplines of psychology has matured considerably during the last decades. Moreover, the interest in the 'scientist-practitioner' role of Health Psychologists is growing. For example, *the Health Psychology Division of the International Association of Applied Psychology* (IAAP) is now its second largest division. Furthermore, the EHPS launched recently a blog called *Practical Health Psychology* (http:/practicalhealthpsychology.com/) aimed to present how Health Psychology is applied in practice; this was undertaken in order to address

1	Develop a global consensus on *what Health Psychology is* and *what is a Health Psychologist*, as well as internationally recognized standards of practice (Hamilton et al, 2017).
2	Develop international standards for Health Psychology education to facilitate mobility (McSharry et al, 2017; Nieuwenboom & Andersson, 2017).
3	Legally regulate and standardize Health Psychology practice within the healthcare systems to inform education and training (Mc Sharry et al, 2017).
4	Define the distinct and unique knowledge and skill set that Health Psychologists possess (Hamilton et al, 2017) to increase visibility (Plass et al 2017).

Box 6.1 Overview of recommendations from the special issue related to applied Health Psychology

the growing interest in applied Health Psychology. On the other hand, a recent article in the *European Health Psychologist* (Byrne, Gethin & Swanson, 2017) concluded that there is a recognized lack of standardized international regulation regarding Health Psychology practice and a clear need for a more global and consistent narrative on who Health Psychologists are and what Health Psychology is, when applied in practice.

What do Health Psychologists do in applied settings?

Hamilton, Miglioretti and Plass (2018) in this issue suggested that there is variability between countries in whether Health Psychologists work under the title of 'Health Psychologist' or within the field of Health Psychology. In some countries, no specialised training in Health Psychology is required to be able to work, while in other countries specialist training is a legal and a regulatory requirement. This picture is further complicated by participants' reports, which suggest that many Health Psychologists end up working as Clinical Psychologists in clinical settings. This has major implications for the professional identity of Health Psychologists and the recognition of Health Psychology as a distinct applied profession. We recently organized a roundtable in the EHPS 2017 Annual Conference (Andersson, Gruszczynska, Kassianos, & Plass, 2017) that reconfirmed the fact that a unique identity is lacking, which is critical for the future development of the field in moving forward and clarifying the roles of Health Psychologists in applied settings, and general visibility of the profession in the society. Having a multidisciplinary nature is beneficial and does not preclude from having a clear identify as with all other fields which exist in a multidisciplinary context.

The question whether Health Psychology is a discipline of psychology was recently discussed in an editorial in *Health Psychology*, the official journal of the Society for Health Psychology of the American Psychological Association (Freedland, 2017). The new journal Editor stated that Health Psychology belongs primarily to behavioral medicine, which in turn, belongs to medicine, healthcare and public health. This view was challenged in this special issue (Hamilton et al., 2018; Plass, Gruszczynska, Andersson & Kassianos, 2018). Although the definitions of Health Psychology that were most commonly used in the member countries varied widely, all definitions were similar in placing Health Psychology in the field of psychology rather than in medicine (see figure 1.1, p. X for key issues, and table 3.1, p. 383 for definitions).

Who do Health Psychologists collaborate with?

Health Psychology as a research area is multidisciplinary, thus bringing together a range of professionals who work in Health Psychology-related research. Nieuwenboom and Andersson (2018) suggested in this issue that equally in applied settings, Health Psychologists work with a wide range of professionals like physicians, nurses and physiotherapists and within different contexts like primary care and health promotion. This is important because recently secondary care was mentioned as a primary focus of applied Health Psychology (Byrne et al., 2017), but primary care can also be a context where illness prevention and management programs can be administered with the contribution of Health Psychologists.

The NDs that were surveyed highlighted that collaboration with other professionals is more prevalent in research than in applied settings with lack of funding and competition with other professionals as serious barriers. The authors also argued that Health Psychologists working in primary prevention can fill important gaps in

existing healthcare and social work programs and that collaboration with other professionals can improve the development of interventions targeting a wide range of health behaviors like physical activity and tobacco use. Interestingly, the authors also presented another barrier for collaboration that exists in Switzerland: language that makes it difficult to work between different language-speaking areas. This can also be a barrier at a European level, and needs to be considered when thinking of future directions for Health Psychology.

What are the legal regulations of professional Health Psychology?

The third paper in this special issue (Berndt, Höfer, Kolesnikova and Vilchinsky, 2018) discussed the legal recognition of the profession and how Health Psychologists are certified in order to guarantee the basic quality of provided care. The authors reinstated the argument made earlier that Health Psychology knowledge should be available to a wide range of professionals but at the same time ensuring that psychologists who want to apply this knowledge are trained in the competencies required to be a 'Health Psychologist'. From the countries that were surveyed there were some with specific regulations for Health Psychologists (e.g. Austria) but the majority of associated countries had no legal regulations protecting the Health Psychology title. The authors suggested aligning profession-specific legal requirements with professional competencies and opening a dialogue with decision-makers involving local Health Psychologists in countries represented in the EHPS on regulatory and reimbursement issues for Health Psychologists.

How Health Psychologists are educated and trained?

When discussing the legal scope of Health Psychology, one of the most important issues is always how Health Psychologists are trained. Mc Sharry et al. (2018) in this issue provided an overview of Health Psychology education in various countries represented in the EHPS. Again, there is a wide range of educational requirements in different countries and that is not surprising. All NDs surveyed called out for further developments in their countries, especially in terms of quality of education provided including continuous professional development. The authors suggested that the educational variability also brings a positive aspect in that we can actually learn from each other. The authors also comment that education is not isolated from other issues like legislation and employability and therefore needs to be viewed holistically as these issues often overlap. Therefore, in thinking about the educational standards in various countries represented in the EHPS, one needs to take into account where Health Psychologists work and what legal standards exist.

Reflections and directions for the future

The limitations of the special issue need to be recognized. First, the articles were based on online survey responses from the EHPS NDs and others may have provided different responses. However, the EHPS NDs are professionals who are active members of their local psychology associations and have a holistic idea of how Health Psychology is implemented in their countries. Second, we need to recognize that not all EHPS NDs responded to the online survey and the articles represent mainly what exists in the countries that their NDs

responded. On the other hand, there was a satisfying response rate (27 out of 37 NDs in total, 73% and 27 out of 29 NDs who opened the online survey, 93%). Finally, we need to recognize that the articles were authored by EHPS NDs and others may have provided different interpretations. Despite these limitations, we are confident that this special issue provides an adequate picture of applied Health Psychology in countries represented in the EHPS and clear directions for the future.

This special issue builds on the article by Byrne et al. (2017) which recognized the variation in Health Psychology training and practice, lack of regulation, coherent training and formal career pathway for Health Psychologists and suggested that we need to move forward together as a profession. Also, the barriers that exist when Health Psychology is applied in practice that were identified in this special issue need to be taken into account. These include language barriers, competition with other professionals, lack of funding, as well as variability in training, education and legislation between different countries. It is our hope that this special issue, including the priorities and recommendations from a range of different countries represented in the EHPS, will stimulate further discussions of the development and application of Health Psychology practice as a vital part of Psychology. The EHPS could have an important role in ensuring that Health Psychology is globally defined, and advising countries represented in the EHPS on how they can better regulate the profession. In addition, the establishment of formal career pathway for Health Psychologists would increase their visibility in the society.

High-quality research, which is focused on providing strong evidence in the efficacy and cost-effectiveness of health-promoting interventions and the refinement of the Health Psychology theoretical models, may also strengthen the identity of Health Psychologists as applied professionals (Keefe and Blumenthal, 2004). Finally, clarifying the settings where Health Psychologists can work may benefit how the Health Psychology principles can be applied in settings like primary care and health promotion (Thielke, Thompson and Stuart, 2011). We hope that this special issue will help future discussions on the application of Health Psychology, by providing priorities and recommendations from a range of different countries represented in the EHPS.

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Angelos P. Kassianos
EHPS National Delegate of Cyprus, University College London (UCL), Department of Applied Health Research, UK
angelos.kassianos@ucl.ac.uk

Ewa Gruszczynska
EHPS National Delegate of Poland, SWPS University of Social Sciences and Humanities, Department of Health Psychology, Warsaw, Poland
egruszczynska@swps.edu.pl

Sven Ingmar Andersson
EHPS National Delegate of Sweden, Lund University, Department of Psychology, Sweden
sven_ingmar.andersson@psy.lu.se

Anne Marie Plass
EHPS National Delegate of the Netherlands, University Medical Center Göttingen (UMG)/ Georg-August-University, Institute of Medical Psychology and Medical Sociology, Göttingen, Germany
annemarie.plass@med.uni-goettingen.de

report

Improving the Implementation of UN Sustainable Development Goal 3:

Enhancing Access to Healthcare by Syrian Refugees Through Community Health Shows

Reem Talhouk
Newcastle University,UK
Chaza Akik
American University of Beirut, Lebanon
Yasmine Koukaz
Baylor College of Medicine, USA
Hala Ghattas
American University of Beirut, Lebanon
Madeline Balaam
KTH Royal Institute of Technology, Sweden
Kyle Montague
Newcastle University, UK
Tom Bartindale
Newcastle University, UK
Patrick Olivier
Newcastle University, UK
Vera Araujo-Soares
Newcastle University, UK

Background

Access to healthcare in developing countries varies due to social inequalities (Gulliford et al., 2002). Inequalities seem to decrease access to healthcare services. Quality and equity of care can be improved by optimising acceptability of services benefeciaries' attitudes and expectations, where negative attitudes could disempower community members accessing the healthcare system. Improving access to healthcare entails addressing barriers that influence community members' ability to perceive, seek, reach and engage with services (Levesque, Harris, & Russell, 2013). This is especially true for marginalized communities, such as refugees, who are accessing foreign healthcare systems. For example, perceived negative attitudes of providers reproductive health services at primary healthcare clinics in Lebanon towards Syrian refugees were found to be the main barrier for refugees access to these services (Talhouk et al., 2016). These perceived negative attitudes rendered women unable to ask healthcare providers key health questions and often made women actively avoid requesting reproductive care (Talhouk et al., 2016). Such findings indicate that for marginalized refugee communities enhancing the quality of interaction between beneficiaries and healthcare providers is essential in improving health and wellbeing (UN Sustainable Development Goal 3, SDG3).

In in low-middle income countries, high penetration of technologies, including internet and mobile phones, has allowed for mobile health interventions to provide reproductive and maternal health through (1) patient reminder systems, (2) communication platforms, (3) test result turn around, (4) peer group support and (4) psychological interventions (Lee et al., 2016). However, there is a need for m-health interventions to not only disseminate health information but also facilitate and enhance relationships between refugee beneficiaries and healthcare providers. In this paper we report on a pilot of a community health show, "Allo Sohtik", mediated through synchronous interactive voice technologies as a means of enhancing interactions between Syrian refugees and reproductive healthcare providers in rural Lebanon. We aim for the findings of this paper to support the European Health Psychology Society in their role as consultants in the Economic and Social Council at the United Nations.

Methods

Four community health shows were piloted with 15 Syrian refugee women of reproductive age (age range: 18-60 years) residing in an informal tented

settlement in rural Lebanon. Through an app, designed to initiate and aid the women in hosting community health shows, four healthcare providers were dialled in as guests for each show. The show was structured so that the healthcare provider delivered knowledge and skill based information on topics selected by the women, divided into two subtopics, and each subtopic is followed by a 'Questions and Answers' segment where women would dial in to ask questions regarding their health concerns.

All the shows were audio recorded and transcribed. Focus groups evaluating the interactions between them and healthcare providers were conducted after each show. Thematic analysis was conducted on show and focus group transcripts (Braun & Clarke, 2006).

Findings

We identified 15 topics of health concern expressed by the women through their questions including issues on: periods, family planning (oral contraceptive pills, natural contraception, and intrauterine devices), fear of labour, foetal health (foetal movement, foetal death), fibroids, asthma, kidney diseases, anaemia, breast-feeding, genital infections, heartburn, diet during pregnancy, nausea and vomiting, blood pressure, and medication intake during breastfeeding. A total of 41 questions were asked and the live nature of the shows allowed for 14 follow up questions to be asked.

Results from the focus groups indicated that women perceived a higher level of engagement by the healthcare provider than those experienced by them when visiting healthcare clinics. The women reported that they felt more comfortable and able to ask questions. The women were able to provide details regarding their medical history when asking their questions, *"I am missing my period, meaning it is late by 15 to 20 days…I am not pregnant…I go to the doctor and she give me medicine and says there is no pregnancy…I want to know why this is happening to me…I have miscarried. Every time I go to the doctor she gives me medicine that makes my period come. What am I supposed to do? Wait?" [W2]*. Such questions in turn led to a high level of engagement by healthcare providers as they probed for detailed symptoms.

The women's perception of a higher level of engagement by healthcare providers, in comparison to engagement when at face to face clinics, enhanced their trust in the health care providers even to the point that they requested to know which clinics the doctors work in, in order to go for face-to-face consultations. Several of the women used the shows to validate health advice they had previously received from healthcare providers in clinics. Ten of the questions asked (24%) were instances where the women sought to seek a second opinion regarding health advice they had previously received at clinics. For example, W4 asked *"when the doctor placed the coil she was telling me that it is not good for the first baby for her to put the coil and that it affects it. Is this correct or not?"*. One listener even asked if the healthcare provider on the show recommends that she go to another doctor than the one she is currently seeing in the clinic: *"Doctor I went to a specialized doctor and he told me I have a fibroid, in this case should I go consult another doctor?" [W10]*. When health care providers were asked by women about advice given to them at clinics, responses ranged from requesting that the women go back to their doctor and request further clinical tests to that of refuting/confirming the previous healthcare advice given. The validation of health advice re-enforced trust in the existing healthcare clinics being accessed by the women and consequently encouraged them to follow up with their current healthcare providers. In the one case where the healthcare provider refuted health advice given in the clinic the doctor encouraged the woman to seek out a new doctor.

Conclusion

Through the community health shows validation of advice previously given and encouragement to follow up with healthcare providers enhanced women's willingness and likelihood to seek healthcare, and increased their levels of trust which have been identified as facilitators for overcoming barriers to accessing healthcare (Levesque et al., 2013). Additionally, the community health shows provided a new platform of engagement with healthcare providers that was perceived by the women to be better than the engagements they were experiencing in primary healthcare clinics. The piloting of 'Allo Sohtik' highlighted the potential for m-health technologies to, not only disseminate health information, but also provide a medium in which interactions between marginalized communities and healthcare providers may be enhanced thus improving access to healthcare and ultimately health and wellbeing (SDG3).

Further research should be conducted to gain a deeper understanding of the key reasons associated with refugee women's perceived levels of trust in their health care providers. We would expect to explore the role of legal, cultural, language and beliefs issues.

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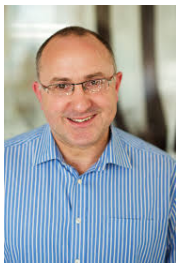
Reem Talhouk
Open Lab, Newcastle University, Newcastle upon Tyne, United Kingdom
R.R.Talhouk2@newcastle.ac.uk

Chaza Akik
Center for Research on Population and Health, American University of Beirut, Beirut, Lebanon
ca36@aub.edu.lb

Tom Bartindale
Open Lab, Newcastle University, Newcastle upon Tyne, United Kingdom
Tom.Bartindale@newcastle.ac.uk

Yasmine Koukaz
Baylor College of Medicine, United States of America
yasmine.koukaz@gmail.com



Patrick Olivier
Open Lab, Newcastle University, Newcastle upon Tyne, United Kingdom
Patrick.Olivier@newcastle.ac.uk

Hala Ghattas
Center for Research on Population and Health, American University of Beirut, Beirut, Lebanon
hg15@aub.edu.lb

Vera Araujo-Soares
Open Lab, Newcastle University, Newcastle upon Tyne, United Kingdom
vera.araujo-soares@newcastle.ac.uk

Madeline Balaam
Media Technology and Interaction Design , KTH Royal Institute of Technology, Stockholm, Sweden
balaam@kth.se

Kyle Montague
Open Lab, Newcastle University, Newcastle upon Tyne, United Kingdom
Kyle.Montague@newcastle.ac.uk

report

The 10th Annual Psychology Day at the United Nations, April 20th 2017, New York

Promoting Well-Being in the 21st Century: Psychological Contributions for Social, Economic, and Environmental Challenges

Sarah Goodman
Icahn School of Medicine at Mount Sinai, USA
Vera Araujo-Soares
University of Newcastle, UK
Nihal Mohamed
Icahn School of Medicine at Mount Sinai, USA

The United Nations' 10th Annual Psychology Day, an event that informed the UN community of recent psychological contributions to the global human rights agenda, took place on April 20th, 2017. Contributing psychologists, who represent various UN-accredited NGOs, come from multiple subspecialties such as clinical, health, educational, social, developmental, counselling, community, and industrial. Not only do they participate in committees and working groups on family, migration, technology, and climate change issues, they present at various UN Commissions and design, implement, and evaluate field projects related to the UN's Millennium Development Goals. This report was written in collaboration with the EHPS UN related activities, and EHPS's affiliation with the UN.

This year's theme was *Promoting Well-being in the 21st Century: Psychological Contributions for Social, Economic, and Environmental Challenges*. One of the event's co-chairs included Dr. Ayorkor Gaba, PsyD, Senior Project Director at the University of Massachusetts Medical School's Department of Psychiatry, and the American Psychological Association (APA) Representative to the United Nations. Dr. Gaba was also moderator of last year's event *From Vulnerability to Resilience: Using Psychology to Address the Global Migration Crisis,* a topic that has remained critically important. This year's other co-chair, Dr. Sonia Suchday, PhD, is the professor and chair of Pace University's Psychology Department. Dr. Gaba began the event by acknowledging the "…success of the psychology community advocacy efforts' culminating in the inclusion of mental health and well-being in the UN's sustainable development agenda."

On September 25th, 2015, UN countries adopted a set of 17 interrelated goals to end poverty, protect the planet, and ensure prosperity for all. Each goal has specific targets, which UN representatives and national officials have agreed to achieve over the next 15 years. For these goals to be reached, everyone must make a concerted effort: governments, the private sector, civil society, and individual citizens. The psychology community has amassed pivotal knowledge that can enhance and expedite the implementation of these goals, particularly SDG 3, which concerns "good health and well-being" for the world's citizens. Dr. Gaba acknowledged that this is the first event during which world leaders jointly acknowledged good mental health and well-being as instrumental to global change. Dr. Gaba also noted that this should have a positive and systemic impact on "communities, families, and individuals." Dr. Suchday later elaborated, "Well-being is achieved only when all living entities inhabiting the earth thrive in all areas of functioning, including psychological, social, economic, political, and spiritual."

The sponsors of this 10th Annual Psychology Day at the UN included Ambassador Rubén Ignacio Zamora of the Permanent Mission of El Salvador to the UN, and Ambassador Dr. Caleb Otto, the Permanent Representative of the Republic of Palau. Zamora, who was a professor at the Universidad de Centroamerica and is now a El Salvadorian politician, framed well-being as a key concept dependent upon multiple factors such as economies, politics, and human rights. Zamora asserted in his speech that, according to recent research from the World Health Organization in Geneva, Switzerland, a mere 3 percent of governments' spending worldwide goes to mental healthcare. Health economics research further indicates that this continued underinvestment deprives the global economy of an astronomical one trillion dollars per year in lost productivity across domestic, workplace, and government domains. Ambassador Otto, a physician, public health specialist, and advocate for the inclusion of "mental health and well-being" to the list of SDG's list, later stated that "diseases and infirmities" have always been the primary focus of health-related investigation. Given the World Health Organization's definition of health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity," Otto remarked upon the "great victory" of societies' and governments' belated inclusion of the latter two dimensions. They must also develop new indicators to measure mental health levels, as well as launch new initiatives for mental and behavioral wellness promotion worldwide.

Next to speak was moderator Dr. David Marcotte, PhD of Fordham University, who argued that psychology is now devoting more of its research efforts towards individuals' adaptation to unstable and challenging environments. Like the previous speakers, Dr. Marcotte then reviewed psychology's critical role in the United Nations' fulfillment of the Sustainable Development Goals, especially where "health and well-being" are concerned. Furthermore, individuals and whole communities alike can learn, develop, and refine mental well-being as a skill. This assertion segued into the introduction of the invited speakers, all of whom are professional psychologists. Each speaker addressed one of the three main pillars – environmental, economic, and social – of the United Nations' 2030 Agenda.

First Presenter, Environmental Pillar: Dr. Minu Hemmati, PhD

Dr. Minu Hemmati is a clinical, organizational, and environmental psychologist specializing in sustainable development and climate-related gender issues. She is also the co-founder the Multi-stakeholder Processes Institute for Sustainable Development, an international charitable association based in Berlin, Germany. Dr. Hemmati's presentation was titled "Psychology and the Environmental Pillar: Impacts of Environmental Challenges on Well-Being and Contributions to Realizing the 2030 Sustainable Development Agenda." The first part summarized how today's environmental changes affect people's health and psychological functioning. After outlining today's top environmental challenges such as climate change, air and ocean pollution, deforestation, loss of biodiversity, soil degradation, overpopulation, and ozone layer depletion, she analysed their subsequent effects on human health and cognition. Medical and physical health complications include heat-related illnesses, allergies, increased exposure to water- and vector-borne diseases, and behavioral changes in physical activity levels, all of which are exposure pathways to health disruption. The subsequent emotional responses to deteriorating environmental conditions (or the perception and anticipation thereof) include stress, anxiety, depression, and grief. Substance abuse, relationship strains, and PTSD are also subsequently increasing in prevalence. The broadest, community-level issues

include increased food insecurity, social instability, interpersonal aggression, violence, crime, and displacement, especially amongst indigenous peoples and in regions where livelihoods depend directly on agricultural performance. Most vulnerable are women (particularly pregnant and postpartum), young children, the elderly, individuals with disabilities, the economically disadvantaged, and those with preexisting physical or mental illnesses, the last of whom are most adversely affected during episodes of extreme heat. "The majority of affected people do recover over time," Dr. Hemmati said. "However, a significant proportion of exposed individuals develop chronic psychological dysfunction. And that is up to 20 percent, depending upon the disaster."

Dr. Hemmati also stressed throughout her presentation the mutual inclusivity of physical, psychological, and social well-being, as well as the many dimensions of environmental change the SDG's must tackle in order to improve population health. Lastly, she emphasized that realizing the SDG's must include psychologists' establishment of partnerships across "sectors, silos, and disciplines" in the absence of stereotyping. One important example of such interdisciplinary cooperation includes the German government's National Climate Initiative, which now employs 14 thousand diverse municipalities working to achieve the nation's Paris Accord climate commitment. Representatives include lawyers, engineers, and administrative professionals, whom psychologists are training in group learning processes. Not only has this shown to be efficient and productive in ultimately reducing CO2 emissions, but it has encouraged effective team building and fundamentally changed the organizational culture of climate action for the better.

Second Presenter, Economic Pillar: Dr. Ann Masten, PhD

Dr. Masten, the Irving B. Harris Professor of Child Development at the University of Minnesota, studies the development of competence, risk, and resilience throughout the life span. In her presentation, Dr. Masten explained how research on human resilience and recovery is integral to informing their realization. Current times are fraught with war, terror, disasters, pandemics, displacement, poverty, homelessness, and other similar calamities, both incidental and chronic. However, there exists a growing multidisciplinary science of evaluating resilience, or "the capacity of a system (person, family, economy, ecology, et cetera) to adapt successfully to challenges that threaten its life, function, or development." Relevant research, especially amongst war and trauma survivors, has uncovered inspiring and actionable information on potential program development and capacity building endeavors that will expedite recovery in trauma-afflicted regions. More specifically, resiliency's three defining areas of focus are:

a) ***The threats*** themselves, such as trauma, neglect, poverty, war, natural disasters, and adverse childhood experiences (ACE's)

b) ***Protections*** at the neurobiological, individual, relational, community, cultural, and societal levels that each foster adaptive success

c) ***Adaptive success*** measures, such as developmental tasks, mental and physical health, happiness, achievement, and parenting

Similar to Dr. Hemmati, Dr. Masten then described the simultaneous interaction of the myriad systems affecting an individual at differing times and degrees, and how systems can also be embedded and interdependent. She elaborated that, for instance, "a child is a living system, and within that child are many other systems that help them function." She then explained how human

systems such as families and communities all involve and depend upon multiple actors. As an example, Dr. Masten described the quality of children's interactions with their teachers, and the environments in which those interactions occur, as key determinants of a child's development. Dr. Masten also acknowledged the role of national policies, which frequently constrain the resources available in each part of the system. These systemic interconnections each create and feature opportunities to leverage change in the interest of promoting synergy.

Dr. Masten then described the most important protective factors that foster an individual's resilience. Healthy brain development, cognitive and self-regulation skills, as well as motivation, are all integral within the individual, whereas good caregiving, food security, emotionally and physically safe conditions, and solid family routines are all critical elements of the individual's immediate environment. School and classroom systems must feature strong leadership, effective teaching, high expectations, support, structure, and a welcoming climate. Community and cultural systems must feature healthcare and emergency services. Governmental and non-governmental services should support families, education, and stress-reducing traditions. Masten affirmed that "human beings have a lot of capacity for recovery and withstanding adversity if these fundamental protections are in place."

Lastly, Masten overviewed the most rapid – and perhaps most important – stage of a person's development: early childhood. The early childhood years contain the largest number of simultaneously developing foundations for a stable, productive, and empowered life thereafter. Early childhood features the swift formation of cognitive function, stress regulation, interpersonal attachments, problem-solving skills, motivation to learn, and the cultivation of empathy and pro-social behavior. Given these skills' increased importance throughout the lifespan as the child (then adolescent, then adult) gain agency and independence, these "neurocognitive and socioemotional tools for life and learning" yield cascading consequences for the near and distant future. The knowledge that success and competence are cumulative should underscore the universal necessity of support for mothers and pregnant women, safe home environments, stable upbringings, violence prevention, food and housing security, and constructive early childhood education programs, all of which invariably yield immeasurable returns on investment. To conclude, Dr. Masten explained, "Investing in healthy lives and well-being builds enduring resilience for societies." Resilience and "the capacity to adapt" are common, "and we can invest and do something about it."

Third Presenter, Social Pillar: Dr. Doug Oman, PhD

The final presenter for this year's event was Dr. Doug Oman, President of the Society for the Psychology of Religion and Spirituality of the APA. He is also an adjunct professor in the School of Public Health at the University of California at Berkeley. Dr. Oman, whose work focuses on occupational health and spirituality, aptly titled his presentation "Spirituality and Religion: Contributions and Implications for Well-Being and Sustainable Development Goals." After a brief historical overview of the history of psychology with Dr.'s William James and Sigmund Freud, he explained how an upswing in academic enthusiasm for religion's positive psychological effects took hold in the 1980's. Dr. Oman stated that modern literature and empirical evidence have revealed that, overall, religion and spirituality are positively associated with improved physical and mental health. Some dimensions of religion and spirituality feature worse outcomes, such as with extremism, internal and interpersonal conflict, and refusal of medical care on religious grounds.

However, Dr. Oman stated that meta-analyses, mostly from Western and US samples, have revealed that mild to moderately religious individuals are 18 percent less likely to experience premature death, with life prolonged for religious US residents an average of 7 additional years (for Black Americans, added longevity averaged 14 years). This is a difference similar to that of smokers versus nonsmokers. Other studies have revealed that spiritual and religious involvement reduces risk of common physical ailments such as cardiovascular disease, stroke, cancer, pulmonary disease, disability, and dementia. Religious and spiritual involvement can also reduce depression and anxiety. Similarly, related "accommodative therapies" have been shown to yield better mental health outcomes than control groups and groups receiving "alternate secular psychotherapies." Lastly, mild to moderate religious involvement has been shown to reduce likelihood of youth risk behavior and substance abuse, as well as improve marital stability and coping skills. Despite these results' relative confinement to the US and Western world, there has been ample cross-cultural corroboration in many other diverse regions for several physical and mental risk factors.

Dr. Oman argued that such findings have important implications for community building and overall achievement of the SDG's. In general, clinicians can support and acknowledge religion and spirituality as valid coping mechanisms for interested patients, as well as develop basic competencies in spirituality-enhanced psychotherapies. Clinicians in medical settings are also encouraged to consider patients' "spiritual histories" during treatment. Accrediting bodies such as the Joint Commission have also begun to require that certain healthcare organizations conduct religious assessments, most commonly in intake settings. Dr. Oman suggested the possibility of healthcare professionals' teaching evidence-supported spiritual and religious practices, yet they must be very careful not to endorse or promote specific practices over others. One noncontroversial example involves allocating brief segments of time to sitting meditation, common forms of which can be religious or secular in nature. Dr. Oman believes that the UN can develop and disseminate professional training and skills workshops to spread knowledge of *common ground strategies*, which are general coping frameworks that align a) the "outsider, etic" insights of professional psychologists' expertise with b) "insider, emic" spiritual traditions. Dr. Oman argued that, not only is this all directed toward well-being, but there is a particular resonance with SDG No. 16, which is to "Promote peaceful and inclusive societies… and build effective, accountable, and inclusive institutions at all levels."

Dr.Gonzales-Canali, MD, advisor at the UN Coordination Division of UN Woman: Critical Issues on wellbeing

Last to speak was panelist Dr. Gustavo Gonzalez-Canali MD, a clinical research physician and Senior Advisor at the United Nations Coordination Division of UN Women. Dr. Gonzalez-Canali, who was formerly head of the Health and Human Development Department of the French Ministry of Foreign Affairs, spoke about critical issues for well-being related to the Beijing Platform for Action. Dr. Gonzalez-Canali first mentioned that women and girls comprise slightly more than half of the world's population, and that they are "more deeply impacted than men and boys by poverty, climate change, food insecurity, lack of healthcare, and global economic crises." However, women's contributions and leadership endeavors are vital to social success, so it is critical to examine a) how the SDG's will affect women and girls specifically, and b) how women and girls can uniquely help achieve them. Dr. Gonzalez-Canali stated that,

"Health in all respects, both physical and mental, is a fundamental human right." Therefore, a right to health, the basis of well-being and the foundation of general participation in public life, must be better expressed as the right to fully access the best possible physical and mental healthcare resources. This language emphasizes societies' obligation to deliver said services, as health statuses depend not only upon biology but the (often discrimination-laden) social environment, political choices, and levels of economic advancement. Worldwide afflictions for women and girls such as unfavorable power dynamics, domestic abuse, and early marriage and pregnancy all cause vastly understated physical and mental health detriments, as well as economic obstacles. Gonzalez-Canali thus stressed the importance of governments' specific attention to gender-based issues and their solutions, especially the many health threats that women still disproportionately face in the 21st century.

Although the topics reviewed in this 10th annual event were comprehensive and far-reaching, it would have been especially productive for a health psychologist to have presented as well. This is because health psychology focuses specifically on health and well-being, i.e. how cognitive, social, and emotional processes affect an individual's illness behavior and physical well-being. Given this branch of psychology's specific relevance to both this year's topic and the achievement of health and well-being across the world's populations, UN interventions can also benefit from knowledge of health-related behavior change mechanisms. Knowledge of health behavior change theories, models, and skills can therefore spur new and enhance existing UN health promotion programs and interventions, especially with additional contributions from implementation and translational scientists. Such programs can have an impact on individuals' health-oriented behavior and resilience skills, the cumulative effects of which should manifest itself in improved population-wide health outcomes.

We agree with Dr Gaba's assertion, "The presentations this year affirm the intersection of psychological science and practice with the economic, environmental and social pillars of the global agenda, showing how interconnected well-being is to the achievement of the sustainable development goals." More generally, the recognition of psychologists and their important partnerships with government delegates in the global human rights agenda is a critical step forward, especially for those who have been historically and economically marginalized. Achievement of well-being is not only interlinked with many other goals of the agenda, including eradicating poverty, restoring ocean health, or combatting climate change, but it is central to a stable society, "the heart" of sustainable development. Despite current progress, there is still more to be done, so in the words of Dr. Otto, "Let's think about reaching for the stars, accepting the moon, and ensuring that, at the end, we don't come up empty-handed."

Sarah Goodman
Icahn School of Medicine at Mount Sinai, New York
sarah.goodman@icahn.mssm.edu

Vera Araujo-Soares
University of Newcastle, Newcastle upon Tyne, UK
vera.araujo-soares@newcastle.ac.uk

Nihal Mohamed
Icahn School of Medicine at Mount Sinai, New York
nihal.mohamed@mountsinai.org