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editorial

A message from the new Editors of the European Health Psychologist

Dear Readers,

We would like to take this opportunity to express our thanks and best wishes for the future to the outgoing editors of the European Health Psychologist (EHP), Dr Falko Sniehotta and Dr Vera Araujo-Soares. During Falko and Vera's two year editorship we have seen an outstanding stream of high quality contributions from leading scientists in the field, which has enabled the EHP to go from strength to strength. Falko and Vera provided excellent leadership for the EHP and will continue to support the work of the new editorial team for 2008-2009.

The EHP editorial board has four new members and we look forward to working with them over the next year. Dr Lukasz Kaczmarek from Poland, Dr Richard De Visser from the UK, Rik Crutzen from the Netherlands and Dr Jenny Fidler from the UK joined as co-editors in October 2008 and we would like to wish them a warm welcome to the EHP team.

The EHP has advanced over the last two years in several respects and in particular it has played an increasingly important role in stimulating key debates in the discipline. The EHP published an article written by Professor Keith Petrie that addressed a number of issues relating to the (in)visibility of international research in US health psychology journals, which was followed up in a next EHP issue by a debate about the internationalization of health psychology. At the 2008 combined EHPS/DHP conference in Bath this discussion was continued by Professor Robert Kaplan, editor of the leading American Psychological Association journal *Health Psychology*. This clearly demonstrated that the EHP is having a significant impact on shaping debate regarding the development of the discipline internationally. Most of the established peer-review journals in the field do not cater for this

kind of contribution or exchange; a void that the EHP is uniquely positioned to fill.

It is our hope that the EHP can continue in this vein to encourage self-reflection among those working in health psychology and provide a forum for setting out new directions for research and practice in the field. Authors are invited to submit scientific contributions including position papers (think pieces), overview papers, research letters, interviews, controversial debate, and country or research group profiles. The EHP provides guidance for potential authors on its website: <http://www.ehps.net/ehp/>.

We would like to stress that authors should not feel constrained by these suggestions. We welcome and consider pieces of any format that may be of interest to the wider health psychology community. Please feel free to contact either of the editors if you have an idea for a contribution that may not fit into any of the conventional categories. In our term as editors we would like to embrace the Einsteinian principle that, "Imagination is more important than knowledge" and we look forward to receiving contributions from the EHPS community and beyond. Relevant contributions from those who may not consider themselves as part of the health psychology community per se provide an ideal vantage point for identifying and evaluating the strengths, weaknesses, opportunities and threats to our burgeoning discipline.

We look forward to receiving further interesting work and relevant information for publication in the EHP ■

Emely de Vet & Gerry Molloy, *EHP Editors*



president's message

Dear colleagues,

I am very happy to be writing my first President's message for the European Health Psychologist. I greatly appreciate that you have entrusted me with the position of President of the EHPS, a position which I now assume for the next two years. The EHPS is the first professional society that I joined after receiving my degrees, and it has been a warm and welcoming home to me throughout the years.

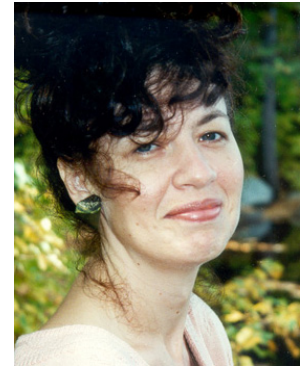
The number of countries represented in the EHPS and the number of members has been growing steadily. The EHPS currently has members from 40 countries! It has actively fostered collaborations with colleagues and societies throughout Europe and beyond, through joint conferences, symposia, workshops and other programs - and we look forward to continuing this tradition which will strengthen our scholarship. In the next months we will work to further solidify the voice of EHPS expertise at the international level by affiliating the EHPS with the United Nations community of psychological organizations. As such, EHPS representatives and members can contribute their scientific and practical knowledge to improving health, reducing health disparities and affecting policy on a global level, through their presence and input in Vienna, Geneva and New York. Susan Michie initiated this application during her term in the EC, and I now ask you to join us in bringing it to completion - by sending me information about your current and past projects and collaborations with UN organisations.

The involvement of EHPS members from Central and Eastern Europe has also grown during these years, and I am very happy that we recently had a very successful conference in Warsaw, Poland, and now new proposals from other CEE countries are coming in (from Romania and the Czech Republic, as well as an inquiry by Hungary). Hosting a conference can provide an enormous impetus to further stimulating health psychology activities in a country, and I certainly look forward to supporting these and other endeavours in Eastern and Central Europe. The rapid political and economic changes in some of the countries of the region have brought into perspective the impact that social change and social inequalities have on health, morbidity and mortality and the important role which health psychology can play.

Through its forums, publications and its education and training events the Society can also ensure a high level of expertise in a diversity of methods of analysis, including broadening the scope and impact of qualitative inquiry.

The new EHPS Executive Committee has both continuity and new members. Britta Renner will

continue her invaluable contribution to the society as Past-president. I feel very well supported by her expertise and commitment to the goals of EHPS. It has been stimulating to work with her both in her role as President and previous roles in the EC, with



creativity and dedication to principles. Yael Benyamini continues her second term as Secretary, and it is impossible to describe the importance of her role in assuring the smooth workings of the Society, as well as her contribution to the synergistic functioning of our committee. Vera Araújo-Soares contributed immensely to making the Bath Conference possible, as liaison with the Bath team, and also continues her active role in the EC as liaison with the European Health Psychologist. I would like to thank the outgoing EC members, Susan Michie, Christel Salewski, David Hevey and Winnie Gebhardt for their creativity, commitment and perseverance. I welcome the new members Paul Norman, Manja Vollmann, Elvira Cicognani, and Holger Schmid - you bring immense experience and ingenuity and I look forward to working with you. The first three months of our term have been quite turbulent and the opportunity to work with such a dedicated team has been very rewarding.

The European Health Psychologist is dear to my heart, as I enjoyed being its Editor for over four years. For two of those years I was joined by Falko Sniehotta & Vera Araújo-Soares as co-editors, who then took on the role of Editors. They have creatively transformed the EHP, and now it is time for them to move to other projects and to hand over the editorial position to a new team. We welcome Gerard Molloy from University College London and Emely de Vet from Universiteit Amsterdam in their new role as EHP Editors, and the editorial team of Nihal Mohamed, Elke van Hoof, Richard De Visser, Lukasz Kaczmarek, Adam Mickiewicz, Jenny Fidler, Rik Crutzen, and Justin Presseau. Our other publications, the journals *Psychology & Health* and *Health Psychology Review* are also doing very well; we are in the process of renewing the contract for *Psychology & Health* with Taylor & Francis and ► will have more information in the next issue. Rona Moss-Morris and Lucy Yardley have sent us the great



president's message

news that the application to have Psychology & Health indexed on Medline has been approved and we can now expect even greater visibility of our journal.

The Fellowship Committee chaired by John Weinman has developed and finalized the procedures for nominating EHPS Fellows. They are posted on the EHPS website, along with explanations of the criteria and the needed nomination forms. As the deadline for nominations is fast approaching - December 20th - I urge all members to visit the website.

The conference in the beautiful city of Bath in September 2008, under the theme of Behavior, Health and Healthcare: From Physiology to Policy, was a wonderfully organized joint EHPS and British Psychological Society (BPS) Division of Health Psychology (DHP) conference. I would like to underscore the success of the conference, with its 713 delegates and the fruitful outcomes of this collaboration between our two organizations, which we can now consider a tradition! On behalf of the EHPS, I would like to thank the members of the Bath Organizing committee and the Scientific committee, and Jo Hart, Karen Rodham and David French. Coordination of the procedures, rituals and programs of the two organizations must have been a taxing juggling act, however, it was handled brilliantly and the results were rewarding for all of us who had the good fortune to be able to attend. The feedback from the evaluation forms testifies to that.

And now, we are excited to look forward to the next major event for the EHPS, the annual conference to be held in the picturesque and historic city of Pisa, Italy. The theme of the conference, Health Psychology: From Knowledge to Interventions, reflects cutting edge areas of inquiry which are central to the scientific endeavours of many of our members and throughout the scholarly health psychology community. It is with great pleasure and anticipation for our meeting in Pisa that I would like to introduce the organisers for the next conference: the President is Mario Guazzelli, Professor of Clinical Psychology, School of Medicine, University of Pisa, Italy; Chair and Co-Chair of the Scientific Committee are Stan Maes (Leiden, Netherlands) and Franco Bonaguidi (Pisa, Italy). The keynote speakers have now been confirmed: Gian Vittorio Caprara (Italy), Linda Cameron (New Zealand), Jim Coyne (USA/NL), and Jane Wardle (UK).

The pre-conference Workshops at Pisa will be: Evaluation Research in Health Psychology – What the little prince can see with Werner W. Wittmann, Narrative Analysis in Health Psychology, with Adriana Baban, and Introduction to the Seventh Framework Programme for Research and Technological

Development (2007-2013) with Alessia Franchini. CREATE is preparing their three-day program on the topic of Advancing the science of behaviour change: methods and theories with Susan Michie, Falko Sniehotta and David French as facilitators. Synergy's program is on the topic of: Pragmatics of running clinical trials: Issues of design, management and the processes of change with Rona Moss-Morris, Trudie Chalder, Alison Wearden and Gijs Bleijenbergh.

As this issue of the European Health Psychologist is going to print, the virtual members' meeting we called regarding the decision about the 2010 conference venue is still on-going. Thank you, Rebecca Jacoby and Adriana Baban, for being so gracious to invite the members of the EHPS to visit your countries and to get to know the accomplishments of the field in each of your Universities. I know that the Society can further catalyze health psychology activities in both Israel and Romania, through the collegial exchange of information and contacts offered by our conferences and other forums, and that that the Society will benefit immensely from your participation.

As I write this, I do not know the outcome of the vote for the 2010 venue, which is not relevant to my message. What I do know is the extent of commitment of time, concern and effort from all members of the Executive Committee needed to prepare and conduct the meeting, and I express my sincere appreciation for their dedication. Manja Vollman's unique expertise in web construction and her endurance, through many revisions of the webpages, have made the virtual implementation of this meeting possible. I know that the motivations driving the Executive Committee have been those of democracy and fairness. I know that both proposers would be very happy to host us in their professional homes, and would organize excellent conferences. And I also know that the emotions surrounding this issue are testimony to the importance of the Society in the lives, the professional identity and networks of its members.

Thus, let's remember the spirit that motivates hosts to invite us to their countries in the first place, and from there we can go forward with the next steps in developing the mission, collaborations and scientific goals of the Society.

Best wishes to everyone for the upcoming holidays and have a wonderfully creative and healthy New Year! Please contact me with comments and ideas! ■

Irina Todorova, EHPS President

an interview with

Erectile Dysfunction (ED): The latest advances in the prevention, diagnosis, and treatment in the US – An interview with Dr. Natan Bar-Chama

with Nihal Mohamed

Erectile dysfunction (ED) affects millions of men in Europe and the USA and is associated with increasing age and such common conditions as Diabetes, Hypertension, and obesity (Dean, 2005). Approximately 25 million American men suffer from ED and more than 600,000 American men aged 40-69 develop ED annually. Recent advances have lead to a greater understanding of male sexual health and the development of new treatment options. The European Health Psychologist discussed the latest advances in the prevention, diagnosis and treatment of erectile dysfunction with Dr. Natan Bar-Chama, MD, associate professor of urology at the Barbara and Maurice Dean Prostate Health and Research Center at Mount Sinai Medical Center in New York.

ehp: *What are the types of sexual problems that men may face? And is it likely that men could have more than one of these sexual problems at the same time?*

NB-C: There are several sexual problems a man may face. These sexual problems include low libido which is having little or no sexual drive or interest in sex, ejaculatory difficulties which can include premature ejaculation (reaching ejaculation too soon) or delayed ejaculation, and erectile dysfunction (ED) which is defined by the National Institutes of Health (NIH) as the persistent inability to get or maintain an erection firm enough for satisfactory sexual intercourse (Thompson, Tangen, Goodman, Probstfield, Moinpour, & Coltman, 2005). A man may have one or more than one of these conditions at the same time.

ehp: *Could you explain what tools are available to help diagnose men with ED?*

NB-C: The Sexual Human Inventory for Males (SHIM) questionnaire with its 5 items was developed and validated as a brief diagnostic tool of ED. This scale can be easily used and incorporated into the patient's routine medical history. Studies that applied the SHIM have shown that this scale has high a sensitivity and specificity in assessing different levels of ED [scoring: >22 = no ED, 17-21 = mild ED, 5-16 = moderate/severe ED]. Many health care providers have indeed incorporated the SHIM scale in to their screening test. For example, the examination centre for career servicemen of the Israel Defense Force incorporated the SHIM into a computerized

**Natan Bar-Chama, MD**

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questionnaire used to collect patients' medical history (Heruti, Yossef, & Shochat, 2004). These kinds of periodic examinations offer maximum privacy and highlight the importance of sexual health as a fundamental component of general health, while addressing sexual dysfunction as an early indicator of underlying disease. The concept of adding an ED questionnaire to a screening program may encourage more men to seek treatment, not only for their ED, but also for the underlying disease.

ehp: *Research and anecdotal reports have shown that psychological and social problems such as anxiety, depression, and conflict and dissatisfaction with the partner can affect men's sexual performance. What are the biological causes of ED? And is ED an inevitable result of aging?*

NB-C: There are many possible causes of ED. ED could be caused by psycho-social factors as you mentioned biological factors, or a combination of these two factors. The psychosocial factors may include an array of emotion- and communication-related factors such as marital/relationship conflict, depression, anxiety about sexual performance, and job-related stress. The biological causes of ED include diabetes, elevated cholesterol levels, hypertension, and obesity. Sexual function does not need to decrease with age. In fact, many men ►

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an interview with

An interview with Dr. Natan Bar-Chama

enjoy their sexual relationships well into their senior years. However, some health problems that men tend to have as they age such as diabetes mellitus and heart disease can affect men's sexual activities and cause ED.

ehp: *Can having ED indicate a presence of or having a risk factor for Coronary Artery Diseases (CAD)? What kind of medical evaluations or referral to other health care providers that you would suggest in this case? And what are the implications of this condition on practice?*

NB-C: Today, urologists as well as the broader medical community better appreciate the linkage between ED and cardiovascular diseases (CVD). ED is often a manifestation of endothelial dysfunction and is now considered an independent risk factor for future adverse cardiovascular events. Therefore, we need to promote awareness of these associations to our patients and medical colleagues. We, urologists, should acknowledge our limitations; we are not trained to treat CVD. However, we can proactively establish the diagnosis of dyslipidemia, hypertension, and endothelial dysfunction in our ED patients. We can say, "Look it's obvious you are overweight, your blood pressure is elevated, you are not exercising, and according to my ED evaluation your cholesterol level and your BMI are abnormal". Our medical colleagues and our patients often respond better to an abnormal lab test than to vague warning about overall health.

ehp: *You mentioned that ED could be a manifestation of endothelial dysfunction that increases the risk of CVD. What role does endothelial dysfunction play in ED?*

NB-C: Endothelium is the layer of cells surrounding the entire vasculature (i.e., the vascular system of the body or any part of it). Endothelial dysfunction is an integral component of the pathogenesis of CVD and ED, and has been shown to be an independent predictor of future cardiovascular events. Once a patient has endothelial dysfunction, its manifestations are broad and can include CVD, diabetes, and ED. We are currently screening patients for endothelial dysfunction in the office using an FDA-approved computer-based device called the Endo-PAT 2000, made by Itamar Medical Ltd. This new technology assesses endothelial function by measuring Reactive hyperemia before and after brachial artery compression. The test takes about 30 minutes to perform by a trained nurse or medical assistant. We have recently presented data that 50% of men with ED have abnormal endothelial function. All men with ED should undergo risk stratification

regarding cardiovascular disease which may include blood pressure, cholesterol profile, Framingham risk score, and assessment of endothelial function.

ehp: *Research also established links between ED and health behaviour such as smoking, alcohol consumptions, poor nutrition, and physical exercise. Should urologists counsel patients about these issues? And what kind of intervention if any a urologist can/would suggest to help patients change or modify the risk behaviour.*

NB-C: The urologist should find out if the patient is smoking and exercising. If the patient is overweight and need help with diet, referral to a nutritionist should be made. The next level of testing may be to assess lipid abnormalities, early diabetes, and endothelial dysfunction. At this point, however, we're entering an arena where it would be helpful to have another medical discipline involved. Very few urologist practices are set up to perform such comprehensive assessments. We should look at treating ED patients as an opportunity to establish referral relationships with the primary care providers (PCPs) and other specialists. At Mount Sinai Men's Wellness Program, we are able to expand our ED evaluation as part of a comprehensive workup. I see patients together with an internist/endocrinologist one day a week. It comforts me to know that my ED patients are being evaluated for diabetes, hypogonadism, and cardiovascular risk by a physician who lives and breaths these diseases, and can offer state-of-the-art testing and treatment. A urologist who does not currently have such an arrangement could suggest to a PCP colleague that he or she come into their office one afternoon a month to see patients who would benefit from this comprehensive approach to treating ED.

ehp: *Depression is common among patients with diabetes, cardiovascular diseases, and is also a major cause of ED (both depression and its treatment). Should urologists monitor and treat depression in ED patients?*

NB-C: Every patient with ED has a psychological issue. The notion that there is a clear split between organic and psychogenic is outdated medicine. I work closely with a psychologist and psychiatrist, and offer their skills routinely to my patients. We can often initiate successful PDE-5 inhibitor therapy first, and then the patient ability to deal with the psychological issues will be markedly enhanced. ►

original article

An interview with Dr. Natan Bar-Chama

Urologists are result-focused; we anticipate that the next time we see our ED patient, he will have made progress. If a tangible improvement is observed, a referral to the psychologist has a better chance of success. However, there are situations where intervention by a psychiatrist or a psychologist is needed immediately, and the referral should not be delayed. These cases tend to be exceptions.

ehp: *Some patients might refrain from discussing ED and other sexual problems with their care providers. How can a urologist break the communication barriers?*

NB-C: When dealing with personal issues like sexual function, it's important to establish an understanding of the individual's expectations and relationship status so you can offer effective therapy. On my intake from and in my discussions, I routinely inquire about these issues. Patients are asked, "Do you have a steady partner? How many years have you been together? Is your partner interested in having sexual issues treated? How often are you sexually active? What are your expectations of the ED therapy?"

ehp: *What are the state-of-the-art treatments of ED? And how successful are they in treating ED and what implications do these treatments have on other ED-related diseases?*

NB-C: The PDE-5 inhibitors such as (i.e., Viagra, Cialis, Levitra) are first line therapy for ED. They have revolutionized the perception of this disease entity and are the mainstay of the global treatment of ED. The medications are being used in other therapeutic areas, such as pulmonary hypertension and lower urinary tract syndromes (LUTS). In addition, all three PDE-5 inhibitors have demonstrated improvement in endothelial function. Furthermore, Research has shown that the benefits of the drugs on endothelial function persist even after the patients discontinue use of medications (Rosano, 2004). One can foresee the possibility of a new algorithm whereby an ED patient with endothelial dysfunction will not only be referred for a more aggressive cardiologic evaluation but the treating urologist will consider initiating chronic PDE-5 therapy to treat ED as well as achieve overall improvement in endothelial function.

ehp: *You lead the Mount Sinai Men's Wellness Program. Could you tell us about the services provided by this program?*

NB-C: The Mount Sinai Men's Wellness Program is a non profit educational organization dedicated to promoting men's overall health. Men die on average six years earlier than women. They are also more likely to die from heart disease and cancer. If you look at the statistics, from health and longevity perspective, men might be viewed as the weaker sex. To address these issues we recognized that it was important to create a multidisciplinary approach that utilizes the expertise of a variety of specialist to look beyond simply urological problems and treat male patients as a whole. The program was designed to look beyond the boundaries of specific medical specialties in order to provide comprehensive, multidisciplinary care for men with low testosterone, ED, osteoporosis, andropause (male menopause), prostate diseases and prostate cancer, and many other urologic and metabolic conditions. Men wellness is best achieved this way where urology is integrated with other specialties including internal medicine, cardiology, endocrinology, and psychology. ■

References

- Dean J. (2005). Characterisation, prevalence, and consultation rates of erectile dysfunction. *Clinical Cornerstone International*, 7, 5-10.
- Heruti, R.J., Yossef, M., & Shochat, T. (2004). Screening for erectile dysfunction as part of periodic exams—concept and implementation. *Int J Impot Res.*, 16, 1-5.
- Rosano, G.M.C. (2004). Vastarel MR: effective and safe for coronary patients treated with a phosphodiesterase type 5 inhibitor. *Heart Metab*, 24, 23–26
- Thompson, I.M., Tangen, C.M., Goodman, P.J., Probstfield, J.L., Moinpour, C.M., & Coltman, C.A. (2005). Erectile Dysfunction and Subsequent Cardiovascular Disease. *JAMA*, 294, 2996-3002.

Disclosure: Professor Bar-Chama has undertaken research and consultancy for companies including Pfizer, Bayer, GSK, Lilly, Solvay, Itamar Medical.



original article

An autonomy-supporting cardiovascular prevention programme: Practical recommendations from Self-Determination Theory

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Abstract

Health promotion is an important challenge for the health sector in the 21st century. Chronic diseases such as cardiovascular disease (CVD) can be avoided by, amongst other things, making prudent lifestyle changes. However, stimulating long-term behaviour change remains an important challenge for health promotion practitioners. Self-Determination Theory (SDT) has been applied in various health care settings to facilitate long-term behaviour change with some evidence of positive outcomes. From the perspective of SDT the effectiveness of prevention programmes should not only be defined as the proportion of participants that comply with recommendations, but should also give information on the level of autonomous motivation of the compliers. SDT would suggest that to stimulate the development of autonomous motivation and long-term behaviour change, autonomy-supporting interventions should be developed. Health care professionals can enhance patient behaviour change outcomes through support of patients' psychological needs for autonomy, competence, and relatedness. However, the health promotion field, involving health practitioners with various professional backgrounds, requires a more practical and specific summary of recommendations to improve the quality of intervention design. The aim of this manuscript is to describe in detail how practical recommendations from SDT were applied to a cardiovascular prevention programme in Belgium.

Introduction

Health promotion is an important challenge for the health sector in the 21st century. Chronic diseases such as cardiovascular disease (CVD) can be avoided by, amongst other things, making prudent life style changes (De Backer et al., 2003). Clear recommendations for addressing the behavioural risk factors for CVD (inadequate physical activity (PA) levels, an unhealthy diet and smoking) exist. For example, for physical activity (PA) recommendations include: participate in at least 30 minutes of moderate PA on most, preferably all days of the week; or participate in 20 minutes of vigorous PA for 3 times per week (Graham et al., 2007; Haskell et al., 2007). For diet, the following advice is given: limit the daily energy intake from fat to a maximum of 30%; and eat at least 2 pieces of fruit and 3 servings of vegetables a day (Casagrande, Wang, Anderson, & Gary, 2007; Graham et al., 2007). However, most people do not follow these



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recommendations at all or lack adherence to them over time (Ryan, Patrick, Deci, & Williams, 2008). The Self-Determination Theory (SDT) has evolved from basic to applied research and clinical trials in various health areas have been conducted using the theory's concepts (Ryan & Deci, 2007). Despite the recognition that "Nothing is more practical than a good theory" (Vansteenkiste & Sheldon, 2006), more detailed recommendations have to be formulated for the application of theory in the field of health promotion. Practical recommendations can already be found in the literature, e.g. in a manuscript on the effect of a supportive versus a controlling communication style on adolescents' academic achievements (Vansteenkiste, Simons, Lens, Soenens, & Matos, 2005). Since health promotion initiatives are carried out by practitioners from various disciplines, a practical and exhaustive summary of recommendations is needed to improve the design of autonomy-supporting interventions.

The cardiovascular prevention programme

The cardiovascular prevention programme (PreCardio) included interventions targeted at the medical and behavioural risk factors for CVD (Claes & Jacobs, 2007). The effectiveness of this programme in reducing these risk factors was investigated in a randomised clinical trial. This trial included 314 highly educated adults who were randomised using a 2/3 ratio to an intensive intervention group (IIG) (n=208) and a minimal ►

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intervention group (MIG) (n=106). The trial was approved by the Hasselt University Ethics Committee and was registered (ISRCTN23940498). The interventions targeted at medical risk factors were available to both groups; a tailored behaviour change programme was only available to the IIG. The medical risk factors were investigated during a medical assessment at the university and the patients' cardiovascular risk profile was determined. A global profile with a summary of the patient's risk factors was sent to the participants. Next, all participants filled out an online questionnaire on psychosocial determinants (e.g. autonomous motivation), the stage of behaviour change (Prochaska & DiClemente, 1992), the fat intake, the fruit intake and PA at baseline and after 6, 12 and 24 months of intervention (Claes & Jacobs, 2007). If participants did not complete the questionnaire, they were sent reminders. The tailored behaviour change programme consisted of a personalised website and individual coaching. The personalised website included 4 sections with information on cardiology, PA, diet and quitting smoking. Each section included several behaviour change techniques (e.g. self-monitoring), self tests and tailored advice (Vandelanotte, De Bourdeaudhuij, Sallis, Spittaels, & Brug, 2005). The individual coaching (IC) was based on a needs assessment that took place at baseline by telephone. IC was organised depending on the participants' preferences for intervention dose and delivery mode (website, e-mail, telephone, face-to-face). Participants were free to choose between limited or intensive IC. IC for diet, PA, and smoking were based on the Theory of Planned Behaviour (Ajzen, 1991) and the Self-Determination Theory (Ryan & Deci, 2000) and were provided by a psychologist with the assistance of undergraduate students (sports or nutrition bachelor).

Autonomy support

The development of the cardiovascular prevention programme involved deciding on the best way to approach participants for a health promotion initiative. Diverse initiatives, often with a commercial undertone and paternalistic attitude, illustrate the need for such an ethical reflection. The autonomy of the participants should be respected. In accordance with SDT, autonomy is defined as the psychological freedom to make a good, informed choice while being aware of one's own needs and values (Ryan & Deci, 2000). Participants will make a free choice if they completely back this choice due to its connection with their values and needs. This does not mean that health promotion programmes should avoid stimulating patients to

behave in a healthier way. The advice should be given in such a way that participants can agree with the advice they receive. Consequently, participants will consider the recommended behaviour change as their own goal in accordance with their values. This favourable outcome in health promotion can be stimulated by an autonomy-supporting context. This is a social context that satisfies 3 inborn needs: the need for competence (or effectiveness), the need for autonomy (or voluntariness) and the need for relatedness (Ryan & Deci, 2000). The need for competence means that people want to feel efficient in the actions they undertake. The need for autonomy means that people want to feel they initiate their behaviour. The need for relatedness consists of the wish to feel supported and loved by others in the actions he/she undertakes. In SDT the assumption is made that, if the social context satisfies these needs, people underwrite the behaviour and become more autonomously motivated.

Practical recommendations from the Self-Determination Theory

Creating an autonomy-supporting context can stimulate participants to become autonomously motivated to make lifestyle changes. To create this context several practical recommendations were derived from SDT and applied to the cardiovascular prevention programme. An autonomy supportive context consists of a number of critical elements: 1) offering choice; 2) respecting choice; 3) giving a meaningful explanation for uninteresting behaviour; 4) avoiding controlling language; 5) avoiding guilt inducing techniques; and 6) avoiding the use of rewards and punishments.

Health promotion programmes preferably offer different choices to participants. The participants from the intensive intervention group in the PreCardio study received access codes for the personalised website where they could choose for different sections: cardiology, PA, diet and quitting smoking. Furthermore, individual coaching was based on a needs assessment. People could freely choose the intervention intensity and delivery mode.

If participants chose to change nothing, this choice was respected and no judgement was made on the decision they made. The health promotion practitioner did not push participants to change their behaviour in the desired direction but asked if he could come back to the topic in a future contact. It is important that people feel appreciated, independent of the choice they make. No values were forced upon the participants as this would only stimulate ►



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introjected regulation. Since long-term behaviour change was the objective, all communication with the participants included a statement that changing nothing at all was fine as well.

If participants didn't have a spontaneous interest for the advised behaviour, the health promotion practitioner gave a meaningful explanation of why to engage in the behaviour (e.g. the benefits of changing behaviour were summarised). For instance, participants who participated in a face-to-face session for PA received a flyer describing advantages of PA. On the website, within the section containing information on cardiology, they could read how CVD can be prevented by making favourable lifestyle changes.

It is important to avoid controlling language because only external regulation is stimulated and autonomous motivation will not occur. Controlling language such as "You should stop smoking" or "You better engage in physical activity" was replaced by "You can choose to quit smoking" or "It is possible to increase daily moderate physical activity". Controlling language was avoided in the individual coaching and on the personalised website.

SDT suggests that guilt or shame inducing interventions should be avoided since this would stimulate introjected regulation and the transition to a more autonomously motivated behaviour would be impeded. The interventions of PreCardio were not guilt or shame inducing. Furthermore, controlling strategies such as deadlines, extrinsic rewards and competitive situations have a negative effect on the autonomous motivation of the participants. Consequently, these were not included in the cardiovascular prevention programme.

Conclusion

Health promotion practitioners can create an autonomy-supporting context wherein participants spontaneously choose to improve their lifestyle. A health promotion initiative is, from this perspective, not successful if the participants engage in physical activity because they feel controlled by a coach or would feel guilty if they miss out on a session. Consequently, one can wonder what a good outcome measure is for health promotion. Most of the time, the effectiveness of health promotion is measured by the proportion of the participants who comply with recommendations for health-related behaviour. In future health promotion research, it is important to investigate not only the compliance to these recommendations but also the quality of the motivation of the compliers. ■

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References

- Ajzen, I. (1991). Theory of Planned Behavior. *Organ Behav Hum Decis Process*, 50, 179-211.
- Casagrande, S. S., Wang, Y., Anderson, C., & Gary, T. L. (2007). Have Americans increased their fruit and vegetable intake? The trends between 1988 and 2002. *Am J Prev Med*, 32, 257-263.
- Claes, N., & Jacobs, N. (2007). The PreCardio-study protocol - a randomized clinical trial of a multidisciplinary electronic cardiovascular prevention programme. *BMC Cardiovasc Disord*, 7, 27.
- De Backer, G., Ambrosioni, E., Borch-Johnsen, K., Brotons, C., Cifkova, R., Dallongeville, J., et al. (2003). European guidelines on cardiovascular disease prevention in clinical practice. Third Joint Task Force of European and Other Societies on Cardiovascular Disease Prevention in Clinical Practice. *Eur Heart J*, 24, 1601-1610.
- Graham, I., Atar, D., Borch-Johnsen, K., Boysen, G., Burell, G., Cifkova, R., et al. (2007). European guidelines on cardiovascular disease prevention in clinical practice: executive summary. *Eur Heart J*, 28, 2375-2414.
- Haskell, W. L., Lee, I. M., Pate, R. R., Powell, K. E., Blair, S. N., Franklin, B. A., et al. (2007). Physical activity and public health: updated recommendation for adults from the American College of Sports Medicine and the American Heart Association. *Med Sci Sports Exerc*, 39, 1423-1434.
- Prochaska, J. O., & DiClemente, C. C. (1992). Stages of change in the modification of problem behaviors. *Prog Behav Modif*, 28, 183-218.
- Ryan, R., & Deci, E. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *Am Psychol*, 55, 68-78.
- Ryan, R., & Deci, E. (2007). Active human nature: Self-determination theory and the promotion and maintenance of sport, exercise, and health. In M. Hagger & N. Charzisarantis (Eds.), *Intrinsic motivation and self-determination in exercise and sport* (pp. 1-19): Human Kinetics Europe Ltd.
- Ryan, R., Patrick, H., Deci, E., & Williams, G. (2008). Facilitating health behaviour change and its maintenance: Interventions based on Self-Determination Theory. *The European Health Psychologist*, 10, 2-5.
- Vandelanotte, C., De Bourdeaudhuij, I., Sallis, J. F., Spittaels, H., & Brug, J. (2005). Efficacy of sequential or simultaneous interactive computer-tailored interventions for increasing physical activity and decreasing fat intake. *Ann Behav Med*, 29, 138-146.
- Vansteenkiste, M., & Sheldon, K. M. (2006). There's nothing more practical than a good theory: integrating motivational interviewing and self-determination theory. *Br J Clin Psychol*, 45(Pt 1), 63-82.
- Vansteenkiste, M., Simons, J., Lens, W., Soenens, B., & Matos, L. (2005). Examining the motivational impact of intrinsic versus extrinsic goal framing and autonomy-supportive versus internally controlling communication style on early adolescents' academic achievement. *Child Dev*, 76, 483-501.

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How to reach a target group with Internet-delivered interventions?

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Once upon a time...

...there was the Internet. This article starts as a fairy tale, since this is in accordance with the way people used to talk about the Internet and its possibilities during the early days of its growth (in the late nineties of the 20th century). This fairy tale turned out to be true, insofar as the growth of the Internet has been enormous. Through its interactive character, for example, the Internet is thought to have great potential as a communication channel that can combine a high reach with tailored or targeted health promotion (Brug, Oenema, Kroeze, & Raat, 2005). The huge increase in possibilities of and access to the Internet has initiated an expansion of Internet-delivered health behaviour change interventions. It has been shown that Internet-delivered interventions can be effective in changing behaviour, but evidence from efficacy trials indicates that exposure rates are low (De Nooijer, Oenema, Kloek, Brug, De Vries, & De Vries, 2005). Exposure rates may be even lower when these interventions are implemented in real life rather than in a research setting (Evers, Cummins, Prochaska, & Prochaska, 2005). These findings touch upon a critical issue regarding Internet-delivered interventions: How could behaviour change ever be established if people are not exposed to the intervention itself? Prior to this question, it is important to know more about how to attract people to an Internet-delivered intervention among innumerable other websites that probably serve their gratification to a larger extent. This issue pertains to the concept of dissemination. Dissemination refers to the distribution of the intervention to the target population, including bringing the intervention to the attention of the target population. Successful dissemination of an Internet-delivered intervention is required before the target population can be exposed to the intervention's content and use its components.

In this article, we will focus on strategies for enhancing dissemination of Internet-delivered interventions. First, we will discuss intervention dissemination in an existing social context. Second, we will discuss possible limitations regarding this strategy and provide an alternative strategy, i.e. dissemination through popular online places. Subsequently, examples regarding the latter strategy and implications for future research and practice will be discussed.



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Embedding in a social context

Embedding the intervention in a social context could be defined as a feasible and appropriate way to disseminate Internet-delivered interventions (Crutzen, De Nooijer, Brouwer, Oenema, Brug, & De Vries, 2008a; 2008b). For example, an Internet-delivered intervention aimed at adolescents could be embedded in a social context by linking the intervention to school activities. Social embedment of Internet-delivered interventions makes these types of interventions comparable to offline (non-Internet-delivered) interventions, where adolescents also indicate that interventions should be provided during class hours instead of by their parents (Martens, Wind, Van Assema, & Brug, 2002). Social context is not limited to schools; the intervention can also be embedded into e.g., sports clubs, youth centres or hospitals. The feasibility, appropriateness and effectiveness of such a social context could be explained by the infrastructure being available and intermediaries (e.g. teachers) being accustomed to such settings (e.g. providing education during class hours) (Reinaerts, De Nooijer, & De Vries, 2007).

It remains, however, questionable whether this is suitable for (1) all available Internet-delivered interventions, because there are too many available interventions that would need social embedment, ►

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and (2) interventions aimed at hard-to-reach, but highly relevant target groups (e.g. school drop-outs) for health behaviour change. An alternative strategy, i.e. dissemination of Internet-delivered interventions through popular online places, will be presented in the next paragraph. This strategy is not dependent on social embedment in a physical infrastructure and not limited to target groups within such an infrastructure, therewith addressing the limitations of embedment in a social context.

Dissemination through popular online places

One could question to what extent people realise that behaviour change interventions are available and delivered through the Internet. Even if people are willing to change their behaviour, they will not search online if they are unaware of the existence of Internet-delivered interventions. In line with the precaution adoption process model (Weinstein & Sandman, 1992), one could assume that people need to be aware of the existence of Internet-delivered interventions and realise that these have personal relevance, before they take action and actually visit websites containing such interventions. If people are unaware of the existence of Internet-delivered interventions, one should question whether a possible solution would be to raise awareness by disseminating these interventions at online places which are already popular.

An example of such a popular online place (in which health promoting interventions are delivered) is Second Life, which is part of the Web 2.0 movement and its future. Second Life is a unique social experience, allowing people to meet and interact with each other (interpersonal) and in groups, using a comprehensive and an integrated range of communication tools, both asynchronous and synchronous¹ (Kamel Boulos, Hetherington, & Wheeler, 2007). It is a virtual world in which multiple users are “present” within a simulated space through their avatars². Second Life could be a suitable place to disseminate health promotion programs. In the Nutrition Game proposed by Ohio University, for example, people can learn about the impact that fast food has on health. This is achieved by allowing people to experiment with different eating styles in simulated fast-food restaurants to learn about the short- and long-term health impacts of their choices (Kamel Boulos et al., 2007). These simulated fast-food restaurants are present in a virtual world (Second Life) which is already popular among and accessed by a large number of people, thereby streamlining the process of dissemination.

Another example of a popular online place is YouTube. Health promotion has embraced both mass media and interpersonal communication, but the field has not fully recognised the growing benefit of hybrid communication forms like YouTube which appeal to a large number of people. The mainstream use of the Internet means that YouTube videos are open to nonstop, widespread observation and could be used to enhance intervention adoption (Lillie, 2008), e.g. as a gateway to another website. This gateway principle is, for example, also applied in an Internet-based HIV-prevention program that uses virtual pursers³ on a popular e-dating website to invite users to the intervention website (Kok, Harterink, Vriens, De Zwart, & Hospers, 2006). The intervention (about dating and sexual behaviour) was brought to the attention of chatters (at an e-dating website for men who have sex with men) by these virtual chatters, before and after they logged on.

Future directions

It is important to realise that Internet-delivered interventions could be disseminated through popular online places, but people may be less interested in health behaviour change when visiting popular online places compared to more “serious” online places (e.g. intervention delivered through the website of a community health service), since they visit these places for other reasons (i.e. distraction) than behaviour change. It should be taken into account, therefore, that people recruited through popular online places may not be very involved and should first be motivated to change behaviour. Moreover, they may have less attention for the intervention’s content. In spite of this, collaborations with (commercial) partners regarding the use of popular online place for health promotion purposes may have a positive effect on dissemination of Internet-delivered interventions. A good example is the collaboration with the chat room operator of a popular e-dating website to promote the previously mentioned intervention about dating and sexual behaviour (Kok et al., 2006). Other possibilities to deploy in the near future are collaborations with social networking websites (e.g. Facebook, MySpace) which are popular among and repeatedly visited by certain target groups (e.g. adolescents). Fruitful collaborations could be established by including these partners in a linkage group at the beginning of the development process of the intervention (Bartholomew, Parcel, Kok, & Gottlieb, 2006) and actively using them for consultation purposes (Kok et al., 2006). Such collaborations, ►

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however, should not interfere with the way in which one would like an intervention to come across.

Although some positive examples of recruitment through popular online places are quoted, it needs to be investigated whether this is effective to successfully disseminate Internet-delivered interventions. An important issue to keep in mind, however, is that motivation to change health behaviour among people recruited through popular online places may be low. Therefore, future research needs to look at other differences regarding socio-demographic, psychosocial, or behavioural measures of people recruited through different online places.

Concluding remark

The possibility to disseminate Internet-delivered interventions through popular online places has been discussed in this article. Although examples of successfully applying this strategy have been provided, there are still issues for future research and practice (e.g. individual differences, collaborations with other parties) regarding this strategy. ■

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References

- Bartholomew, L. K., Parcel, G. S., Kok, G., & Gottlieb, N. H. (2006). *Planning health promotion programs: an Intervention Mapping approach*. San Francisco, California: Jossey-Bass.
- Brug, J., Oenema, A., Kroeze, W., & Raat, H. (2005). The internet and nutrition education: challenges and opportunities. *European Journal of Clinical Nutrition*, 59, S130–S139.
- Crutzen, R., De Nooijer, J., Brouwer, W., Oenema, A., Brug, J., & De Vries, N. K. (2008a). Internet-delivered interventions aimed at adolescents: a Delphi study on dissemination and exposure. *Health Education Research*, 23, 427–439.
- Crutzen, R., De Nooijer, J., Brouwer, W., Oenema, A., Brug, J., & De Vries, N. K. (2008b). Qualitative assessment of adolescents' views about improving exposure to Internet-delivered interventions. *Health Education*, 108, 105–116.
- De Nooijer, J., Oenema, A., Klok, G., Brug, J., De Vries, H., & De Vries, N. K. (2005). *Bevordering van gezond gedrag via internet: nu en in de toekomst [Promotion of healthy behavior through the Internet: now and in the future]*. Maastricht: Maastricht University.
- Evers, K. E., Cummins, C. O., Prochaska, J. O., & Prochaska, J. M. (2005). Online health behavior and disease management programs: are we ready for them? Are they ready for us? *Journal of Medical Internet Research*, 7, e27.
- Kamel Boulos, M. N., Hetherington, L., & Wheeler, S. (2007). Second Life: an overview of the potential of 3-D virtual worlds in medical and health education. *Health Information and Libraries Journal*, 24, 233–245.
- Kok, G., Harterink, P., Vriens, P., De Zwart, O., & Hospers, H. J. (2006). The Gay Cruise: developing a theory- and evidence-based Internet HIV-prevention intervention. *Sexuality Research & Social Policy*, 3, 52–67.
- Lillie, S. E. (2008). Diffusion of innovation in the age of YouTube. *American Journal of Preventive Medicine*, 34, 267.
- Martens, M., Wind, M., Van Assema, P., & Brug, J. (2002). De (on)mogelijkheden van voedingsvoorlichting aan twaalf- tot veertienjarige jongeren [Opportunities and pitfalls of nutrition education for adolescents aged 12–14]. *Nederlands Tijdschrift voor Diëtenisten*, 57, 71–77.
- Reinaerts, E., De Nooijer, J., & De Vries, N. K. (2007). Fruit & vegetable distribution program versus a multi component program to increase F&V consumption: which should be recommended for implementation? *Journal of School Health*, 77, 679–686.
- Rogers, E. M. (2003). *Diffusion of innovations*. New York, NY: The free press.
- Weinstein, N. D., & Sandman, P. M. (1992). A model of the precaution adoption process: evidence from homeradon testing. *Health Psychology*, 11, 170–180.

Notes

¹ Asynchronous communication refers to communication with a significant time delay between one person's message and another person's response to this message, while synchronous communication refers to real-time interaction between those communicating.

² An avatar is an Internet user's representation of him/herself, whether in the form of a three-dimensional model used in computer games (Lessig, 1999) or a two-dimensional icon used on Internet forums and other communities (Fink, 1999).

³ Virtual pursers are listed as users on a chat box and invite other chat box users to the intervention website.



CREATE 2008 Report: Exploring risk perceptions and developing risk communications

By Grainne Johnston*, Staffordshire University & NHS Wakefield District, England

The 2008 workshop took place in the beautiful UK city of Bath. The workshop was then followed by the 2008 BPS and EHPS joint conference. For those people who attended the workshop and the conference that meant spending a full week in Bath, which provided ample opportunity to appreciate the city.

The workshop saw Prof. Britta Renner and Dr. Stephanie Kurzenhauser brought together for the first time in facilitating this workshop on Risk Perception and Risk Communication. The dual facilitation was excellent, as the facilitators provided a relaxed and engaging learning environment that stimulated many ideas and questions. The workshop utilised interactive presentations and group work. The facilitators split the participants into groups; who then worked together for the duration of the workshop. Each group was required to design a leaflet about the human papillomavirus (HPV) vaccination and present the leaflet at the end of the workshop.

The content of this year's workshop encompassed the hazards that people perceive as risks, facts about HPV, presenting statistics in quantitative communication, mechanics of personal risk perception, reactions to personalised risk communication and the relationship between risk perception and risk behaviour. This demonstrates that the topic is broad in scope, with many issues to consider. Risk perception extends into many domains, and it plays a role in motivating health behaviour change (Weinstein, 1988). Social cognition health behaviour models such as the Health Belief Model and Protection Motivation Theory place risk perception as a precursor to intention (Norman and Connor, 2005). The evidence for the influence of risk perception upon behaviour is weak (Norman and Connor, 2005). However, according to Weinstein and Nicolich (1989) there are many possible explanations for these findings and risk perception is important in the early stages of motivation to change behaviour (Weinstein, 1988). Therefore, an underestimation of risks may result in risky behaviour taking place.

Using the HPV vaccine as a case study, this workshop provided the opportunity to study the

methods that can be used to communicate risk with the aim to enable informed choice or to facilitate persuasion in some instances. The newly introduced HPV vaccine can help prevent 70% of cervical cancer cases caused by the HPV virus, strains 16 and 18. Various vaccination programmes started this year and so there has been a great deal of information produced about cervical cancer, HPV and the vaccine in the last 6 months. This provided plenty of material to scrutinise and critically evaluate in preparation for designing our own leaflets within the workshop. One factor that unites the decision to opt in or out of the HPV vaccine is the perception of risk of cervical cancer. Therefore there is a need to understand the way in which risk is calculated in order to influence vaccination behaviour.

Risk experts and laypeople calculate risk in different ways. According to experts, probability \times severity = risk. The lay method of calculating risk is based on subjective characteristics such as controllability, voluntariness of exposure and potential for catastrophe (Slovic, 1987). Therefore, risky activities such as smoking, lack of exercise, alcohol and high fat consumption may not be viewed as risky by laypeople as these activities are within an individuals volitional control and beliefs about self regulation may bring about unrealistic optimism (Weinstein, 1987). Therefore it is the task of the experts who are knowledgeable about the risks to support people to recognise risks as personally relevant and to take action to reduce such risks.

Numbers and statistics are frequently used to communicate risk. Number of annual fatalities is the only qualitative characteristic that laypeople do attend to when assessing risk (Slovic, 1987). For example, when making a decision about having surgery, one of the most prominent features of an explanation of the risks of surgery is risk of death. In these circumstances, numerical risk is presented so that patients are able to make an informed choice. On many occasions however, risk is presented in a manner that is aimed at persuading an individual into a particular course of action. Taking the example of the HPV vaccine, many of the information leaflets ►

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we evaluated had used persuasive techniques. Some of the techniques involved concerned different styles of presenting numbers (Lipkus, 2007). Numbers can be presented in many ways, and often are difficult to understand even for 'experts'. For example, numbers may be presented without the reference class that the numbers refer to or with an irrelevant reference class, which leaves interpretation open and often causes incorrect interpretation of risks. Reviewing these techniques resulted in a discussion about the role of a psychologist when communicating risk. As mentioned above, risk communication can be used to persuade or to inform. With regard to the HPV vaccine we questioned whether we were in a position to know if the vaccine is really the best course of action for an individual or population and concluded that our role was to provide unbiased theory based communication about risk to enable an informed choice to be made. We also felt that it is the role of psychologists to educate health professionals on methods of effective risk communication.

This workshop provided a broader understanding of risk perception and a toolbox of skills to effectively communicate risk. The timing of this workshop was perfect for me personally, having just collected data for my own risk perception research. My research has focused on adolescent risk perceptions related to condom use, pregnancy and sexually transmitted infections. I looked for the unrealistic optimism effect and was surprised that I did not find this effect in my data. I was usefully provided with some possible explanations for these unexpected findings. This was really a bonus because this workshop provided an excellent source of professional development over and above that which I could apply to my research directly.

It was a rare opportunity to participate in this workshop with other PhD students from many countries in Europe and as far away as New Zealand. On the first evening the CREATE team organised for participants to meet in Bath city centre for dinner. This was a chance to see the city for the first time and to meet the other participants informally, over some excellent Italian food and wine. This served as a good kick-off for networking during the workshop. The networking was facilitated by the CREATE team who did a great job of organising the workshop and social programme, including the second CREATE football match. Based on my experience, I would recommend next years CREATE workshop in Pisa and I certainly hope to be there myself. ■

References

- Lipkus, I.M. (2007). Numeric, verbal and visual formats of conveying health risk: suggested best practice and future recommendations. *Medical Decision Making*, 27, 696-713.
- Norman, P. and Conner, M. (2005). Predicting and changing behaviour: future directions. In, Conner, M. and Norman, P. (2005) *Predicting Health Behaviour*: Open University Press.
- Slovic, P. (1987). Perception of risk. *Science*, 236, 280-285.
- Weinstein, N.D., (1987) Unrealistic Optimism and susceptibility to health problems: conclusions from a community wide sample. *Journal of Behavioural Medicine*, 5, 441-460.
- Weinstein, N.D. (1988). The precaution adoption process. *Health Psychology*, 7, 355-386.
- Weinstein, N.D. & Nicolich, M. (1989). Correct and incorrect interpretations of correlations between risk perceptions and risk behaviours. *Health Psychology*, 12, 235-245.

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. 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**

All potential contributors should contact the editorial team in advance to discuss ideas or potential submissions. Further details regarding publication guidelines can be found on the EHP website www.ehps.net/ehp/author_instructions.html



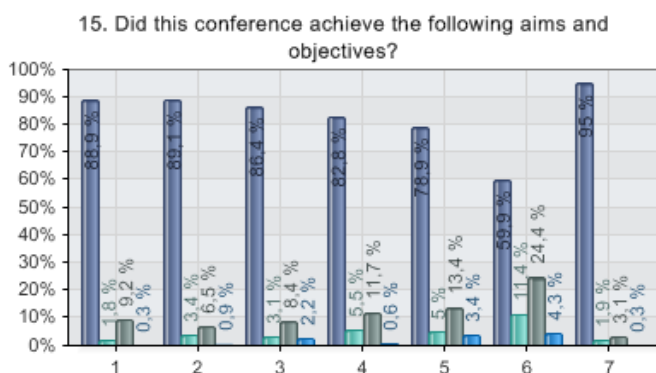
Annual EHPS Conference Report 2008

By Keely Gunson, Lucy Hackshaw & Charlotte Mounce,
University of Bath

This year a joint British Psychological Society Division of Health Psychology (BPS DHP) and EHPS annual conference was hosted by the University of Bath, UK. There was a total of 713 delegates. The keynote speakers were: Professor Joop van der Pligt, University of Amsterdam, the Netherlands; Professor Suzanne Skevington, University of Bath, UK; Professor Janice Kiecolt-Glaser, Ohio State University, USA; Professor Nichola Rumsey, University of the West of England, UK. Over 700 abstracts were submitted and almost 700 accepted. In the programme there were 152 oral presentations, 15 Symposia, 1 workshop and 441 poster presentations. The social programme included reception drinks at the Roman Baths and dinner and disco at Bath Pavilion.



Keynote Speaker Professor Van der Pligt



1. Enabled the dissemination of good quality research?
2. Included papers with a range of theoretical approaches to understanding health and illness?
3. Included papers that applied theoretically based interventions across health care settings?
4. Included papers with a range of methods to explore research questions?
5. Included papers with research questions of relevance to clinical practice?
6. Addressed issues of relevance to all aspects of a health psychologist's work?
7. Provided opportunities to meet and talk with colleagues?

Responders to conference feedback

Three hundred and twenty seven (46%) of delegates completed the online feedback for the conference. Of the responders this year, 36% were full members of the EHPS (23% full members, 10.8% student members, 2.5% eastern European members), and 64% were non members, while 41% were a DHP member (22.3% full members, 18.6% student/trainee member) and 59% non members. Of those who responded, 53% had not attended an EHPS annual conference in the last five years, and 60% had not attended a DHP annual conference in the last five years. Only nine per cent had never attended a conference before with 41 per cent having been to a

social science conference, 34 per cent had been to an applied conference and 53 per cent another type.

Conference aims and objectives

Responders' answers reflected an overall feeling that the aims of the conference were achieved. For the following aims, responders were required to answer yes, no, or unsure as to the achievement of the conference in those aims.

Overall, the majority of responders seem to believe the aims of the conference were met. However, 36 per cent of responders were unsure or did not feel that aim six was achieved. This may ►

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reflect a feeling that some of the research presented was not relevant to the field of health psychology or it could be that some people believed relevant health psychology issues were missing, such as health psychology in practice.

Conference ratings

Various components of the conference were assessed using a rating scale (poor – excellent, 1-5). Mean ratings are shown below.

- How would you rate the overall quality of the conference? 4.0
- What was the quality of the symposia? 4.1
- What was the quality of the workshops? 4.2
- What was the quality of oral presentations? 4.1
- What was the quality of poster presentations? 3.9
- How was the timekeeping and chairing? 4.2
- How was the social programme? 3.5
- How was the overnight accommodation? 3.4
- How would you rate the conference in terms of value for money? 3.5

The components based around quality of the conference, presentations, workshops and timekeeping were rated favourably (3.9-4.2), while the components based on non scientific aspects of the conference – social events, accommodation and value for money were rated a little less favourably (3.4-3.5), this was reiterated in the free response section.

Balance of activities

Participants were asked to rate the balance of activities at the conference with the options of either: fine, too much, too little, or don't know/NA. 'Fine' answers shown by per cent.

- ↳ Number of workshops? – 48.5 % (34.6 per cent don't know/NA)
- ↳ Number of oral presentations? – 80.6%
- ↳ Number of poster presentations? – 74.8%
- ↳ Number of keynotes? – 83.1%

It appears that the majority of responders were satisfied with the balance of each of the activities at the conference.

Written responses

The overall impression of the conference from the free response section was positive, it was a successful meeting where an exhilarating environment was created which encouraged the exchange of research findings,

examples of health psychology and practice to be shared and a community to network and discuss future research collaborations. The main points responders made on what worked well were the joint organisation of the DHP and EHPS, and the wider scope of research that this allowed for. The high quality standard of the scientific programme was repeatedly praised.

However a number of points were raised by delegates who highlighted some aspects that they would change to make the next conference even more successful. Both positive aspects and suggestions for improvement fall under four headings; conference organisation, scientific programme, accommodation and food and social events.

Conference organisation

The general conference organisation was highly praised; in particular a positive aspect mentioned was the joint nature of the conference. This is the second joint conference between the British and European societies (the first was held at St Andrews in 2001). Delegates thought that bringing the two together made for a better quality and higher standard of conference and responders commented that they preferred the wider focus of the research. The organising committee and stewards (known as the 'Green Army' because of their distinctive t-shirts) were considered to be very helpful and attentive, and instrumental in creating a friendly environment within the conference.



The Green Army

A few ideas were highlighted which could improve future conferences. The considerable ►



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number of delegates meant that keynote and plenary sessions were often crowded, it was suggested that the University of Bath was slightly too small a venue for a conference this size. With respect to future joint conferences between Britain and European societies responders suggested that a larger venue to accommodate everyone could be more beneficial. Furthermore, a number of respondents suggested moving refreshments away from the poster presentations, as the background noise reduced the ability to hear the presenters.

Scientific programme

There were few suggestions made in relation to improving the scientific programme. Responders commented on the wealth and high quality of oral and poster presentations and many responders made very positive remarks about the excellence of the keynote speakers. Some delegates however felt that a wider variety of papers and theories needed to be presented, in particular more focus on health psychology in practice and 'real world' examples, in exchange for a less academic focus. A small number felt that there were too many papers presented, however a similar number felt that there were too few, illustrating that delegates have different expectations and thus not all can be completely satisfied. The rating scale responses, however, suggest that the majority of delegates thought that the number of oral presentations was fine. Many responders put forward suggestions for future keynote speakers, from multiple areas of health psychology. These will be taken into consideration for future conferences.

Accommodation and food

Two concerns were raised by delegates in relation to accommodation and food. A number of those who stayed in university accommodation were unhappy with the quality and comfort of their room; they did not provide the luxuries that some hotels do. However using university accommodation allowed these delegates to be just walking distance away from the main conference venues and also kept conference price to a minimum. The other point discussed by some delegates was the quality of the lunch provided, a number asked for more fruit and a healthier option, especially due to the nature of the conference. By providing lunch in individual bags, it allowed delegates the freedom to move around the campus and take advantage of the picturesque open space, however some felt that a seated lunch area would allow for further networking.

Social events

The social calendar was very busy, and on the whole enjoyed and appreciated by delegates. The tour of the roman Baths was a highlight for many and responders commented that Bath was a beautiful city that provided a fantastic back drop to the conference. Positive comments were also made about the meal event on the Wednesday evening where a number of restaurants were booked throughout Bath and hosted by DHP and EHPS representatives. However feedback about the conference dinner on the Thursday evening was more mixed. The venue was very crowded and there unfortunately was insufficient seating for the number of delegates. People had to queue for their buffet dinner and it was felt by many that a sit down meal would have been more appropriate. The lack of space and seating was predominately caused by the huge numbers that attended, it was suggested that the dinner could have been held in two venues or at two sittings. This is something that will be taken on board for future joint conferences. However for most who commented on this aspect, this did not ruin the enjoyment of the evening

"I think the obvious thing to change was the conference dinner, however this was a small glitch in an otherwise very well organised conference"

Training and professional development

There were a number of pre conference workshops this year: 'Missing data analysis', 'Writing highly cited health psychology papers and what to do when one is rejected' along with a CREATE workshop on 'Risk perception and risk communication' and a Synergy workshop on 'Internet-based health psychology interventions: maximising their potential'. In addition a 'Meet the experts' session took place before the start of the conference to allow experienced psychologists to pass on their knowledge. A single workshop took place during the conference: 'Preventing type 2 diabetes: Are recommendations on achieving lifestyle change from the IMAGE guideline development project valid and achievable?' Finally, there was one post conference workshop on 'Discourse analysis'.

DHP and EHPS joint conference

This year's conference was jointly organised by the British Psychology Society Division of ►

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Health Psychology (DHP) and the European Health Psychology Society, which allowed for a mix of work from other countries as well as the UK. Responders commented on how well this worked and reported that the two societies contributed to a more international perspective on Health Psychology. Additional comments were made that this allowed for good networking opportunities and for a variety of opinions and ideas to be exchanged. Suggestions on improvements for future joint DHP and EHPS conferences were that presenters could talk more clearly as many delegates were not native English speakers.

Poster presentations

This year the poster sessions were organised in a different format to previous DHP conferences, there were four dedicated viewing sessions in the main hall in which 441 posters were presented in total. Poster sessions were chaired and themed in groups of up to six posters. Each presenter gave a 2-3 minute summary of their work, followed by a 3 minute group discussion facilitated by the chairs. The delegates were very positive about the poster sessions, saying that the format helped to promote informal discussion, the large room allowed delegates space to move around the poster displays in a relaxed environment. The only critical point raised was that due to the refreshments being served in the same location, it was sometimes difficult to hear the presenters over the background noise.

Final comment:

Jo Hart (National Conference Organiser) & Karen Rodham (Conference President)

In spite of some of the practical and logistical constraints which we worked hard to overcome, and from which we have learned valuable lessons for future conference organisation, we are very pleased with the feedback received. This was the largest health psychology conference that has (to date) been organised in Europe and thus highlights the growth of health psychology in the UK and in Europe. We were thrilled with the number of high quality submissions to the conference – this level of excellence was reflected in the media coverage that the conference generated in the UK, Europe and further afield, including India.

As Conference Organisers, we would like to thank the following for their involvement in the

conference: Dr David French, Chair of the Scientific Committee; The DHP and EHPS Committees for advice and support in promoting the conference; the British Psychological Society Conference and Media Office for supporting the conference; the Stewards who worked tirelessly to ensure the conference ran smoothly; Christina Shoesmith who managed the Registration Desk; Dr Caroline Henderson (Incoming National Conference Organiser); Dr Di Harcourt and Dr Julie Turner-Cobb who managed the press releases; Exhibitors for sponsoring the conference; Taylor and Francis for sponsoring the drinks reception; Bath Chairman, Councillor Belotti for sponsoring the Roman Baths drinks reception; finally the University of Bath for hosting the conference (especially Sarah Bull).

Both societies and the organisers take your feedback very seriously. A number of outcomes from the conference feedback are in progress:

- Both the DHP and the EHPS have initiated large scale reviews of their annual conferences
- In the short-term, feedback has been given to the organisers of both 2009 conferences and they have already implemented changes
- Jo Hart, on behalf of the organisers, felt that some aspects of the conference did not meet our expectations, and therefore made complaints to both the University of Bath and those in charge of the conference dinner; negotiating substantial reductions from both these organisations (over £18,000). This amount plus a small surplus will be given to the DHP and EHPS, in the proportion agreed in their contract. We know that this additional money will be put to good use in the societies.



conference announcements

conference title	date	location
UK Society for Behavioural Medicine 4th Annual Scientific Meeting	6 – 7 January 2009	Exeter, England
Society of Behavioral Medicine Annual Meeting & Scientific Sessions	22 – 25 April 2009	Montreal, Canada
11th European Congress of Psychology	7 – 10 July 2009	Oslo, Norway
116th Annual APA Convention	6 – 9 August 2009	Toronto, Canada
British Psychological Society Division of Health Psychology	9 – 11 September 2009	Aston, England
23rd Conference of the EHPS	23 – 26 September 2009	Pisa, Italy
Keynote Speakers		
<ul style="list-style-type: none"> ▪ Linda Cameron (University of Auckland, New Zealand): <i>"Self-regulation and health, an intervention perspective"</i> ▪ Gian Vittorio Caprara (University of Rome "La Sapienza", Italy): <i>"Optimal functioning: turning potentials into well-being"</i> ▪ James C. Coyne (University of Pennsylvania, USA): <i>"The role and responsibilities of the critic in moving health psychology forward"</i> ▪ Jane Wardle (University College London, UK): <i>"Health behaviour change and cancer prevention"</i> 		

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