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Facilitating health behaviour change and its maintenance: Interventions based on Self-Determination Theory

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Despite many recent technical breakthroughs in health care, human behaviour remains the largest source of variance in health-related outcomes (Schroeder, 2007). People's health and well-being are robustly affected by lifestyle factors such as smoking, hygiene, diet, and physical activity, all of which involve behaviours that are potentially controllable by the individual. In addition, outside of acute care settings, the effectiveness of most health care interventions is highly dependent on the patient's adherence to self-care activities such as taking medications, performing self-examinations, or refraining from specific activities or habits. A significant problem is the poor adherence to prescribed changes or recommended behaviours over time.

In the perspective of self-determination theory (SDT: Deci & Ryan, 2000; Ryan & Deci, 2000), recognition of these behavioural mediators of health outcomes suggests that we attend more carefully to the patient's experience and motivation. According to SDT, maintenance of behaviours over time requires that patients internalize values and skills for change, and experience self-determination. The theory further argues that by maximizing the patient's experience of autonomy, competence, and relatedness in health-care settings, the regulation of health-related behaviours is more likely to be internalized, and behaviour change will be better maintained (Williams, Deci, & Ryan, 1998).

As a general theory of motivation, SDT has spawned experimental and field studies of how factors such as rewards, sanctions, use of authority, provision of choice, and level of challenge impact patients' experiences, and in turn their behavioural persistence and outcomes (Deci & Ryan, 2000). Over the past 15 years a growing body of work has applied SDT in studies of health-related behavior change (Patrick, Williams, Fortier et al., 2007; Ryan & Deci, 2007; Williams et al., 1998). Such work has examined how factors in treatment environments associated with patients' autonomy, competence, and relatedness, affect both the initiation and maintenance of change. More recently a number of controlled clinical trials have tested the efficacy of SDT-framed interventions for



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issues as diverse as tobacco dependence, diet, physical activity, and dental care. Our aim in this brief paper is to explicate the SDT model of health behaviour change and provide a partial review of its empirical support and limitations.

Self-Determination Theory

Health researchers (e.g., Rothman, 2000) have described the process of health behaviour change as entailing the dual tasks of initiating and maintaining change. Although there are many approaches to initiating change, from external pressure and control to the positive use of incentives or rewards, the ingredients essential to maintenance are often missing.

SDT, in contrast, is particularly focused on the processes through which a person acquires the motivation for initiating new health-related behaviours and maintaining them over time. SDT argues that developing a sense of *autonomy* and *competence* are critical to the processes of *internalization and integration*, through which a person comes to self-regulate and sustain behaviours conducive to health and well being. Thus, treatment environments that afford autonomy and ►

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support confidence are likely to enhance adherence and health outcomes. Equally important to internalization in the SDT view is a sense of *relatedness*. People are more likely to adopt values and behaviours promoted by those to whom they feel connected and in whom they trust.

Autonomy. Most health-related behaviours, such as increasing physical activity, taking medications, or quitting smoking, are not intrinsically motivated or inherently enjoyable activities. Thus, if such behaviours are to be successfully enacted and maintained outside of treatment settings or controlled environments, individuals must come to value the behaviours and personally endorse their importance.

Unfortunately, many people engage in behaviour changes only because of what in SDT is labelled *controlled motivation*. One common form of controlled motivation is *external regulation*, in which a person acts only to get an external reward, avoid a punishment or to comply with social pressures. Practitioners often create external regulation by suggesting incentives or contingencies, or by trying to motivate through mere authority. Another form of controlled motivation is *introjection*, in which a patient might act to receive approval or praise, or to avoid disapproval or feelings of guilt. Introjection is often cultivated by practitioners as a way of goading patients into action by conveying contingent approval. According to SDT, both forms of controlled regulation, external and introjected regulation, are largely unrelated to long term adherence.

In contrast change can be a function of *autonomous motivation*. One form of autonomous motivation is *identified regulation*, in evidence when one personally endorses or identifies with the value or importance of a behaviour or health practice. Identification is facilitated when practitioners provide relevant information and meaningful rationales for change, and do not apply external controls and pressures that detract from a sense of agency or choice. Even more autonomous is *integrated regulation*, in which a person not only values a behaviour, but has also aligned it with other central values and lifestyle patterns. Practitioners facilitate integration by supporting patients as they explore resistances and barriers to change, and helping them identify congruent pathways to health. According to SDT both identified and integrated regulations are autonomous and are associated with enhanced maintenance and transfer of behaviour change.

Competence. Along with a sense of autonomy, internalization requires that a person experience the

confidence and competence to change. In SDT, support for competence is afforded when practitioners provide effectance relevant inputs and feedback. This means that the patient is afforded the skills and tools for change, and is supported when competence or control-related barriers emerge. Patients are not over challenged, but rather helped to experience mastery in terms of the health behaviour change that needs to be engaged.

In the SDT model of change, gaining a sense of competence is facilitated by autonomy. That is, once people are volitionally engaged and have a high degree of willingness to act, they are then most apt to learn and apply new strategies and competencies (Markland, Ryan, Tobin, & Rollnick, 2005). Moreover, in contradistinction to self-efficacy theory (Bandura, 1989), SDT predicts that competence alone is not sufficient to ensure adherence; it must be accompanied by volition or autonomy.

Relatedness. Many models of intervention and change have suggested that the practitioner-patient relationship is an important medium and vehicle of change. In health care this is especially so, as vulnerable individuals, often lacking in technical expertise, look for the inputs and guidance of professionals. In this process a sense of being respected, understood, and cared for is essential to forming the experiences of connection and trust that allow for internalization to occur. The impact of relatedness on patients' openness to information and likelihood of complying with recommendations is thus high.

The Self-Determination Health Behaviour Model

The SDT model of health behaviour change is schematically represented in Figure 1. As depicted, the patient's experiences of autonomy, competence, and relatedness are affected by autonomy-supportive health care climates, by individual differences in personality regarding autonomy, and by the intrinsic and extrinsic nature of the patient's aspirations or strivings (Kasser & Ryan, 1996), which impact lifestyle and value priorities. In turn, when humans feel their psychological needs are being supported this has been associated with better mental health (less depressive symptoms, anxiety, and somatization), greater quality of life, and better health-related outcomes, such as greater intake of fruits and vegetables, reductions in smoking, better glycemic control for patients with diabetes, more physical activity, and improved adherence to prescribed medications. ►



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Field studies and controlled clinical trials. A most important development has been the movement from basic motivational research framed by SDT to the study of existing clinical interventions and the construction and testing of new treatment approaches based on the model. As indicated in the lower right of Figure 1, there have been a number of large field studies and randomized controlled trials of interventions based on the SDT approach to change. Field studies have shown, for example, that long term medication adherence is substantially a function of patient autonomy, which in turn is promoted by prescriber autonomy support (Williams, Rodin, Ryan, Grolnick & Deci, 1998). Similarly, maintained weight loss has been linked to treatment autonomy support, and the internalization of treatment goals (Williams, Grow, Freedman, Ryan, & Deci, 1996). In the domain of substance abuse, studies have shown linkages between autonomy support, internal motivation, and treatment outcomes (e.g., Zeldman, Ryan, & Fiscella, 2004).

The way in which goals are framed also has implications for health-care interventions and

outcomes. SDT distinguishes intrinsic and extrinsic life goals, with the former focused on inherently satisfying goals such as personal growth, generativity, physical health, and relationships, and the latter focused on acquiring wealth, having fame, and being physically attractive (Kasser & Ryan, 1996). A focus on extrinsic goals has been associated with more risky, less healthy behaviours (Williams, Cox, Hedberg, & Deci, 2000). Moreover, a clinical intervention for obese children showed that a focus on the intrinsic goal of health rather than the extrinsic goal of attractiveness as reasons for change resulted not only in greater initial weight loss, but also better maintenance over a two-year period (Vansteenkiste, Simmons, Braet, Bachman, & Deci, 2007).

There have also been some randomized controlled clinical trials testing the efficacy of SDT-based interventions. These include interventions concerning tobacco dependence (Williams et al., 2006), physical activity (Fortier, Sweet, O'Sullivan, & Williams, 2007), and dental hygiene (Münster, Halvari & Halvari, 2006). Taken together ►

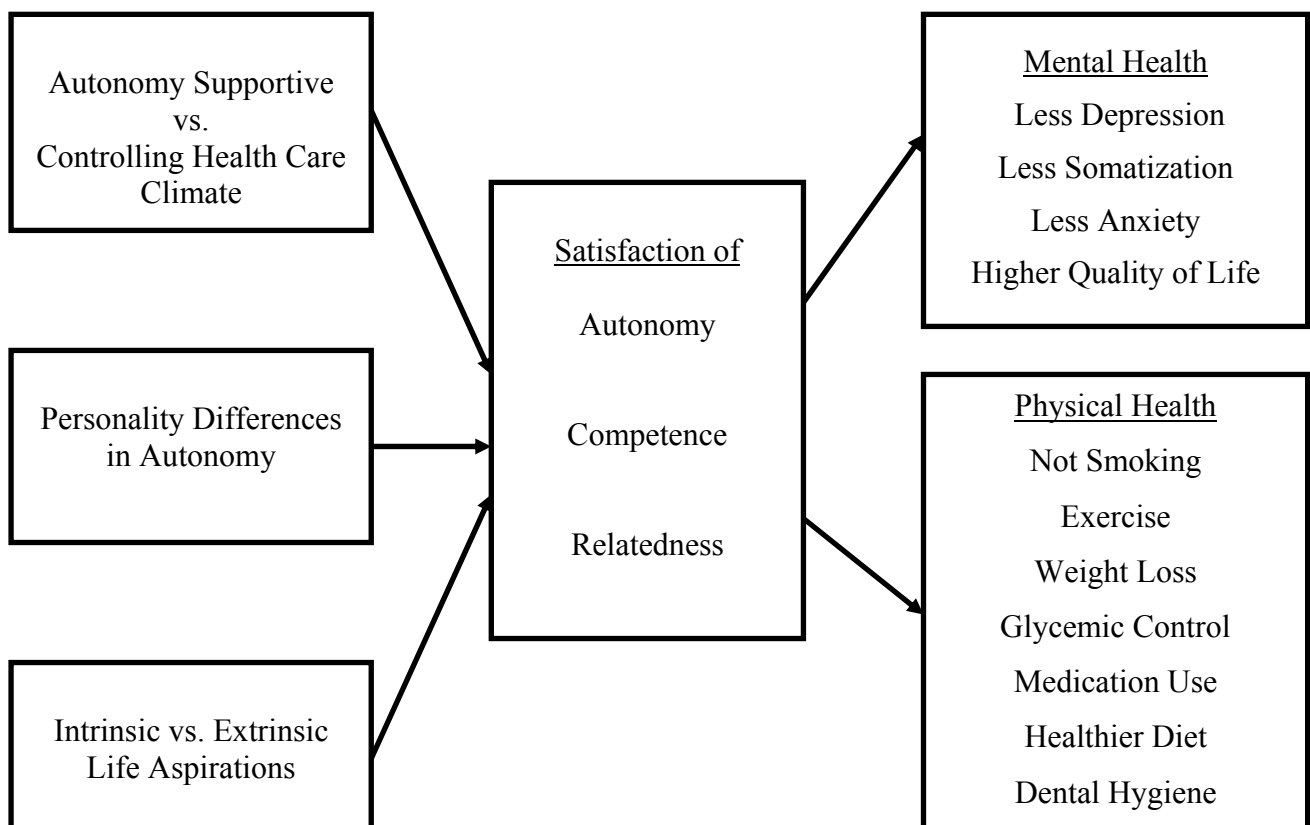


Figure 1 Self-Determination Theory Model of Health Behaviour Change

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these interventions have been shown to facilitate the internalization of autonomous self-regulation and feelings of competence, and thereby improved treatment outcomes (Patrick et al., 2007). In these studies not only did autonomy support enhance outcomes, change in autonomous self-regulation was typically shown to have its own unique effect on outcomes, a pattern of results consistent with the causal role that autonomous motivation can have in health-related behaviour change.

Summary

Research relating self-determination theory to health behaviours supports a consistent and interesting pattern of findings. When patients have their psychological needs for autonomy, competence, and relatedness supported in the process of their health care, they experience more volitional engagement in treatment and maintain outcomes better over time. This pattern of findings appears to hold for broad lifestyle changes such as smoking cessation or dietary regulation, as well as discrete behaviours such as the adherent use of medications.

These findings call for additional research to more clearly elucidate the active components of autonomy, competence, and relatedness supports, the types of practitioner care that facilitate effective change. Health behaviour change research will move forward if such research includes assessment of theory-based mediators and outcomes that are assessed long enough after the end of treatment to reflect maintained change. Despite the complexities of modern health care, including advanced technologies and capacities for direct intervention, it remains the case that human behaviour plays a critical role in health outcomes and in the efficacy of most treatments. Given this, evidence based on SDT suggests that health care professionals can enhance their efficacy through support of patients' psychological needs for autonomy, competence, and relatedness. Doing so not only enhances important patient outcomes but also approximates the ethical ideals of promoting patient autonomy and responsibility in health care decision-making and intervention. ■

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an interview with

Prof. Stephen Lepore

by Nihal Mohamed, Co-editor

Stephen Lepore is Professor of Public Health and PhD Director in the Department of Public Health, Temple University. Previously, he has held faculty posts at Columbia University, Brooklyn College, and Carnegie Mellon University. Prof. Lepore is one of the most outstanding researchers in the field of quality of life research (QOL) in the US. He completed his undergraduate training in psychology at Clark University, received his Ed.M degree from Harvard University, and his Ph.D. in Social Ecology from the University of California, Irvine. Professor Lepore's work addresses social disparities in health, particularly through the development and application of evidence-based behavioral and social interventions, among others. Professor Lepore is a Fellow of the Society of Behavioral Medicine and has received numerous awards in recognition of his research accomplishments, including an Award for Outstanding Contributions to Health Psychology from Division 38 of APA, and the Young Investigator Award for Outstanding Contributions to Behavioral Medicine from the Society of Behavioral Medicine, and a Fulbright Award. His current projects include several National Institutes of Health-funded randomized controlled trials that are designed to test the efficacy of educational and behavioral interventions for resolving diverse health problems, including increasing informed decision making about prostate cancer testing in men of African descent and promoting quality of life in colorectal cancer patients using expressive writing therapy.*

On the Front Lines: Improving Prostate Cancer Decision Making and Quality of Life**Prostate Cancer**

Prostate cancer (Pr Ca) is the most prevalent solid tumor malignancy and the second leading cause of cancer-related death in the United States (US). Early medical interventions of Pr Ca can cure a potentially disabling and deadly disease, however, evidence suggests that the commonly recommended Pr Ca treatments may not improve survival and may result in adverse effects.

The *european health psychologist* interviews Prof. Stephen Lepore about some of the conflicting issues in Pr Ca screening and the psychosocial care needs of patients and their families.

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NM: Prof. Lepore, can you talk about prostate cancer screening and early detection?

SJL: The incidence of prostate cancer is quite high throughout the world and the only chance of curing the disease is to catch it and treat it in the early stages. However, there is much controversy related to prostate cancer screening. Although the incidence and number of deaths from prostate cancer is quite high, the vast majority of men diagnosed with prostate cancer die from other causes. Because of this, identifying and treating all men with prostate cancer may result in many men receiving unnecessary treatments—treatments that can have serious untoward side-effects, such as urinary and sexual dysfunction. In addition, the prostate cancer tumour is often slow-growing and the majority of men get it at a late stage in life when they may be susceptible to more lethal illnesses. Finally, due to a lack of clinical trials showing that screening actually saves lives, current national guidelines do not recommend prostate cancer screening. Instead, various medical societies, including the American Cancer Society, recommend that men over the age of 50, or over 40 for high-risk men, participate in decisions about whether prostate cancer tests are right for them after learning about the disease and the potential benefits and limitations of testing. Increasingly, men are getting tested for prostate cancer, but it is not clear whether they are making fully informed decisions ►

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about testing. Many primary care physicians do not have the time to educate their older male patients about prostate cancer testing or they may not know the best way to present the possible risks and benefits of testing in a balanced and effective manner. Thus, men may get tested with little more than a simple recommendation from their physician. There is even evidence of so-called "opportunistic testing," in which physicians order a PSA tests as part of a panel of other blood tests during a routine physical exam without discussing the test with the patient. Thus, there is a major need for more public education and awareness about all aspects of prostate cancer testing and for men to talk with health care providers about whether testing is right for them. This need is especially great among those segments of our population who are at especially high risk for prostate cancer morbidity and mortality. Health psychologists are uniquely qualified for designing programs that facilitate decision making under uncertainty and doing so with cultural sensitivity.

NM: *What are the biggest concerns that men have when they consider the different treatments options for early stage Pr Ca? And how can the medical care providers help patients during the decision processes?*

SJL: Despite recent trends suggesting declines in the incidence and rates of death from prostate cancer, it is still the big "C". First and foremost, patients, their families and physicians are concerned with curing early stage prostate cancer to prolong life. However, there is no strong evidence that one form of treatment is better at prolonging life than any other form of treatment. Indeed, in many cases, treatment may be no better than observation, or so-called "watchful waiting". A patient's age and overall health status often influence treatment decisions. For example, a 70-year-old man with heart disease is not a good candidate for surgical removal of the prostate. Another consideration is the potential short- and long-term effects of different kinds of treatments on a patient's quality of life. Research with my colleagues suggests that men treated by radical prostatectomy, or surgical removal of the prostate gland, tend to report more post-treatment urinary and sexual problems and more general physical dysfunction than men treated by radiation therapy. Patients and their families should be fully educated about the treatment options and the potential consequences of their choices. Patients can become more knowledgeable by seeking second (or third) opinions about treatments from an oncologist or other cancer specialists, trying to talk with men who have been treated for prostate cancer, possibly in a local support group or through an Internet-

based group, and reading books on the subject. There also are decision aids which can be found on websites, but these are not yet widely available or recommended by physicians. These aids typically educate patients about different treatment options, explain the potential risks and benefits that can be expected, and include exercises that help patients to weigh the relative importance of different risks and benefits so they can make a decision that is concordant with their values. Greater integration of patient decision aids in physicians' practice, or simply greater availability of these aids through public sources, such as the Internet and libraries, would be extremely valuable to patients and their family members who are facing very tough decisions.

NM: *How do you define quality of life and why have you focused on quality of life after prostate cancer treatment?*

SJL: In the context of prostate cancer, health-related quality of life would be those aspects of a man's normal life that have been affected by the disease or its treatment. Because we are talking about "quality" of life, there is necessarily a subjective element: the patient has to interpret the impact of the disease and treatments in relation to prior functioning or his personal expectations and goals. For example, one patient may experience urinary incontinence as a highly bothersome and distressing outcome of treatment, whereas another may view it as a nuisance. There are many areas of an individual's life that may be affected by prostate cancer, including physical, emotional, cognitive, and social functioning and well-being. There has not been much research on the topic, but it is also possible that men can experience positive changes in some areas of their life – for example, after the scare of prostate cancer, a man may decide to retire early and spend more time travelling with his wife and enjoying life.

My work has focused on quality of life outcomes in men treated for prostate cancer for several reasons. First, different treatment protocols – surgery, hormones, radiation, watchful waiting – have very different effects on quality of life, but none has an obvious survival advantage. Thus, understanding the effects of different treatments on quality of life may be critical to men considering treatments. Second, when my colleagues and I started our research in this area, there was relatively little known about the wide-range of effects of prostate cancer on quality of life in men and their families. Third, the majority of ►



an interview with

Prof. Stephen Lepore (cont'd)

studies that have attempted to improve quality of life outcomes in people who have had cancer have focused on women, specifically women with breast cancer. Until we began our intervention studies, there had been no large-scale, controlled studies comparing different methods for improving quality of life outcomes in men who had been treated for prostate cancer. At least a half-dozen intervention studies have now been conducted with men treated for prostate cancer and we are learning that a variety of approaches may be effective at improving quality of life, particularly for men with high need and relatively low coping resources. There is still much to do, however, to find ways to disseminate promising interventions. In addition, there has been little research addressing the psychosocial needs of men and their families who are coping with advanced prostate cancer. This is an important direction for future research.

NM: *You have conducted controlled trials that are designed to test the efficacy of educational and behavioural interventions for resolving diverse health problems among minority and underprivileged patients, including Pr Ca patients. Were these interventions successful in achieving their goals? Are there any factors that moderated their efficiency?*

SJL: In the context of prostate cancer, we have conducted studies on the effects of educational and support group on quality of life in men treated for localized prostate cancer. In addition to survivorship studies, we have conducted an education intervention designed to enhance informed decision making about early detection (e.g., prostate specific antigen tests and digital rectal exams) and dietary practices in black and African American men, who have an exceptionally high risk for prostate cancer incidence and mortality.

Our research on the efficacy of education and support groups showed overall beneficial effects on employment status and psychological adjustment to sexual dysfunction. However, men with high needs (e.g., high psychological distress) and low coping resources (e.g., low levels of education) showed a broader range of benefits, including improvements in physical functioning and psychological symptomatology, relative to their counterparts with relatively low needs and high coping resources. This makes a lot of sense and suggests that psychological interventions can help to reduce social disparities in quality of life outcomes in cancer patients. In our

research on informed decision making related to prostate cancer testing, we are finding very strong positive effects of tailored telephone education and counselling on knowledge about testing, participation in prostate cancer decision making, as well as reductions in decision conflict. In addition, we are finding that brief telephone counselling is also effective at improving fruit and vegetable intake in men of African descent who have very low fruit and vegetable intake. Preliminary results suggest that these effects are quite strong and do not appear to be moderated by other factors.

NM: *How can spouses/partners of patients enhance their adaptation to Pr Ca treatment side effects?*

SJL: This is an excellent question. I would add that cancer affects many people in the patient's social network, including children, friends, co-workers, other family members, and that this is seldom considered in psychological interventions targeting people with cancer. For example, many men in our prostate cancer support groups mentioned that they had not discussed their disease with their adult male children. This is obviously not in the best interest of those male children, because prostate cancer is partly hereditary. Of course, after the patient the spouse is often the one person most directly affected by the disease and its implications. Our research on support groups included spouses of men treated for prostate cancer. However, we have not yet specifically focused attention on helping spouses to cope with their partner's cancer. We did collect data from spouses in our support group studies and found some evidence that they tend to have more cancer-specific distress (e.g., intrusive thoughts) than the patients. Thus, there is some indication that couples-based interventions may be warranted. We are currently developing such interventions for men with advanced prostate cancer because the caregiving demands escalate significantly in this population. ■

Recommended readings:

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For more information on Stephen Lepore's lab and reprints, see:
<http://www.temple.edu/chp/research/SBHI.htm>

Call for contributions

The European Health Psychologist (EHP), the official bulletin of the European Health Psychology Society, would like to issue a general call for contributions to members of the EHPS. The quarterly online publication of the bulletin reaches all members of the EHPS and as such is a vehicle for transmitting timely and thought-provoking ideas and research. Past issues have featured wide ranging scientific topics written by contributors based both within and outside of Europe and the EHP aims to continue this trend into the future. Over the past year, you may have noticed a movement towards publication of empirical results, with an eye on filling a niche which does not fall within the remit of *Psychology & Health* or *Health Psychology Review*. Nevertheless, a diversity of contributions may include, but are not restricted to:

- **Position papers (think pieces)**
- **Overview papers**
- **Research letters**
- **Interviews**
- **Controversy**
- **Reports about conferences and workshops**
- **Country/research group profiles of EHPS conference host countries**
- **Other important information relevant to EHPS members**

Manuscripts must not currently be under review, accepted for publication, or published elsewhere unless express consent is given by the original publisher, and must be written in English. Though all manuscripts are considered, we urge potential contributors to contact the editorial team in advance to discuss ideas or potential submissions. An informal peer-review process consisting of one of the Editors, an Editorial Assistant, and a co-editor will read all submissions and provide timely feedback on submissions. Further details regarding publication guidelines can be found on the EHP website (http://www.ehps.net/ehp/author_instructions.html), and any questions can be directed to the editors.

We look forward to discussing your ideas for potential pieces in upcoming issues of the EHP.

Cordially yours,
 Falko F. Sniehotta & Vera Araujo-Soares, Editors
 On behalf of the European Health Psychologist Editorial Team



original article

Self-ratings of health and longevity: A health psychologist's viewpoint on epidemiological findings

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“How, in general, would you rate your health: excellent, very good, good, fair, or poor?” This simple question often serves as an opening to many large sociological and epidemiological health-related surveys because it is a simple, convenient and polite way to begin an interview or a questionnaire on personal health matters. Could this simple single item be more than just a convenient way to begin a survey? Does it reflect more than just a momentary assessment of how we feel? Could it be a valid measure of one's health status? As health psychologists who have been trained to use multi-item scales with good internal reliability, the answer to these questions is not obvious. In this article I will briefly introduce the current state of research on these questions.

How do people view their own health?

Subjective perceptions of global health have been extensively studied, mostly by sociologists and anthropologists. Qualitative studies have consistently shown that these perceptions span the entire illness-wellness continuum and provide comprehensive summaries of the myriad factors which people view as part of their concept of health. For example, Herzlich (1973) concluded, on the basis of interviews with French adults, that health is viewed as “being” (ill or well), “doing” (being physically and socially active) and “having” (a reserve of strength and fitness). Quantitative studies have also provided evidence that self-rated health (SRH) is associated with diseases and symptoms, functional ability, health care utilization, medication use, mental health, social support and social networks, and socioeconomic factors (see, for example, meta-analysis by Pinquart, 2001) and that they are strongly affected by positive affect and function and not only by disease, disability, and negative affect (Benyamini, Idler, Leventhal, & Leventhal, 2000).

In other words, people's subjective perceptions of health capture physical, psychological, and social factors, in line with the view of health in the bio-psycho-social model and similar to the WHO definition of health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 1948). Such a holistic view of



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health is not only a modern ‘new age’ phenomenon; it has been around since before the time of the ancient Greeks and has always been part of people's own view of their health. The question is whether such self-reports of health are also valid in comparison with other measures of health. Can researchers and practitioners rely on them instead of more complicated and expensive measures (such as medical examinations, functional tests, or even longer questionnaires such as the SF-36)? Should they use them in addition to such measures?

Are subjective perceptions of health valid?

In 1982, Mossey and Shapiro reported a most intriguing finding: SRH is not only concurrently related to various health measures, it also predicts longevity. This finding had attracted the attention of many researchers. Given that many health surveys included a SRH question, secondary analyses of data from longitudinal studies were soon conducted, with the aim of exploring the SRH-mortality association. Idler and Benyamini (1997; Benyamini & Idler, 1999) reviewed dozens of studies, all with large representative community samples and follow-up periods ranging from 2 to 28 years. Some of ►

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these studies investigated the predictors of mortality and as they included a SRH measure, they inadvertently provided information relevant to the predictive power of this measure. Other studies have aimed directly at explaining the SRH-mortality association by adding covariates that might eliminate this association. Nevertheless, in over 80% of the studies in those reviews, an independent effect of SRH remained, regardless of the covariates added: respondents who reported better SRH at baseline survived significantly longer than respondents who reported poor SRH, after adjusting for age, gender, and a large variety of health-related measures. These findings have also been replicated in patient populations and with future health outcomes other than mortality (e.g., new morbidity, hospitalisation, nursing home placement, recovery from illness, changes in functional ability). They are all the more impressive in light of the differences among studies in the wording of the single SRH question and its response options and the large number of countries (over 20) in which these studies were conducted in many languages. Such findings have led many researchers to use SRH as a proxy measure for health, instead of more detailed measures. Our interest, however, is in the unique effect of SRH, independent of other measures.

Why does SRH predict future health states?

Do people know something about their health that is not tapped by the measures that are typically used in research and practice? Or, does SRH in itself play a causal role, affecting future changes in health? Idler and Benyamini (1997) proposed four possible explanations for the validity of SRH: (1) SRH is a more inclusive measure of health status and health risk factors than the covariates used; (2) SRH is a dynamic evaluation, judging trajectory and not only current level of health; (3) SRH influences behaviours that subsequently affect health status; and, (4) SRH reflects the presence or absence of resources that can attenuate a decline in health. In the decade since this review was published, new studies provided support for these explanations.

The first explanation argues that SRH better summarizes all of one's diseases (including those in preclinical, yet undiagnosed, states), symptoms, and risk factors, as well as the effects of co-morbidity. Another way to view this is that SRH "corrects" for inaccurate or insufficient measurement of these factors. In light of the robustness of the effect, even in studies with detailed measurement of health and risk factors, it

is unlikely that this is the sole explanation for the SRH-mortality association. However, there is evidence that directly supports this explanation: SRH predicted future physician ratings of health but not vice versa (Maddox & Douglas, 1973); it predicted new morbidity, and it was even found to be more accurate among participants with a cardiovascular disease, who presumably knew what to look for and adjusted their SRH according to changes in these signs and symptoms (Idler, Leventhal, McLaughlin, & Leventhal, 2004).

As for the second explanation – "the trajectory hypothesis" – SRH indeed reflects changes in health, lifestyle, and life circumstances. It is sensitive to daily changes in symptoms and affects (Winter, Lawton, Langston, Ruckdeschel, & Sando, 2007), but not to induced moods (Barger, Burke, & Limbert, 2007). Changes in SRH predicted mortality better than one-time baseline ratings (Ferraro & Kelley-Moore, 2001), possibly through its indirect effect on current SRH (Wolinsky & Miller, 2007).

The third explanation is supported by many studies showing relationships between good self-rated health and adherence to health behaviours. Moreover, self-rated health seems to be an enduring part of one's self-concept and as such, may take part in the process of setting behavioural goals and striving towards them (Bailis, Segall, & Chipperfield, 2003).

The fourth explanation is comprised of two parts. First, SRH has been found to be related to various environmental and social resources that contribute to one's ability to cope with health threats. Second, SRH has been found to be related to negative affective states, which can reflect or even affect physiological systems. Indeed, in the past few years, studies reported associations of self-rated health and changes in self-rated health with various physiological measures, including immunological and endocrine factors.

What is the valid "heart" of SRH?

Self-ratings of health are far from being 100% accurate as predictors of future health states. In other words, they consist of a "valid" core but include additional "noise". An attempt to break SRH down to its components revealed that this valid core includes one's evaluation of functional ability, level of physical activity (in general, not only "formal" exercise), feelings of energy, fatigue and ►



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Benyamini, Y. (cont'd)

somatic depression symptoms (such as difficulty "getting going" in the morning). The "noise" part, i.e., predictors of SRH that did not predict mortality, included self-rated oral health and negative affects (that did not predict mortality after positive affect and function were accounted for). Thus, the valid core of SRH seems to reflect an overall sense of vitality and hardiness, which may be difficult to assess with medical tests (Benyamini, Leventhal, & Leventhal, 1999). This may also explain why SRH has been found to predict mortality even within relatively healthy samples and also why spouse (van Doorn, 1998) and even other observer ratings of health (Brissette, Leventhal, & Leventhal, 2003) also had unique effects on mortality. External observers may be able to detect the sense of vitality yet are less affected by optimism and less likely to discount the effects of risk behaviours. This sense of vitality may be a better reflection of one's health status and could be related to a more active and full life which helps to preserve health.

Are there limits to the validity of SRH?

Beyond specific correlates of SRH that are not valid predictors of mortality, there is also evidence that its validity differs among subpopulations. For instance, SRH is a more accurate predictor of mortality among men in comparison to women. A probable explanation is that men's SRH are more closely focused on their health status whereas women's SRH includes more "noise", that is, it is more strongly affected by negative affect related not only to their own health but also to the health and life circumstances of their close ones. Another example of differential validity of SRH is observed with respect to age: SRH is a more accurate predictor of longevity among the old (up to age 84) compared with the old-old (≥ 85 ; Benyamini, Blumstein, Lusky, & Modan, 2003). This can be explained by the trajectory hypothesis: if part of the validity of SRH is due to its relation with changes in health, that is, to people deducing current and future health from past health, than such judgments, in particular those based on good health experienced so far, are more likely to be inaccurate at very old age, when unexpected changes are likely to occur.

Another important question is the accuracy of self-rated health in different cultures and ethnic groups. Raw ratings of health differ among cultures. Regarding the more interesting question of whether the accuracy of SRH as a predictor differs between cultures, the findings to date are inconsistent. The extent that one

can rely on self-ratings of health among people with psychological disorders is also unknown. Researchers have only begun to probe SRH among people with hypochondriasis, PTSD, and other disorders.

Final conclusions and implications

Given 21st century medical technology, do we still need to listen to what people say about their health? Though this may seem to be a simple question for health psychologists, it is far from being straightforward from the viewpoint of the medical professions. This brief review shows that SRH contains important and valid information. If its effects on future health states stem from its greater accuracy as a measure of current health, then all health professionals should be very attentive to these ratings, especially when they are not in accord with more objective measures. If it has a causal effect on future health, then we should be looking for ways to turn the wheel back in the other direction. For ethical reasons, we cannot simply convince people that they are healthy (since this could result in behaviours such as stopping to take their medication). We can however encourage them to lead as full and active a life as possible, given their physical or other limitations. ■

Note: More on views of research on SRH can be found in interviews with Idler and Benyamini at

http://www.in-cites.com/papers/Idler_Benyamini.html

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EHPS conference report

Meet the Expert: Past experience and future plans

By Yael Benyamini and Evie Kirana, on behalf of the EHPS Executive Committee

Health psychology is a relatively new field. In the last decades, research advances were not only rapid but also of great clinical significance. In order for the field to evolve, there is an evident need to support the development of abundant human resources and encourage scientists to actively contribute to this research field.

In this respect, the EHPS Executive Committee launched a new initiative last year named "Meet the Expert". The aim was to assist young scientists to improve the effectiveness of their current and future research activities by providing them a unique opportunity to consult with an expert in the field.

The group of experts were established research leaders with numerous scientific publications and outstanding academic teachers in health psychology worldwide. Five experts, Profs., Michael Diefenbach (USA), Marie Johnston (UK), Hannah McGee (Ireland), Herman Schaalma (Netherlands), and Wayne Velicer (USA) were selected between those with major teaching and research experience, and agreed to facilitate the initiative. The above group of experts proposed a very broad range of health psychology domains for consultation; cancer, disability, risk perception, ageing, theory and measurement were only a few of the domains.

The participants included 17 young scientists from Canada, Cyprus, Germany, Greece, Hungary, Italy, Mexico, the Netherlands, Norway, Poland, Portugal, Slovakia, Spain, Turkey, and the UK – a truly international team of experts and participants! Even a quick look at the application forms showed what an energetic, talented and ambitious group of people had signed up to participate, many of them close to the end of their PhD or recently graduated, at a crucial junction in their lives, eager to hear feedback and ideas about their research and their future options. Many of the participants came from countries in which health psychology is not well established and were looking forward to this opportunity for personal contact with experienced researchers from around Europe and the US. Even those from countries with a longer history of research and practice in health psychology, welcomed the opportunity to meet in person a distinguished scholar from outside their university and discuss their research. Many of them mentioned that they experienced barriers in their research, which they believed would be diminished through contacts with a wider international network.

The consultations were 30-minute one-on-one sessions that took place on the morning before ►



EHPS conference report

Meet the Expert: Past experience and future plans (cont'd)

the opening of the annual conference in Maastricht. Participants were asked to send in relevant information in advance and the experts had studied this information carefully and thus made optimal use of the meeting time. The consultation aimed to respond to the needs of each participant and included the provision of advice on:

- ▶ research perspectives and ideas (in order to encourage research originality),
- ▶ issues relevant to study design (e.g. research tools selection and outcome measures),
- ▶ how to combine clinical practice with research and specifically, how to develop interventions and combine this with research.
- ▶ important papers or books (where this was relevant, experts mailed the participants additional materials upon their return home).
- ▶ how to apply for and obtain funding.
- ▶ career and networking opportunities.

Many of the participants walked into the sessions shy and a bit tense ("How am I going to spend 30 minutes with the famous Professor so and so...?!) but all walked out smiling and relaxed. Anyone who walked by the meeting rooms that morning, could have witnessed scenes such as someone walking out of a session, holding her head as if it's about to burst from all the information she had received, and muttering to herself: "This woman knows so much!"

Feedback collected more systematically showed that these sessions fulfilled participants' expectations and they found the sessions to be very useful, of high quality and optimal length. Many participants added their impressions from this experience:

- ▶ 'The atmosphere was very friendly'
- ▶ 'I received some feedback on my research and a couple of hints how to improve it.'
- ▶ 'A truly positive experience; I got plenty of food for thought'
- ▶ 'A great way of discussing your ambitions'.
- ▶ 'I am glad to be a participant in this event and thank you very much for providing this opportunity to me.'
- ▶ 'I got some advice and also it was inspiring'
- ▶ 'This meeting moved my work a few steps further on.'

- ▶ 'Keep it up; it's a great opportunity for researchers to talk to other leading researchers in their field.'

Of course there is always room for improvement. Feedback from both participants and experts had led us to the decision to focus in the future mainly on research advice. We will also consider small group meetings, depending on the issues raised in advance by the applicants. We will ask participants to be even more specific in defining the issues to be raised in this consultation.

Plans for the coming year

Therefore, in light of the positive feedback, we are excited to announce that we will continue with this initiative in order to provide young researchers with the opportunity to consult with leading scientists in their field of interest.

A carefully selected panel of key scientists, willing to pass on their knowledge and experience will be there in order to:

- ▶ assist young researchers in planning a research project;
- ▶ provide young scientists with information and resources responding to the needs of their current research work. Participants may be provided with useful materials and tools, as well as with advice concerning the overcoming of specific obstacles they may be facing;
- ▶ provide guidance for participants' research perspectives;
- ▶ provide young researchers with the opportunity of long term networking opportunities.

The event will take place again on the morning on the opening day of the conference in Bath. Evie Kirana (Greece), who participated in "Meet the Expert" last year, has joined the organizing team and we both hope that this will be a success again. ■

We invite you all to take part in this effort – as experts or participants!

country research profile

The British Psychological Society Division of Health Psychology A profile of health psychology in the UK

By Althea Valentine, BPS DHP support officer

In September 2008 the British Psychological Society (BPS) Division of Health Psychology (DHP) will jointly host a scientific meeting in Health Psychology with the European Health Psychology Society (EHPS) in Bath, England. This will be the second time the BPS DHP will jointly host the conference with the EHPS after the enormous success of the joint conference in St. Andrews, Scotland in 2001. This article provides a brief outline of health psychology in the UK, summarises some of the recent major achievements and issues health psychology has faced, and provides an overview of UK health psychology training.

The BPS DHP was developed from the BPS Special Group in Health Psychology in 1997. Dr Daryl O'Connor (DHP Deputy Chair), who has been involved with the DHP committee in various capacities for the past eight years, talks passionately about how health psychology has grown over this period. He said: "many members have helped shape health psychology in the UK. It's amazing how the discipline has grown from the small beginnings of a few dedicated individuals. Now there are approximately 1300 Divisional members, including nearly 700 Chartered Health Psychologists, 300 individuals in training and numerous successful accredited training programmes. Over this time, health psychologists in the UK have also made important contributions to the international health psychology research agenda and to UK Government policy initiatives such as the recent White Paper entitled *Choosing Health: Making Healthy Choices Easier*".

What does the Division of Health Psychology do?

The DHP represents the interests of health psychology practitioners and researchers in the UK by promoting the profession of health psychology, developing and supporting the training and education of health psychologists (e.g., continuing professional development), and supporting research (e.g., supporting scientific meetings, securing secondments to the Department of Health) and contributing to official health policy (e.g., responding to health-related consultation documents). The interests of the DHP are served by a committee of elected and co-opted representatives. The committee work hard to ensure

that UK health psychology continues to progress each year. DHP members also receive and contribute to *Health Psychology Update*, the quarterly publication of the Division.

At the DHP AGM in 2007, Dr Martin Hagger (DHP Chair 2007-2008) stated that in the upcoming year the committee would endeavour to: "continue to represent the DHP in key policy areas, lead new initiatives to further career paths, broaden the profile of the DHP, and provide value for money in DHP membership". Martin Hagger organises all of this alongside his daily work as a Reader in Social and Health Psychology at the University of Nottingham and is co-editor of *Psychology and Health*, a member of the advisory board of the *British Journal of Health Psychology*, and UK National Delegate for the EHPS.

When asked about new initiatives to further careers, Martin Hagger talked about the excellent progress DHP-Scotland have made over the past few years to develop career paths for Health Psychologists in Scotland: "Vivienne Swanson and Ronan O'Carroll, have worked with the Scottish Health Boards and National Health Service (NHS) Education for Scotland (NES) to successfully develop a funded pilot project for Health Psychologists in Training to work in a public health setting, to support NHS Scotland to meet health improvement targets. This means that trainees, two of whom began at the start of 2008, will be funded to work towards Chartership whilst being employed in the NHS. It is an excellent step forwards and we wish trainees every success".

The BPS DHP, in addition to supporting the excellent initiatives by DHP-Scotland, have recently agreed to support the establishment of a Northern Ireland branch of the DHP. DHP-NI will represent the interests of health psychologists in Northern Ireland and have been granted start up funds by the DHP UK executive. The inaugural DHP-NI meeting will be held in May 2008 at the BPS Northern Ireland Branch annual conference with themes of Health, Forensic and Educational Psychology, for details see www.nibps.org.uk. ►



country research profile

The British Psychological Society Division of Health Psychology A Profile of Health Psychology in the UK (continued)

Promoting Health Psychology

As part of the strategic aim of the DHP to lead new initiatives to further career paths, the DHP publicity and liaison subcommittee began to develop a series of leaflets to highlight and promote the competencies and skills health psychologists can offer to various populations. Dr Diana Harcourt (Chair of the DHP Publicity and Liaison Subcommittee 2005-2008), mentioned: "these leaflets will help us to promote health psychology to a range of audiences within the UK, including health care professionals and the general public. We particularly hope that they will help employers see what health psychologists can offer them and the feedback we've had so far has been very positive. We're planning to develop the range of leaflets over the next year and they will be made available as downloadable PDF versions on the DHP website" (www.healthpsychology.org.uk).

Supporting Members

As well as promoting and developing health psychology in the UK, the DHP also organise events, to support the interests of members of the Division in their activities in health psychology, fulfilling the strategic aim of providing initiatives to support members and provide value for money for membership.

Dr Jo Hart (DHP National Conference Organiser 2006-2008), combines her research and teaching at the University of Manchester with organising the BPS DHP annual conference each year, a major event in the UK health psychology year. The 10th DHP Annual Conference was held in Nottingham in 2007 and was a resounding success with an excellent scientific programme with contributors from the UK and internationally. The Keynote speakers were: Professor Alan Christensen (University of Iowa), Professor Mark Conner (University of Leeds), Professor Susan Michie (University College London), and Professor Jane Ogden (University of Surrey). As in previous years, the conference attracted a high standard of research papers, and delegates included academic and practicing health psychologists, as well as health psychology students. In true Nottingham tradition, jesters, Robin Hood and Maid Marion kept delegates entertained at one of the social events held during the conference, which the delegates rated highly!

Dr Hart is currently organising a joint conference with the DHP and EHPS in Bath from 9-12th

September this year. She commented: "the conference is combining the British and European format, so there are eighteen different tracks running through the conference, covering the whole spectrum of health psychology and I think they will be very interesting. Although we've already had a lot of good submissions and there is still chance to submit poster abstracts to the DHP until the 1st May. The scientific committee and reviewers are really looking forward to receiving these and finding out the latest in health psychology research and practice from across Europe". For submission and conference details see the conference website (<http://bath2008.org.uk>).

Secondment to the Department of Health

The Division also continues to provide health psychology input to the Department of Health as part of its strategic aim to represent the DHP and health psychology in key policy areas. This aim seeks to develop opportunities to inform government policy and transfer research into practice. Health Psychologists (Professor Nicky Rumsey and Professor Susan Michie) provide part-time consultancy to the Department of Health's Division of Public Health on the application of health psychology. Prof Rumsey and Prof Michie are past Chairs of the DHP and actively promote health psychology in the UK and Europe. Professor Rumsey was a founder member of EHPS and is Co-Director of the Centre of Appearance and Health Psychology at the University of West of England. She is also a keynote speaker at the BPD DHP/EHPS conference in Bath in 2008. Professor Michie, a past President of the EHPS, works at University College London and is also Director of Health Psychology Research for the Camden and Islington Mental Health NHS Trust and Camden and Islington PCTs and Deputy Director of the Centre for Outcomes Research and Effectiveness. Both Profs Rumsey and Michie are outstanding examples of leading researchers and practitioners in UK health psychology and illustrate that the UK is a leading nation for health psychology practice and research in Europe.

Upcoming Changes to Health Psychology in the UK

One of the issues that the Division has been addressing over the past few years is the Statutory Regulation of Psychologists. Currently, ►

country research profile

The British Psychological Society Division of Health Psychology A Profile of Health Psychology in the UK (continued)

health psychologists that have satisfied the competencies set out by the BPS for the practice of health psychology apply for voluntarily regulation through the BPS as Chartered Psychologists. It is likely that during 2008, UK Psychologists who are providing a service to individuals, groups or organisations will be required to be regulated by law. Psychologists meeting the appropriate standards of proficiency, likely determined by the BPS, will register with the Health Professions Council (HPC) under statutory regulation. The DHP has drafted the Standards of Proficiency for Health Psychologists with the BPS as part of the preparatory work in advance of regulation by the HPC and has commented on all consultation documents relating to statutory regulation.

Throughout the past year, the Division has also made a significant contribution to the New Ways of Working for Applied Psychologists initiative which has considered how applied psychology can develop to take account of the changing NHS workforce context. The group's work concluded in July last year and focused on seven project areas of which Health Psychology was represented in six.

Training to be a Health Psychologist in the UK

When the DHP was first established it included a 'grandparenting' route to allow Health Psychologists with appropriate experience and skills to become full members of the Division and Chartered Health Psychologists. This route recently closed and individuals now in training for Chartership as a Health Psychologist will follow the a two stage training model that has been in place for three years now, after completion of an approved undergraduate degree:

- ▶ **Stage 1:** Taught Masters degree programme or BPS examination to establish a substantial knowledge base
- ▶ **Stage 2:** Two years supervised practice, covering core competencies in generic professional skills, research, consultancy and teaching/training, as well as two additional optional competencies. This stage can be completed either through a University programme or via the BPS independent route.

One of the main difficulties postgraduates in health psychology face is funding for training. The Workforce Planning subcommittee of the DHP continues to pursue

the case for Department of Health funding for postgraduate training in health psychology in England and Wales. There are twenty five approved taught masters programmes (Stage 1) throughout the UK. Many students complete this first stage, but much fewer go on to the second stage. There are approximately forty Stage 2 Independent route trainees and nine taught programmes incorporating Stage 2 training. Last year, the Division was proud to see the first graduates achieve Chartership through both the University and the BPS Independent routes.

In conclusion, health psychology in the UK has vastly developed over the past decade. Despite changes within the NHS and applied psychology as a whole, health psychology continues to move forward each year in research, practice, consultancy, and teaching/training. The UK continues to be a centre of excellence for the research and practice of health psychology in Europe and the DHP continues to be proactive in developing this key discipline and representing the interests of health psychologists in the UK. ■

If any of the pieces in this or past issues of the **European Health Psychologist** have inspired you to want to write a reply, please contact the editorial team.



**Collaboration And Innovation In Theory And
Research In The European Health Psychology
Society**



Internet-based Health Psychology Interventions: Maximising their Potential

**Synergy 2008 workshop
6th - 8th September 2008, Bath, UK**

The SYNERGY annual workshop is organised to provide an opportunity for discussion between health psychologists conducting research in core fields within health psychology. The focus is on advancing the standard of work within the field by pooling expertise, sharing critical evaluations, and stimulating networking and collaborative research between researchers from all over Europe in an informal and supportive atmosphere. It is also an opportunity for researchers to present their research for discussion in depth with other experts working in the same field in a friendly and relaxed atmosphere.

Internet-based health psychology interventions are set to play an increasingly important role in health psychology, because of a number of advantages they offer over traditional methods of delivering interventions. Currently delivered principally over the web, internet-based interventions will increasingly be accessible through mobile phones, interactive digital TV etc. However, despite the potential of internet-based interventions, and many examples of successful individual interventions, there is no clear evidence yet that they are reliably effective. This year's SYNERGY workshop will provide an opportunity to bring together experienced and more novice researchers in this fast developing field to consider the theoretical and applied potential of internet-based interventions, critically examine their limitations and how these might be overcome, and share experiences of what methods seem to be more or less successful when using this rapidly evolving technology. The workshop will address three key topics:

- ▶ What are the implications of advances in information technology for the future of health psychology interventions?
- ▶ How can psychological theory best be used in the development of internet-based interventions?
- ▶ How can internet-based interventions help to motivate and sustain desired behaviour?

This year's workshop will be facilitated by: **Prof Lucy Yardley**, University of Southampton, UK; **Prof Pål Kraft**, University of Oslo, Norway; **Prof Stephen Sutton**, University of Cambridge, UK. Facilitators will guide the work, support and moderate the discussion.

The workshop fee is £185 (approximately EUR 241). En-suite accommodation is available on campus for approximately £45 (EUR 60) per night. Note that the EHPS is offering 2 grants to those who want to attend the SYNERGY workshop but do not have sufficient financial resources. Each grant will be 500 Euros. Only participants from the countries listed as eligible for reduced fees (available on the EHPS registration website) are eligible to apply for a grant.

To apply, please use the **online application form** which should be **submitted by the 2nd of May 2008**. For further information please go to:

<http://ehps.net/1024/index.html>, and choose the option "Upcoming Conference/Workshops" and then "6th Synergy Workshop".

For further questions or information please contact the workshop organisers: Felix Naughton fmen2@medschl.cam.ac.uk or Camille Alexis-Garsee c.alexis-garsee@pcps.ucl.ac.uk ■

2008 workshop



CREATE is happy to announce its 10th anniversary workshop which will take place in Bath, UK in September 2008. The workshop will be held on the three days preceding the EHPS conference (6th - 8th September) and will be facilitated by Prof. Britta Renner (University of Konstanz) and Dr. Stephanie Kurzenhäuser (Federal Institute for Risk Assessment, Germany).

Risk perception and risk communication

At first glance, perceiving a health threat seems to be the most obvious prerequisite for the motivation to change risk behaviors. If one is not aware of the risky nature of one's actions, motivation cannot emerge. Therefore, a crucial barrier for health communication is to increase the personal relevance of a health issue to focus people's attention on information that pertains directly to their personal risk. However, numerous empirical studies demonstrated that people tend to underestimate their risk and that they are reluctant to accept unfavorable risk feedback.

Accordingly, the 2008 CREATE workshop will focus on the two key questions:

- (1) How do people judge health risks?
- (2) What are the psychological and behavioural consequences of risk communication?

The workshop at a glance:

- ▶ **When:** 6th-8th September 2008
- ▶ **Where:** University of Bath, UK
- ▶ **Application:** Please use the application form on www.ehps.net/create
- ▶ **Accommodation:** CREATE will not provide accommodation, there is the possibility of booking rooms on campus. More information will be provided on the CREATE website
- ▶ **Food:** Coffee and tea will be provided during break times. A dinner will be organized on the first night of the workshop. Lunch and dinner for the 2 other nights won't be included
- ▶ **Price:** The workshop fee is 95€, a reduced fee of 55€ will be available for participants from countries listed on the EHPS registration website as eligible for reduced fees
- ▶ **Grants:** The EHPS is offering grants for graduate students who plan to attend the CREATE workshop but do not have sufficient financial resources. For more information please refer to the EHPS registration website.
- ▶ **Deadline:** June 15, 2008

More about CREATE:

Collaborative Research And Training in the EHPS (CREATE) is a subdivision of the European Health Psychology Society (EHPS). CREATE provides further training and promotes collaboration among early career health psychologists. In addition, it has formed an international network of researchers who can provide support and expertise to other researchers. It is hoped that this international network can help identify and discuss common research interests and concerns. If you are interested in finding out more about CREATE please visit the CREATE website: www.ehps.net/create



EHPS pre-conference workshops 2008

Writing Highly Cited Health Psychology Papers and What to Do When One Is Rejected

Date

9th September 2008, 9 Am – 12 PM.

Rationale

A recent column in the European Health Psychologist lamented that international health psychologists are invisible in the American health psychology journals and documented the claim well. European health psychologists complain of difficulties getting published in these journals even when the English in which their manuscripts are written is faultless. This workshop is organized around the assumption that at least some of the difficulty international researchers encounter are cultural: they fail to appreciate important differences in how effective American writers craft their work, starting with effective cover letters and continuing through the creation of an effective story line, and, if necessary appealing an initial rejection. The workshop does NOT assume there is a superiority to American practices, but only that a lack of awareness of these practices disadvantages international researchers. This workshop demonstrates key aspects of the process, documenting them with concrete examples. In what is anticipated to be a lively exchange with the audience, examples and material will be solicited from them, and feedback offered as to what is needed to increase the likelihood not only of publishing in American journal, but achieving a high rate of citation.

The topics to be covered include (a) why try to be highly cited; (b) tracking citations and interpreting citation analysis; (b) does it help to self-cite?; how to research the most appropriate journal; (c) the importance of title and abstract; (d) crafting a highly cited paper is crafting a good story line (e) promises made in the introduction; (f) promises delivered in the discussion (g) writing an effective cover letter; (h) promoting an accepted paper and (i) why to appeal a rejection, why not to; and (j) case studies of effective appeals

Facilitator

James C. Coyne
University of Pennsylvania
jcoyne@mail.med.upenn.edu

The workshop leader is listed by the Institute of Scientific Information as among the 225 most cited psychologists and psychiatrists in the world. In citation analyses, Dr. Coyne consistently ranks in the top 20 of all North American psychologists for impact of his work. He has served on many editorial boards across disciplines and has been an ad hoc member of numerous AHCPR and NIH study sections and advisory boards. He is a fellow of the American Psychological Association

Missing Data Analysis

Date

9th September, 9 Am – 12 PM.

Rationale

A workshop on missing data was the most frequently endorsed option in the responses to the EC's survey of members in relation to desired workshops. Increasingly in applied research, the impact of missing data is acknowledged and the workshop aims to provide participants with an overview of current approaches to missing data.

Facilitator

Mark Huisman
University of Groningen
j.m.e.huisman@rug.nl

EHPS post-conference workshops 2008

Navigating the EU Framework 7 Program Application

Date

12th September 2008, 14.30 – 17.30 PM.

Abstract

This workshop is intended to introduce health psychology researchers to the FP7. The European Union has devoted €50.5 billion for research in the seventh Framework Programme (FP7) 2007-2013 and €6.1 billion for funding the theme Health in the sub-programme cooperation for the same period. During first part of the workshop, there will be a brief explanation of the programme. Opportunities for psychology research to be funded under the FP7 will be explored. Tips will also be given on remaining informed of the calls via the CORDIS website. Advices on how to apply to a FP7 project will be the core of the second part of the workshop. The main requirements will be pointed out and light will also be shed on finding international partners and helpers such as consultants. Guidance on filling an application form will be given. Therefore this workshop should be useful for those who may be interested in participating in international projects. This is also a good occasion to have a better understanding of the FP7 and maybe to meet future project partners.

Facilitator

Jon Hunt (and colleagues)
University of Bath
J.Hunt@bath.ac.uk

Discourse Analysis

Date

12th September 2008, 14.30 – 17.30 PM.

Abstract

This workshop introduces the basics of discourse analysis. Discourse analysis is a methodology that came into the frame in social psychology in the mid-eighties and it has been at the fore of the surge of qualitative methods in psychology. In more recent years it has been increasingly used in health related topics. This workshop will introduce the origins and principles of discourse analysis before moving on to looking at how to design a piece of research using discourse analysis and the types of topics and questions that can be answered with a discursive methodology. From here, the workshop moves to analysis of data from health care settings and the workshop participants will have the opportunity to work within small groups and brainstorm analysis of selected excerpts of health related data. The workshop is aimed at those relatively new to discourse analysis, but with a keen interest in qualitative methodologies.

Facilitator

Abigail Locke
University of Huddersfield
A.Locke@lboro.ac.uk



EHPS conference grants 2008

The Executive Committee of EHPS is pleased to announce that EHPS and its interest groups CREATE and Synergy will be able to offer grants to support conference and/or workshop attendance at our Bath 2008 Annual Conference. This year we are offering a total of seven grants. The purpose of these grants is to encourage talented researchers and graduate students who don't have access to funding to attend the EHPS conference and CREATE or Synergy workshops. We hope that this experience will encourage them to be more involved in the Society and its interest groups in the future.

Grant Description

For the upcoming 2008 conference the following grants will be offered:

- 1) **Synergy Workshop participants:** 2 grants for researchers who plan to attend the Synergy workshop and who are EHPS members. Each grant is for 500 Euro toward workshop registration and travel.
- 2) **CREATE Workshop participants:** 2 grants for graduate students who plan to attend the CREATE Workshop. Each grant is for 300 Euros toward workshop registration and travel.
- 3) **EHPS Conference only:** 3 grants for graduate students and researchers. Each grant is for 500 Euro toward conference registration and travel. Grant is contingent upon acceptance of your paper or poster for the conference.

Grant Application

To apply for the grant, please submit the following application materials.

- ▶ A one-page narrative, describing your reasons for applying for the grant, your planned participation in the specific workshop and/or EHPS Conference and your financial need. Please indicate which one of the three grants you are applying for.
- ▶ Curriculum Vitae.
- ▶ Abstract of your paper or poster that you will be submitting for the EHPS Conference.
- ▶ For the graduate student grants, proof of student status, such as copy of student ID.

- ▶ An official statement from your employer or supervisor that no funding is being provided from your University or Institution and confirming your financial need. See the EHPS webpage for a sample letter.
- ▶ CREATE applicants please also fill out the CREATE Workshop application form; Synergy applicants please also fill out the Synergy Workshop application form; Forms are available at www.ehps.net

Selection Process

The selection of grant recipients will be conducted by a committee consisting of a CREATE, Synergy and EHPS Executive Committee member. The selection criteria will be demonstrated financial need and relevance of the applicant's work to the topic of the workshop (for Synergy). The committee will also aim to distribute the grants to representatives from a wide range of European countries. It will be expected that after the conference grant recipients submit a letter describing how the grant has supported their work.

Deadline for the grant applications is June 16th, 2008. You will be informed of the results by June 30th, 2008.

Please send all application materials electronically (include scanned copies of the official letters and student ID cards) to David Hevey: heveydt@tcd.ie ■

conference announcements

| conference title | date | location |
|--|-----------------------|-----------------------|
| Society for Behavioural Medicine 29 th Annual Meeting & Scientific Sessions | 26 – 29 March 2008 | San Diego, USA |
| 29th Stress and Anxiety Research Society Conference | 16 – 18 July 2008 | London, UK |
| XXIXth International Congress of Psychology | 20 – 25 July 2008 | Berlin, Germany |
| 12th World Congress on Pain | 17 - 22 August 2008 | Glasgow, Scotland, UK |
| 2008 European Health Psychology Society / Division of Health Psychology Conference | 9 – 12 September 2008 | Bath, England |

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