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in this issue

an interview with

Public Health Genomics and its potential for health psychology: an interview with Angela Brand

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Professor Angela Brand, director of the European Centre for Public Health Genomics (ECPHG), began her career as a paediatrician. Later, at Johns Hopkins University, she became interested and trained in public health, especially in the then emerging field of public health genomics. She was one of the pioneers in Public Health Genomics in Germany and in Europe and established the European Centre for Public Health Genomics (ECPHG) at Maastricht University. Together with Bartha Knoppers from Montreal she is the editor-in-chief of the international journal Public Health Genomics.

Professor Angela Brand

Director of the European Centre for Public Health Genomics (ECPHG), Head of the Department of Social Medicine, Caphri, Maastricht University, The Netherlands.

How would you describe the role of Public Health Genomics?

We increasingly understand that whether or not a disease develops always depends upon the interaction between genomic factors *and* environmental factors that include social factors, lifestyle factors, and psychological factors. Public health has always been interested in the role of environmental factors in disease, but has so far ignored the genomic part. It is the goal of Public Health Genomics (PHG) to integrate genomics in every public health task, varying from the surveillance of infectious diseases, the improvement of nutrition, or in the psychological field, the empowerment to behavioural change. PHG, therefore, implies doing translational research.

Genomics shows us that there is a permanent interaction between the genome and the environment and that there is not a single 'determinist' factor. Our behaviour, for example, is not only influenced by social factors, but also by our genomic make-up with its multiple variants. If for example, we try to empower people to stop smoking, we see that there are people for whom it is almost impossible to quit, and today we know that to a large extent this may be due to genomic variants that specifically predispose to nicotine addiction (Berrettini & Lerman, 2005).

Genomes are not static, but dynamic and highly complex systems. We know now, that social factors, like certain experiences and life events – including therapeutic interventions - may result in changes at the level of our genomes (Sweatt, 2009). That is what we have learned from recent insights in epigenomics and it is highly relevant for public health.

Can you give some further examples of the public health effects of epigenomics: can't it be that environmental factors modify and trigger health outcomes by changing the genome?

Yes. Take obesity, for example. Before and during the Second World War there was not much food. This may have affected the susceptibility of future generations to developing diabetes, as children conceived during the years of famine carry epigenetic 'signatures' of this hunger period (Heijmans et al., 2008). Then suddenly this changed after the Second World War and for the last generations of people a lot of food was available while their body was not adapted to this abundance. So, obesity figures grew. Today, we see that obesity figures do not grow anymore in children, partly because we adapted to the availability of food. That is, our genome no longer carries the epigenetic 'signature' of severe famine. Nevertheless, obesity consists of several different subtypes which are totally different entities. There are subtypes of obesity in which epigenomic effects are not that strong. ►

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A very different example is the case of child abuse, where interventions normally focus on the social background and family members of the child. New evidence suggests that child abuse has also to do with genomics, and that it has long-lasting epigenomic effects (McGowan et al., 2009; Welberg, 2009).

To what extent does this relate to specifying outcome measures?

We should use the concept of health outcomes instead of diseases, because a health outcome can actually be the state that results from a clustering of different disease phenotypes that we did not bring together in the past. However, some of these diseases may have a common genomic background. Disease associated genes have been mapped to pathways and it has been found that a number of different diseases often share the same pathways. Li and Agarwal, for example, found that diseases as different as myoclonic epilepsy, Turner syndrome and Wegener granulomatosis all map to one pathway (Li & Agarwal, 2009). By linking genetic disorders ("disease phenomes") with known disease related genes ("disease genomes") networks can be constructed that show the various "diseasomes": clusters of related disorders (Goh et al., 2007). However, even if we know the genomic variation, we still do not know which diseasome will develop during the lifespan of the individual. One further relevant issue is that traditional epidemiological models do not fit anymore, since the new developments stress the importance of looking at the individual level and this means that we cannot generalize our findings, as we used to do. It comes down to personalised health care (Brand, 2009), we should focus on long term monitoring of processes within the individual instead of focusing only on comparisons between individuals.

In one of your articles in the European Journal of Public Health you state that "It should be kept in mind that we have to be careful about the message 'prevention and health promotion is good for everybody…'" (Brand, 2005). Could you elaborate on this?

By that I mean that a public health message based on the strategy of "one size fits all" is not adequate. Let's take the example of the message that soya is good for everybody, while in fact it is not. It can be a protective factor regarding certain types of cancer, but in certain situations it can have the opposite effect, for example when a person has a carcinoma in situ. The same goes for olive oil, and also for physical activity. The sudden death among young sportsmen with a particular genomic variant in the beta myosin heavy chain gene (Marian et al., 1994) is an extreme example of this, but it can be prevented even though the incidence rate is low.

One further example is alcohol consumption. Some people can get very aggressive after consuming only a very small amount of alcohol. They can't control themselves anymore. Should they be responsible for that situation? Therefore, prevention for these people should not focus on consuming less alcohol, as may be the general public health recommendation, but on preventing that these people end up in a situation in which their aggressiveness can get triggered by alcohol consumption. Thus, here the message should be, that these individuals should never start drinking alcohol at all. Finding this variant in a genome and communicating this message to the individual is at the core of personalized health care.

What does this mean for public health messages?

The message is that one cannot claim that all generally good interventions are good for everybody. Interventions should be more target-oriented, and in the end it comes down to individual approaches taking also the genomics into account, as early as possible. This is practically and politically very difficult and it raises the question of how early is as early as possible? We can for example test for genomic variation during pregnancy, but what are the consequences? We should debate this issue in a transparent way, as newborn screening is established in almost all developed countries for over 40 years and it can be extended to include many health outcomes. The biggest challenge is how we will manage this. Genetic counsellors will play their part, but there are also possibilities for other health professionals including psychologists.

To conclude, do you have a take home message for health psychologists in general?

The competences of health psychologists are needed, since public health genomics is a multidisciplinary task. Genomics is just one factor among many other factors that we need to consider within the multifaceted task of public health. If in every single task there is a certain awareness of the role of genomics, then we can solve the challenges we face.

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conference report

SOPHIA, The Symbol of Wisdom, welcomes psychologists from the region and the world.

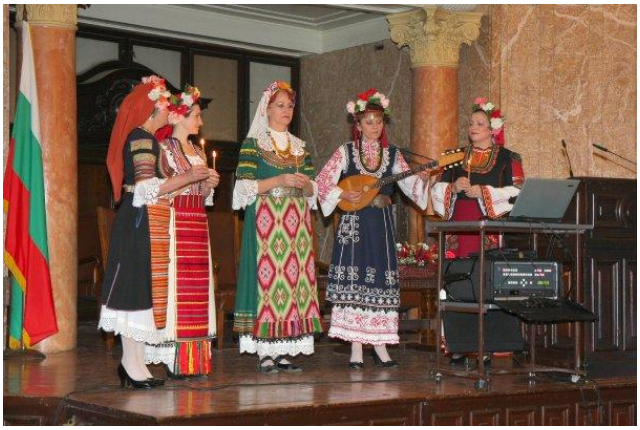
Irina Todorova
President
European Health Psychology Society

At the end of October 2009, an important event took place in Sofia, Bulgaria: The Southeast European Conference of Psychology: Paradigms, Schools, Needs and Achievements of Psychology in the Region. The place was Sofia University "St.Kliment Ohridski", the organizer was the Bulgarian Psychological Society, in collaboration with The Institute of Psychology (Bulgarian Academy of Sciences) and the Association of Young Bulgarian Psychologists.

The Conference had two main aims: to present the achievements of psychology in the region and also to support capacity building for teams and organizations in the area of Southeastern Europe, as well as in broader international collaborations.

Regional conferences of psychology have been taking place since 1995, when the first one was held in China. They are an initiative of the International Association of Applied Psychology (IAAP), in partnership with the International Union of Psychological Science (IUPsyS) and European Federation of Psychologists' Associations (EFPA). They take place every 4 years, alternating with the IAAP conferences. Sofia was the location of the 8th Regional Conference, which addressed the accomplishments, needs and professional networks of psychologists in Southeastern Europe and aimed to foster connections between scientists and professionals. Additionally, this year, the SEERCP was also held under the auspices of the International Association of Cross-Cultural Psychology (IACCP) and the European Health Psychology Society (EHPS).

The EHPS received an invitation from Plamen Dimitrov, President of the Bulgarian Psychological Society and of the SEERCP to support the Conference – I presented this to our EC and it was accepted enthusiastically. Our support took the form of widely publicizing the conference among our members, both from the Eastern European region and beyond, liaising with other professional organizations to ensure a substantial and high quality representation of the health psychology field at the conference through symposia, papers and posters, ensuring EHPS members' participation in the conference and working on developing the program. The EHPS and the IAAP, particularly the Health Psychology Division of IAAP, have a long and productive history of collaboration, through supporting each other's activities and organizing invited symposia at each other's conferences. I saw the SEERCP as another opportunity to realize a collaboration between IAAP, EHPS and the Bulgarian Psychological Society.



Opening ceremony: Bulgarian folk songs

The Conference received over 350 submissions, which were mainly from the SEE Region (from Bulgaria, Romania, Macedonia, Turkey, Serbia, Greece, Russia, etc.) but also from many other areas of the world, including US, Canada, Northern Ireland, Australia, Iran and others. Thus, the scientific program included plenary and keynotes sessions, 12 thematic streams and in tune with the capacity building aims of the event – also a wide variety of more than 25 workshops, open forums and round tables. The opening session included welcoming remarks from Plamen Dimitrov (BPS and President of the SEERCP); Michael Knowles (President of IAAP), Rainer Silbereisen (President, International Union of Psychological Science IUPsyS), Irina Zinovieva, Department of Psychology at Sofia University, the Bulgarian Minister of Science and Education, and the ambassador of South Africa to Bulgaria. I welcomed the delegates on behalf of EHPS, presented the resources that our society has for health psychologists, and coincidentally, the string of EHPS annual conferences which will be taking place in the region: Cluj-Napoca, Romania in 2010, Crete, Greece in 2011 and Prague, Czech Republic, 2012.

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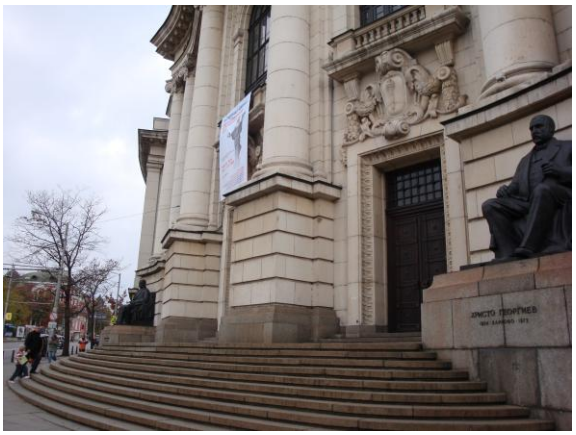
SOPHIA, The Symbol of Wisdom, welcomes psychologists from the region and the world.

With the Program Committee we organized the health psychology stream, and identified relevant papers and posters. After some discussions about
which papers should be in the Health Psychology stream and which in the Clinical Psychology stream, we still created a full-day Health Psychology program. Our stream began with the following three keynote lectures:
Ray Fowler (US, President-elect of IAAP) Positive Psychology and Positive Health: Increasing Longevity, Health and Happiness
Linda Berg-Cross (US, Howard University) Defining Issues in Health Psychology and Behavioral Sleep Medicine
Irina Todorova: Bulgaria, Health Psychology Research Center: The Role Of Health Psychology In The Health Crisis Of Southeastern Europe.



SEERCP at Sofia University St. Kliment Ohridski

We continued with the full day paper session in health psychology – thankfully, we co-chaired it with Adriana Baban and took turns, and even managed to have a lunch break and finish on the dot. Many posters in the poster sessions also addressed health psychology topics. The presentations attested to the development of health psychology in the SEE region, as well as to the importance of this field for the region, considering that many of the health problems have significant psychosocial dimensions and that many health inequalities are evident. The papers were impressive with the diversity of topics, the sophistication of the theoretical frameworks being not only used, but creatively developed. The papers showed detailed attention to mechanisms of interaction of psychosocial, behaviors and health constructs, and employed quantitative and qualitative methods. Additionally, the health psychology stream had diverse international representation from the SEE region and beyond: from Romania, Serbia, Northern Ireland, Croatia and Bulgaria. Many of the papers were already in partnerships between different countries and institutions. Youth health was a major topic and several joint projects were presented: collaborations were between Bulgaria and Romania; Poland, Germany and Bulgaria; Greece and Bulgaria.

However, the stream offered opportunities for discussion of future plans for cross-cultural research. Plans were made for attending the 2010 EHPS Conference in Romania.
Though taking place in the peak of the flu season in Sofia, the conference was very well attended and highly successful in achieving its goals. I am happy that the EHPS supported this successful and network building conference in the SEE region, and as such was able to collaborate with the Bulgarian Psychological Society, The International Association of Applied Psychology, The International Union of Psychological Science, the International Association of Cross-cultural Psychology and The European Federation of Psychologists' Associations. When starting my term as president of EHPS an important part of my platform was to highlight the accomplishments of health psychology in Eastern Europe, and expand health psychology initiatives and presence in the region, of which the whole EHPS has also been very supportive. What happened at SEERCP for health psychology was very important, and I am particularly moved by the fact that it happened in Sofia. I'd like to thank all delegates for coming to our beautiful city and making it all possible!

Irina Todorova

President, European Health Psychology Society

original article

Integration of Psychologists in the European health care system. Challenges and opportunities from a Swedish perspective.

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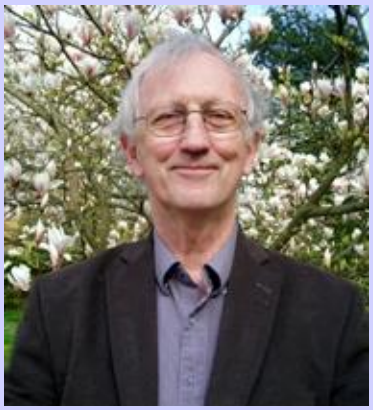
The Swedish Board of Health and Welfare recently (February, 2009) recommended use of psychological methods, e.g. cognitive behaviour therapy (CBT), as a first-hand option in the treatment of depression disorders and anxiety syndromes (www.socialstyrelsen.se). This was big news and both a challenge and an opportunity for professional psychology to enhance and to protect its qualified professional expertise and patient safety on the first line. It is a challenge to provide, insofar as possible, such availability of professional psychologists in each health care centre, thereby guaranteeing patient access to appropriate diagnosis and treatment. There is also a need to enhance beneficiary access to the range of services of primary care psychologists. Failure to achieve this involves a risk that health-care personnel who lack the qualifications of the psychologists will take over or that the present over-prescription of drugs will prevail. This may not only cause harm but also decrease patient confidence in the quality of care that psychologists provide.

What has now happened with regard to the initiative taken by the Board of Health and Welfare in Sweden? Because the recommendations were criticized from many quarters such as psychiatrists and other types of psychotherapists than cognitive behavioural ones, the National Board of Health and Welfare has decided to postpone the ratification of the recommendations until next year. In their comments, The Swedish Psychiatric Association argues that publication of the preliminary guidelines was "premature" and could be damaging from a public educational perspective when statements such as "cognitive behavioural therapy is better than drugs" is given national mass media circulation (www.svenskpsykiatri.se). The association argues that recommendations concerning treatment must be based first of all upon scientific evaluations of effects and side-effects, other matters involved being resources (economical considerations and accessibility). According to the psychiatric association, the recommendations provided of always recommending cognitive behavioural therapy (CBT) – or, as far as that goes – electro-chock therapy (ECT) prior to use of drugs are not in harmony with international practice and contain so many uncertainties that the legitimacy of the National Board to make statements on psychiatric treatment has been damaged.



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With regard to effects and side-effects, the Swedish Psychiatric Association argued that there are several evidence-based treatments of depression of both a pharmacological and a psychological nature with authoritative studies showing anti-depressive drugs to be better than CBT in treating depression and no studies showing that CBT is better than anti-depressive medication. In practice, these recommendations can result in higher priority being given to milder depressions than to severe ones for which the evidence-base for effects of CBT is weak. As to side-effects, the National Board of Health and Welfare concluded that there are no side-effects of CBT. This was criticized by the Psychiatric Association in terms of there being no evidence for such conclusions, since side-effects in psychotherapy are seldom taken note of, quite in contrast to studies of drug effects. The psychiatric association mentions attachment to the therapist, problems in concluding therapies, rebound-effects and lack of attention to co-morbidity on the part of psychologists, and the need of further medical investigation and treatment to ►

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determine whether there are side-effects that have not been studied scientifically.

With regard to resources (economy and accessibility) the psychiatric association argued that in Sweden today there are 500-600 educated cognitive behavioural therapists who hardly can carry out 15-20 consultations with the one million Swedes who suffer each year from depression or anxiety. Also, CBT is regarded by the psychiatric association as being very expensive, neither the costs of establishing CBT on a broad front nor the capacity or energy of patients to adhere to the therapeutic method being adequately borne in mind. The psychiatric association welcomes computer-assisted CBT but argues that studies of CBT and computer-assisted CBT are scarce and provide no sufficient basis for conclusions in support of it.

The Swedish Psychological Association argues that about 5-7 % of the grown-up population suffers from depression and about 6% from anxiety and that some 455 000 persons or more of the adult population are in need of psychological treatment for depression or anxiety (www.psykologforbundet.se). Today, less than one out of 10 persons who consult health care for psychological problems are given specific psychological treatment, indicating that some 420 000 persons do not receive such care. It is argued that offering theses persons good evidence-based psychological care would cost some 420 000 000 EURO. If half the patients suffering from mild to moderate depression or anxiety benefitted from such treatment, this would result, according to the Psychological Association, in a yearly saving of some 1 140 000 000 EURO. Providing an additional 420 000 patients evidence-based psychological treatment could require a larger number of psychologists being educated than today, such extension needing to proceed, in this case, in step-wise fashion.

The problem is seen as that of providing evidence-based psychological treatment in which people ask for it to the same degree as they need it. Yet according to the Psychological Association the idea of not providing such treatment being due to a lack of psychologists represents a misunderstanding. A recent questionnaire investigation suggested the 2000 psychologists now in private practice to be able to provide their services to 44 000 more patients each year than at present. At the same time, this raises the issue of whether psychological health in Sweden is a matter of class. The Psychological Association argues that many patients seeking care are not admitted to psychological treatment since the counties responsible for care of the population have not employed or made agreements with a sufficient number of psychologists, seventy percent of health care centres in Sweden lacking such services. Another reason for the lack of access to psychological treatment is seen to be that of evidence-based psychological treatment having developed much later than the use of drugs.

According to the National Board of Health and Welfare, 70% of those seeking care for depression and anxiety consult primary health care. However, it has been found that less than a tenth of the patients in primary health care with depression or anxiety are provided with specific psychological treatment of the sort recommended, i.e. with cognitive psychotherapy or cognitive behaviour therapy (CBT). It has also been found that 66% of the population prefers psychological treatment to drugs if given the possibilities of receiving it, only 9% selecting drugs first.

What are the lessons of this for psychology in the future? I consider it important to cooperate more closely with family physicians and general practitioners (GPs). Physicians should discuss with psychologists which patients with psychological problems should be referred to psychologists for more thorough psychological diagnosis and treatment. In the near future, most patients with psychological problems of a minor or moderate character will need to be handled by GPs, if only because of a lack of psychologists at these facilities. The Psychological Association argues that there should be a psychologist in every health care centre. An important initial aim should, in my opinion be that of having at least one psychologist in every five GPs and the counties responsible for the care provided seeing to it that such a system is established. I also believe it to be important for psychologists to not work in isolation at health care centres but to join together with one or more of their colleagues to ensure that none of them are overwhelmed by the psychological problems of their patients and that they have the opportunity to discuss with them thoroughly the problems they have at their workplace.

The frustration noted among representatives of the psychiatric profession of having psychologists available on the first line in primary health care centres can be understood as a question of “who knows most”, which is ultimately a question of power. It could easily be argued that having psychologists with their education and emphasis on coping and prevention and their skills in assessment and measurement available at the primary health care centres would result in more appropriate diagnoses, so that persons with minor or moderate problems would be differentiated more adequately from those with more serious problems. The resistance of ►

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representatives of the psychiatric profession to having psychologists as health care workers is evident in many countries. In the US, for example, the resistance of psychiatric associations to the quest of psychologists for the right to prescribe psychopharmacological drugs has been extreme. Nevertheless, such rights are now a reality in various US states, many of the other states also being on the verge of passing laws providing psychologists who have been given advanced psychopharmacological training such prescription rights. It is highly important that psychologists be knowledgeable of basic psychopharmacology so as to be able to discuss medication and side-effects of medication with their patients and also that they have the right to "un-prescribe" inappropriate medication when this is indicated. The rights of psychologists to prescribe psychopharmacological drugs can be thought to ultimately result in a parity of psychologists with physicians in terms of reimbursement and professional opportunities in this area, a development that should be encouraged in the European countries as well. Psychologists in the Netherlands, for example, are seeking prescription rights through their professional organization. Last year (2008), 22 Dutch psychologists selected the psychopharmacological training program presently available in New Mexico, the Prescribing Authority Act there providing properly trained psychologists prescriptive authority (see Tablet: Newsletter of the Division 55 of the American Psychological Association: www.division55.org/TabletOnline.htm).

For psychologists in primary health care, more than simply mental problems of patients should be taken into consideration. Appraisals and coping are involved in many other illness and diseases, such as diabetes, cardiovascular disease and cancer, not to mention the so-called fashionable diseases, such as fibromyalgia and chronic fatigue syndrome. One problem involved in illnesses of as well as in the treatment of other groups in the population, such as the elderly, is that of extensive drug use. At a health care centre the individual should be able to gain contact with a person who acts in his or her interest. This person can be a physician, a psychologist, a nurse, an employment counsellor, or an insurance administrator. When a person has a variety of problems, there is a much better chance of finding a satisfactory solution if those with the ability to help work together. Integrating psychologists within the work of primary health care units would be an excellent and, I believe, necessary means of furthering public health and research. In Sweden, as in many other European countries, the training of professional psychologists at institutions of higher learning is primarily geared to the basic diagnosis of problems and to systematic psychotherapeutic work. Students of both medicine and psychology, in fact, are confronted with far too few "ordinary" patients. The health care training of psychologists should include experience in dealing with primary health care patients rather than simply that of working with patients typical at somatic and psychiatric clinics that represents a far more selective clientele. The tendency in medical education to gradually adopt a problem-oriented rather than an organ-oriented perspective has brought about an increase in inter-disciplinary collaboration between general practice and psychology. To foster such developments, which are in the interest of both individual and public health, considerable educational and organizational efforts are needed. Concerted European efforts are urgently called for to establish a coordinated form of health and psychological education of psychologists involving a broad focus, one that includes basic somatic and psychopharmacological knowledge. Here, organizations such as the European Union, the European Health Psychology Society and the European Federation of Psychologists' Associations (EFPA) each have an important role in achieving this.

workshop report

Create 2009 report: "Advancing the science of behaviour change: methods and theories"

Zoe Stavri

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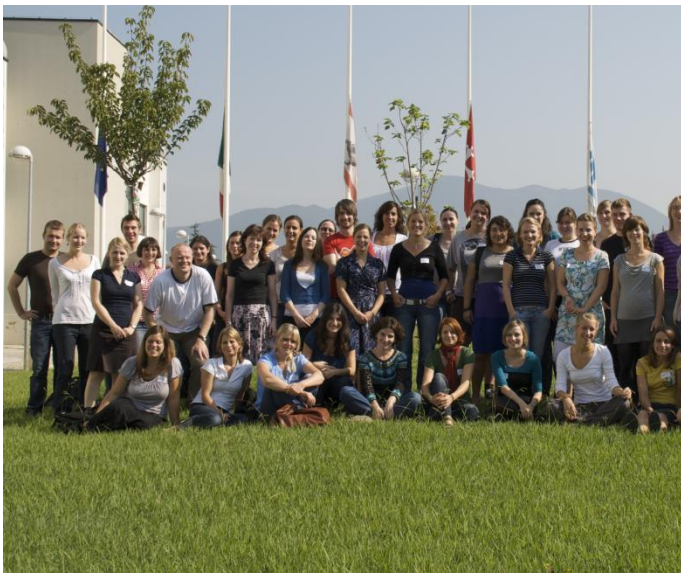
The largest ever CREATE workshop took place in the historic city of Pisa over three days before the EHPS conference. The workshop had received an unprecedented number of applicants. This may have been due to the prospect of a week in the Italian sunshine, but it was more likely due to the highly valuable content of the workshop, overseen by its three world-class facilitators.



Create 2009 in Pisa

Professor Susan Michie, Dr Falko Sniehotta and Professor David French, all experts in the field of developing and evaluating behaviour change interventions, put together a programme of presentations and group activities. The learning environment was informal and interactive, encouraging lively discussions of the content and providing the opportunity to pose questions to the first-rate facilitators. The workshop was organised by CREATE's executive committee, Amelie Wiedemann, Stephan Dombrowski, Jana Richert, Natalie Mallach and Nelli Hankonen. All are early-career researchers and the group did a brilliant job of managing both the workshop and the social programme.

The focus of the workshop was thematically similar to that of the conference: the translation of knowledge into interventions. Specifically, this year's CREATE workshop aimed to increase understanding of the principles of good science within health psychology, applying health psychology theory to intervention development and evaluation and methods for testing and developing theory. These issues are at the core of health psychology and these issues were discussed within the context of the participants' own work.

The workshop content was structured around the MRC guidelines for developing and evaluating complex interventions (Craig, Dieppe, Macintyre, Michie, Nazareth & Petticrew, 2008). These guidelines view development of behaviour change interventions as a process involving the stages of development (including the preclinical "theory" phase), feasibility and piloting, evaluation and implementation.

The development phase involves identifying the evidence base and selecting appropriate theory. Methods for developing a theory-based intervention and reviewing evidence were discussed. It is necessary to assess the evidence base to discover which components of interventions work and why. This is hindered by poor reporting of intervention content: while guidelines exist for reporting of interventions (e.g. the CONSORT statement; Moher, Schulz & Altman, 2001), identifying intervention content from published journal articles is a difficult task. This issue led to Abraham and Michie (2008) developing a theory-linked taxonomy of 26 behaviour change techniques, which has since been extended to 40 techniques. The taxonomy provides a useful tool for identifying effective techniques in interventions, process evaluation of interventions (e.g. Michie, Hardeman, Prevost, Taylor & Kinmonth, 2008) and could be used to facilitate better reporting of interventions. One of the many group activities was an exercise in coding intervention descriptions using the taxonomy. ►

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We found that it was much easier to do so from a protocol, providing practical experience the difficulty identifying intervention content.

The importance of theory was a major focus of the workshop, as it is a crucial aspect of good science in health psychology. In particular, the importance of using theory in developing interventions was discussed. A coherent theoretical basis is a crucial aspect of an intervention: theory-based interventions are more likely to be successful than those which do not use theory (Albarracin, Gilette, Earl, Glasman, Durantini & Ho, 2005). Several different approaches can be used to develop a theory-based intervention, such as intervention mapping (Kok, Schaalma, Ruiter, van Empelen & Brug, 2004), using a theory which explains how to change behaviour (e.g. Social Cognitive Theory, Bandura, 1997; Self Regulation Theory, Carver & Scheier, 1998) or modifying theoretical mediators of behaviour.

The practical issues of developing and evaluating interventions were worked through interactively beside the conceptual points. Given the interactive nature of the workshop, at every step we were given the opportunity to discuss the issues raised within the context of our own work. Many of the group were working on intervention studies, while others were undertaking theoretical work. The workshop gave us the opportunity to solve problems and get advice from others in a similar situation as well as the expert facilitators.

One of the purposes of the CREATE group is to provide a support network for early career researchers, offering opportunities to meet others from Europe with similar research interests. This was easily achieved through both the workshop content itself, which included a session where we informed one another's intervention design, and through the social programme. It's not often that I get to discuss behaviour change over a glass (or three) of wine! CREATE was valuable for those within the later stages of their PhDs and those like myself who have just started. I left Pisa with my brain buzzing with ideas for directions and I now have met dozens of people who can provide me with advice. Because of this wonderful experience, I look forward to CREATE's 2010 workshop in Romania, and I would recommend it to other early career researchers.

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conference report

Conference report EHPS 2009: From Knowledge to Interventions?

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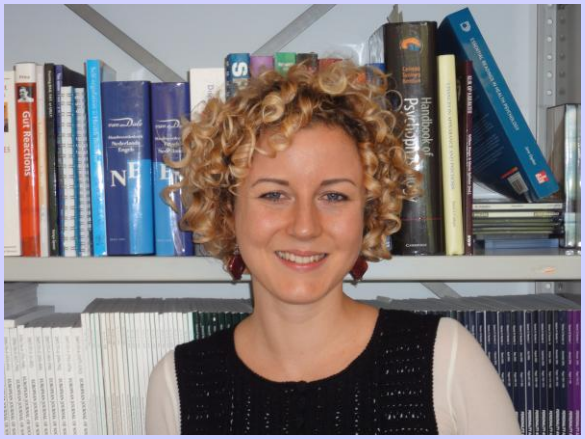
Despite the tempting Tuscan weather, hundreds of health psychologists chose the somewhat less tempting conference hall of Pisa to participate in the 23rd Conference of the European Health Psychology Society (EHPS) held between 23 and 26 September 2009. The growing popularity of health psychology was clearly apparent in this year's conference. Not only were conference halls completely filled, the number of submissions was also larger than ever. While the organising committee of the Bath (UK) conference in 2008 received a top number of 700 submissions, this year over 1300 abstracts were submitted.

Having such a large number of participants warranted a great diversity of themes and subjects. Under the heading "From Knowledge to Interventions", virtually all topics in health psychology were touched upon: from positive psychology to models of health and behaviour and the role of culture in health. With 275 oral and 1000 poster presentations scheduled, the conference offered enough opportunities to make it a useful and inspiring stay.
At the same time, such a varying and diverse programme poses some challenges to give a general impression of the conference and do justice to the many participants, symposia and presentations. In an attempt to give an impression of the conference, I therefore highlight some innovative presentations that aptly illustrate the conference's theme From Knowledge to Interventions.

Health Psychology: Answering or producing questions?

In agreement with the conference theme, besides many intervention- and applied studies, much space was offered for more fundamental experimental research on health and health-related behaviour. The knowledge that such experimental studies generate about mechanisms explaining health (behaviour) change, are of great importance for the development and improvement of health interventions. However, knowledge about these underlying mechanisms is not always easily translated into effective interventions. Some illustrative examples of this were presented in a symposium on self-control and health behaviour, which I will describe in some more detail below.



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The paradox of health behaviour explained?
One the most striking paradoxes in health behaviour is that many people continue their unhealthy habits, despite their good intentions and strong desires not to do so. Smoking cessation and weight loss attempts, for instance, more often fail than succeed.

According to Dr. Wilhelm Hofmann (University of Würzburg), this apparent contradiction can be explained with a dual-system model of health behaviour. Hofmann presented results from his research, in which he considers health behaviour to be the result of a competition between automatic, impulsive influences and controlled, reflective processes. To exemplify; a person who finds himself confronted with a tasty chocolate bar might automatically evaluate this chocolate bar as positive and tempting; the impulsive system. At the same time, this person might be aware that eating this chocolate bar competes with his goal to lose weight; the result of the reflective process.
Which of these two systems will become dominant and eventually will result in behaviour, depends on a number of factors. ►

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The studies presented by Hofmann showed that when the cognitive capacity required to engage in reflective processes was reduced by a cognitive load (by remembering an eight-digit number), behaviour was determined by automatic, impulsive processes. As a consequence, participants ate more chocolate in a taste test. When participants had to remember a one-digit number, and thus had sufficient cognitive capacity available, their behaviour was determined by controlled, reflective processes and participants subsequently ate less chocolate on a taste test.
Whereas this dual systems theory nicely integrates paradoxical health behaviours, two other presentations showed that developing interventions based on this model might not be as straightforward as expected.

Impulsivity: good for health?

The previously described dual-process model suggests that health behaviour could be facilitated by triggering the reflective processes, thereby reducing impulsive influences. However, Dr. Bob Fennis, social psychologist at Utrecht University, presented a series of experiments that showed that triggering impulsive processes and limiting reflective processes could actually be beneficial for stimulating healthy behaviour. The underlying hypothesis is that when individuals are in a state of reduced cognitive capacity for reflective processing, people will rely on cues and easy-to-process information in their environment.
Fennis experimentally manipulated reflective capacity and participants were then exposed to health promoting information, such as the advantages of keeping a dietary diary. Participants with limited reflective capacity were more likely to automatically follow the information. The participants in this condition were more susceptible for the health message, attached more value to this message, and reported a stronger intention to follow the recommendations in the message.

Can chocolate keep you slim?

Another conclusion that could be drawn from the dual-process model of health behaviour, is that it is better to avoid strong temptations. These strong temptations would activate impulsive processes and thereby trigger unhealthy behaviour. In her presentation, Floor Kroese, PhD-student at Utrecht University, refuted the proposition that individuals who are trying to lose weight should avoid temptations like chocolate pie.
Floor Kroese's research suggests that automatic responses to strong food temptations, might actually lead to more self-control, while weak food temptations might form a potentially larger threat to a dietary goal. This is based on the idea that strong food temptations are strongly associated with dieting behaviour and restrained eating: when dieting women find themselves confronted with a tempting chocolate pie this may signal hedonic pleasure, but at the same it time might prime the notion that chocolate pie can harm the dieting goal. Therefore, seeing a strong food temptation would automatically activate the dieting goal and thoughts about dieting, which in turn are translated into controlled and healthy eating behaviour. Weak temptations on the other hand, do not signal a threat to the dieting goal and will therefore not activate the dieting goal; consequently less control will be executed over the eating behaviour.
Three experiments showed that weak food temptations were indeed less strongly associated with dieting, whereas strong food temptations activated a strong association with the dieting goal. This process influenced intentions to eat healthily as well as actual snacking behaviour; those who were exposed to strong food temptations actually made more healthy food choices.

From knowledge to intervention?

How can these insights contribute to the development of effective interventions aimed to promote healthy behaviour? Or in other words, how would this knowledge lead to interventions? Should we confront individuals with attractive and tempting foods, or should we rely on using more health education? Or both? And under what conditions? New knowledge is not always easily transferred to practice and ready-to-apply interventions. However, with the fast-growing research field of health psychology, there is hope that the solution is within reach. Perhaps the next EHPS conference in Cluj Napoca (Romania) in September 2010 will bring us another piece of the puzzle.

International Conference on Support for Self Management of Health

The Alliance for Self Care Research is pleased to anounce the 2010 International Conference on Support for Self Management of Health at the Stirling Management Centre, University of Stirling, Scotland for 3 days, May 11th - May 13th 2010.

The conference is run by the Alliance for Self Care Research in association with the National Primary Care Research and Development Centre at the University of Manchester and the Long Term Conditions Alliance Scotland.

Self management of health is a top priority in every health system. It includes support for staying healthy, support for managing everyday symptoms and support for managing the impact of long term illnesses and disabilities on people lives. It involves people themselves, voluntary sector and consumer organisations, professionals working in health and social care and government policy makers.

The international conference will provide a forum for researchers, health experts and policy makers to meet and to discuss their work and its implications. Three international speakers have already agreed to participate: They are:

- Professor Richard Osborne, University of Melbourne, on health literacy and self-management and on measuring outcomes for improving self-management programmes.

- Professor Tanya Packer, University of Western Australia, on research to help the voluntary sector support self-management;

- Dr Sue Mills, University of British Columbia, on a new framework for supporting self-management developed with international participation (including from Scotland).

The programme is designed for all those involved in support for self-management around the world who want to discuss their work and learn from one another.

The programme includes an exciting mix of workshops, keynote speakers, panel discussions, symposia and poster sessions. Conference themes include:

- Reaching marginalised groups with support for self-management;
- Support for self-management in the voluntary sector;
- Consulting skills for supporting self-management;
- Values in developing and evaluating support for self-management;
- Innovative research methods for support for self-management;
- Using personal experience for support for self-management.

24th Annual Conference of
The European Health Psychology Society

1st- 4th September 2010, Cluj-Napoca, Romania

Universitatea BABEŞ-BOLYAI

Romanian Association of Health Psychology

Dear Colleagues,

The European Health Psychology Society invites you to participate in the 24th Annual Conference to be held in Cluj-Napoca, Romania, 1-4 September 2010. The conference provides the opportunity to present research findings and to share working experience with colleagues from countries all around the world, to strengthen current networks and build new ones. Your participation and scientific contribution can broaden and deepen our understanding of global health in light of the conference theme, *Health in Context*.

Cluj, the treasure city of Transylvania, which from the Middle Ages onward has been a multicultural city characterized by diversity and intellectual effervescence, offers the perfect setting for the 2010 Annual Conference of the European Health Psychology Society.

We look forward to seeing you in Cluj,
Adriana Baban
Conference President

Scientific Programme

The 24th Conference of The European Health Psychology features a variety of formats including: Keynote lectures, Symposia, Oral and Poster sessions; Round-tables/Panel discussion; Pre-conference workshops; Synergy and Create workshops.

Keynote Speakers

Prof. Michelle Fine (City University of New York, New York, USA)
Prof. Michael Murray (Keele University, Keele, UK)
Prof. Mircea Miclea (Babes-Bolyai University, Cluj-Napoca, Romania)
Prof. Suzanne Segerstrom (University of Kentucky, Lexington, USA)

Important Dates

February 15th 2010 – Deadline for abstract submissions
April 15th 2010 – Abstract acceptance notification
May 15th 2010 – Deadline for early registration and hotel accommodation
June 15th 2010 – Deadline for Synergy and Create application/registration

Website: http://www.ehps-cluj2010.psychology.ro/
Email: contact_ehps@psychology.ro

Local organizers

Babes-Bolyai University, Cluj-Napoca & Romanian Association of Health Psychology

conference announcements

conference title	date	location
11th International Congress of Behavioral Medicine	4 – 7 August 2010	Washington DC, USA
31st World Conference on Stress & Anxiety Research: STAR 2010	4-6 August 2010	Galway, Republic of Ireland.
British Psychological Society Division of Health Psychology	9 – 11 September 2009	Belfast, Northern Ireland
24th Conference of the EHPS	1 – 4 September 2010	Cluj-Nacopa, Romania
9th International Conference on Grief and Bereavement in Contemporary Society and Association for Death Education and Counseling (ADEC) 33rd Annual Conference	21-25 June 2011	Miami, Florida, USA.