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**CONFERENCE
ISSUE**



Editorial

Dear Readers,

Many of you will be reading this conference issue of the European Health Psychologist (EHP) in Cluj-Napoca, Romania. This is testament to the fact that the EHPS has been flourishing well beyond an initially small number of countries in North Western Europe over the last 25 years. The EHP too has been steadily developing and expanding over the last several years. We are particularly pleased that the three contributions from the conference keynote speakers in this issue (Fine and Segerstrom, US and Murray, UK) reflect that the EHPS and the EHP continue their commitment to representing the diversity of work in Health Psychology, ranging from the socio-political determinants of health and health psychology research to the potential consequences of individual differences for health at the micro-biological level.



Gerry Molloy & Emely de Vet
Editors

Our editorial team have attracted a range of articles covering both science and practice issues over the past year. We have continued to have authors of the highest international standing write for the EHP. The quality of the authors that have agreed to write for the EHP indicates that those at the top of the profession recognise the role of publications like EHP in communicating key ideas in Health Psychology in a concise and refreshing way. We would suspect that more people read EHP articles in their entirety than most conventional academic journals and we feel that this fact is not lost on leading scientists and practitioners who continue to willingly write thought-provoking and compelling pieces for the EHP. We would ask all potential authors to keep this in mind for the coming year and to get those contributions submitted to the EHP!

We have recently appointed Natalie Mallach as the new editorial manager. Natalie has already made an excellent contribution to the EHP and in particular this conference issue. I (Gerry Molloy) will be standing down as Editor of the EHP after two years at the helm and I would like to thank all those members of the editorial team and all EHP authors over the last two years for their excellent work. Dr Nihal Mohamed from the US and Dr Richard DeVisser from the UK will also be ending their term as co-editors after this issue. Many thanks also go to Dr Jenny Fidler from the UK, Dr Lukasz Kaczmarek from Poland and Dr Elke van Hoof from Belgium who also served as co-editors at various times over the past two years. Rik Crutzen has agreed to take over as an editor in September. The Editorial Board plans to assemble a new editorial team in the coming months. CVs plus a covering letter explaining why you would like to join the team and why you would be suitable for the position should be sent to Rik Crutzen (Rik.Crutzen@GVO.unimaas.nl). Decisions will be made by the Editorial Board who will evaluate applicants on previous relevant experience, professional standing (i.e. well-known/respected in the field), the letter explaining why applicants would like to join the team, the strength of the applicant's link with EHPS (i.e. conference attendance, etc.) and organisational ability. All applicants must be members of the EHPS.

The new editorial team look forward to receiving and publishing new thought-provoking pieces in 2010-2011.

Gerry Molloy & Emely de Vet, Editors



EHPS president's message

Dear EHPS Members, colleagues and friends,

We are now approaching the 24th EHPS Conference to be held in Cluj, Romania, September 2010. I am happy to have this opportunity to welcome everyone to the conference and share with you the beautiful printed issue of the European Health Psychologist, always anticipated with interest by its readers.

As the term of the current Executive Committee is wrapping up, I would like to share with you a brief overview of the past two years. I will summarize some of the main principles that have shaped our work during the past two years, specifically developing new initiatives, international collaborations, and diversity.

Interesting ideas and suggestions for *new initiatives* have come from EHPS members, from the Executive Committee, and the Subdivisions, and I am happy to say that we have been able to implement many of them. For example, CREATE, represented by Jana Richert, proposed several new initiatives, including the establishment of two tandem grants, and two visiting scholar grants. The EC supported these ideas for annual awards and the first recipients of the grants were named last year. It has been a joy to work with the enthusiastic teams of CREATE, they have solidified and enriched the mission and vibrancy of this subdivision.

Members inquired about potential EHPS support for collaborative research activities, and after some time to consider how to structure this support, we developed the procedure and announced a call for Research Networking Grants. The deadline for the first application for such a grant is October 30th 2010, and we hope that you will take advantage of this opportunity to develop research networks and partnerships and start-up collaborative research initiatives.

The Fellowship Committee was elected several years ago, and last year they launched the first cycle of nominations and selection of new EHPS fellows. At the 2009 Members' Meeting in Pisa the first elected fellow was announced; we look forward to new fellows being introduced at this year's 2010 Members' Meeting in Cluj. A new call will be issued in the fall of 2010 and I encourage you to nominate and self-nominate new fellows and thus honour members' contributions to health psychology.

The rising complexity of decisions regarding venues and organization of conferences, led us to create a new position of Conference Officer within the EC. This position will help streamline the tasks surrounding conference organization and additionally ensure continuity of information and procedures. The expanding



Irina Todorova

President - European Health Psychology Society

contacts with members and colleagues motivated the EC to establish the position of Communications Officer in the EC. The communications area includes multiple activities, including corresponding with EHPS members, sustaining contact with the European Health Psychologist, maintaining the website and new Facebook page, offering useful resources to members –you will be seeing more of these in the next few months.

During these two years, the EHPS has expanded its *international collaborations and representation*. One example of this is the planned affiliation of EHPS with the United Nations, through which members will be able to contribute to improving health, reducing health disparities and affecting policy on a global level. It took all of the past two years for us to prepare our application materials, as this required collecting letters of recommendation, financial audit, documentation proving EHPS status, and illustrations of current EHPS collaborations with United Nations organizations. Thank you to members who sent us examples of their UN related work and helped with preparing documents; and in particular to Susan Michie, who as Past-President initiated the idea, Suzanne Skevington, Margreet Scharloo, Ad Kaptein and the entire EC! We have submitted the application and hope to have positive news to share with you soon and to ask you to nominate EHPS representatives to the UN.

We have sustained and expanded our connections with collegial professional organizations. For example, for the UN application we received support and recommendations from IAAP, APA, ISTSS and the Romanian Association of Health Psychology. EHPS supported the Southeastern European Regional Conference of Psychology (SEERCP) in Sofia, Bulgaria 2009, organized by the Bulgarian Psychological Society under the auspices of IAAP, IUPsyS, IACCP, EFPA and EHPS. We have renewed contacts with APA Division 38 and with their president-elect and are planning more





EHPS president's message

invited symposia at each other's conferences in 2011, and inviting publications in each other's newsletters. Britta Renner and I were invited to publish a paper about EHPS in *Psicologia Della Salute*, and I have prepared a piece about the EHPS for the APA publication Psychology International.

Another principle that has organized our work has been one of *diversity of representation* in EHPS committees, subdivisions, conference venues and publications. Ensuring diversity of international representation, whenever possible, has always been an important principle in the EHPS and has been an aim during these two years, though there is much more that can be done in this direction. For example, the network of EHPS member countries has expanded to 32 countries. The EHPS website is now re-designed and includes a webpage for each member country. CREATE has been mindful of this principle and has aimed to have international diversity in the Board, as well as in the workshops. Their activity in approaching many countries and using a variety of communication channels resulted in workshop applications from 23 different countries this year. Synergy has also used this principle in ensuring international diversity in the Synergy Board, as well as content diversity in the Synergy workshops for advanced researchers. It has been very gratifying to witness the development of Synergy during the years since its establishment, and to welcome the new Synergy Board with convenor Karen Morgan.

I am very happy that the EHPS has broadened its presence in Central and Eastern Europe and the awareness of the role of health psychology in these regions of Europe; now we are here in Cluj, Romania, we will be in Crete, Greece in 2011 for the 25th anniversary conference and in Prague, Czech Republic in 2012! The EHPS support of the SEERCP in Sofia, Bulgaria in 2009 also significantly contributed to this goal.

The EHPS publications also offer a forum for diverse topics and opinions. *The European Health Psychologist*, with Editors Gerard Molloy and Emely de Vet, has an explicit policy of printing unique pieces, new ideas and debates. The two EHPS journals also ensure academic excellence and scholarly diversity. During the term of Lucy Yardley and Rona Moss-Morris, *Psychology and Health* published on diverse health psychology topics, increased its impact factor during 2008, was indexed by Medline, increased to 10 issues per year, and recently Taylor & Francis proposed to start publishing monthly issues in 2011. The first Editorial board, including Joop van der Plicht as Editor and Denise de Ridder, Alexander Rothman and Brian Oldenburg as Associate Editors, successfully established

the new EHPS journal *Health Psychology Review*. The new Editor Martin Hagger and the Associate Editors Noel Brewer, Linda Cameron, Denise de Ridder, Antonia Lyons, and Falko Sniehotta, whom we welcomed in 2009, also represent diverse areas of health psychology and are continuing to build the journal's strengths.

We trust that we have also been able to represent diversity of members' opinions and have aimed to expand ways in which we can hear them – through different forms of member consultations, new technologies such as on-line surveys and voting and social networks, as well as through asking for your feedback through regular channels. We are always open to further suggestions on how to ensure this representation.

As the two-year term of this Executive Committee, as well as my term as President is coming to a close, I look back with much gratitude for the constructive and warm relationships within the EC. I express my sincere thanks to Vera Araujo-Soares, Yael Benyamini, Elvira Cicognani, Paul Norman, Britta Renner, Holger Schmid, and Manja Vollmann, who have worked actively in their specific areas, but have also been there to offer invaluable feedback and suggestions at every step. Thank you to the past presidents, who have also offered support and ideas. Congratulations to the newly elected Executive Committee and I wish you a constructive and exciting term!

The hosts of the 24th EHPS Conference have worked hard over the past two years to create a wonderful meeting place - we greatly appreciate your hospitality and are impatient to start the conference! We are grateful to Taylor & Francis for sponsoring this issue of the *European Health Psychologist* and their support of this EHPS publication during the past years. Thank you to all EHPS members for your involvement in EHPS initiatives, consultations, sub-divisions and committees - your contributions have been invaluable for the growth of the Society.

It has been a stimulating and fruitful time for me and I am content that many of the goals I had envisioned at the start of this term have been realized or propelled into soon becoming a reality. I am honoured to have been entrusted with the Presidency by the EHPS members for the past two years. I look forward to continuing to work with the new Executive Committee in a different role. I will always remember and treasure the friendships fostered during these years. ■

Irina Todorova
EHPS President
July 2010, Sofia



Keynote article

The Uneven Distribution of Social Suffering: Documenting the Social Health Consequences of Neo-liberal Social Policy on Marginalized Youth

Michelle Fine*¹, Brett G. Stoudt², Maddy Fox¹, Maybelline Santos³

¹the Graduate Center of the City University of New York, ²John Jay College of Criminal Justice, ³Polling for Justice Project

In 2009, British epidemiologists Richard Wilkinson and Kate Pickett published *"The Spirit Level: Why Greater Equality Makes Societies Strong"*, in which they argue that severely unequal societies produce high rates of 'social pain': adverse outcomes including school drop out, teen pregnancy, mental health problems, lack of social trust, high mortality rates, violence and crime, low social participation. Their volume challenges the belief that the extent of poverty in a community predicts negative outcomes. They assert instead that the size of the *inequality gap* defines the material and psychological contours of the chasm between the wealthiest and the most impoverished, enabling various forms of social suffering to saturate a community, appearing natural. In societies with large gaps, one finds rampant State and socially reproduced disregard, dehumanization, policy neglect and abuse. As you might guess, the income inequality gap of the US ranks the highest in their international comparisons. Furthermore, New York State ranks the highest among other states and a recent report published by the United Nations (UN-HABITAT, 2008) has found New York City to rank as one of the highest among other major cities in the country. Moving these notions into social psychology, we have been studying what we call *circuits of dispossession and privilege* (Fine & Ruglis, 2009) as they affect the uneven distribution of social health among privileged and marginalized youth in New York City.

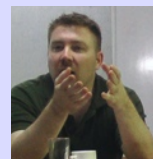
Theorizing Dispossession: The redistribution of resources, opportunities, dignity and suffering

Drawing from political theory, neuro-biology and critical justice studies, we are studying the distributive patterns, social psychological mechanisms and policy mediators by which neo-liberal social policies affect the psychological, social and physical health of youth. Political theorist David Harvey writes on neo-liberalism and dispossession: "Accumulation by dispossession is about dispossessing somebody of their assets or their rights...we're talking about the taking away of universal rights and the privatization of them so it (becomes) your particular responsibility rather than the responsibility of the State (Harvey, 2004, p. 2). In the US, public



Michelle Fine

Professor of Psychology - the Graduate Center of the City University of New York



Brett G. Stoudt

Assistant Professor of Psychology with joint appointment in the Gender Studies Program - John Jay College of Criminal Justice



Maddy Fox

Project Director - Polling for Justice



Maybelline Santos

Youth Researcher - Polling for Justice

resources, opportunities, dignity and therefore aspirations are being re-distributed by public policy. Youth of color, those living in poverty, and youth who are immigrants are increasingly denied access to or detached from public access to high quality education and health care as their families and housing are destabilized. (Fine and Ruglis, 2007)

While few psychologists have studied how social policies move under the skin of youth and what kinds of "resilience generating institutions" might mediate this relationship, epidemiologists and sociologists have forged the path. A special volume on *The Biology of Disadvantage*, published in the *Annals of the New York Academy of Sciences*, articulates a series of pathways by which social stressors, national policies and neighborhood effects move through the body to affect physical and mental health (e.g. see Roux & Mair, 2010, p. 125). While much is relevant to the work of the European Health Psychology Society, one article is particularly useful for this discussion.

In "Socioeconomic Gradients in Health in International and Historical Context" Dow and Rehkopf (2010) map international comparisons of health outcomes and an analysis designed to invite hypotheses ►

*Corresponding Author: Michelle Fine; email: mfine@gc.cuny.edu

Keynote article

Fine, Stoudt, Fox, and Santos (cont'd)

about why the US is such an outlier with respect to over-spending on public health, despite continued health disparities and lower life expectancy than neighboring and “equivalent” democracies. The U.S. over-spends and under-achieves in terms of life expectancy compared to our geographic neighbors (Canada and Mexico) and peer liberal democracies, including Australia, the United Kingdom and Japan. The US life expectancy is equivalent to that of Denmark, Portugal and South Korea which spend half the per capita GDP of the U.S., systematically challenging explanations that rest on genetics, climate, consumption patterns or even per capita spending. Dow and Rehkopf entertain, and then investigate, the extent to which national policy or investment predicts overall social health. Using both Costa Rica and the U.S. as case examples, they offer evidence on the rapid health gains of Costa Rica during the 60s and 70, a time of dramatic government investment in social programs. In comparing US and Canadian life expectancies, they demonstrate in parallel that state investment in individual and collective well being, a national priority in Canada, diminishes the discrepancies in national health. If, as Dow and Rehkopf suggest, national policies and structural conditions can *narrow* the social health gap and attenuate the impact of environmental stressors, it may be important to study how state investment and policies can support and sustain youth through *resilience generating public institutions*.

Documenting the impact of Resilience-Promoting Environments

In a classic chapter on resilience, health psychologists Stephen Lepore and Tracey Revenson explicate the conditions of resilience-promoting environments (2006), that is, environments that bolster the human capacity to respond effectively to cumulative environmental stressors. Reviewing the available evidence, Lepore and Revenson conclude that while early social environments affect basic functioning in the face of stressors, proximal social environments can affect young people's capacity to “bounce back” or recover from stressful events. Lepore has demonstrated that trust is a foundational predictor of people's ability to deal effectively with stress, enabling them to disclose problems, seek help, mobilize social support and access relevant resources – even in risky situations. Reviewing the neurological consequences of stress and the mechanisms that can facilitate resilience, McEwen (1998) offers a similar empirically-driven argument. He has demonstrated that allostatic load – the cumulative effect of multiple stressors on youth and adults – is highly correlated with predisposition for coronary heart disease, high blood pressure, diabetes, obesity and a set of re-

lated health conditions. Work in this area also suggests that social stressors do not necessarily move directly into biology *if* youth are supported within highly responsive contexts. (McEwen, 1998)

In a related argument, Robert Sapolsky (2005) shows that it is not solely the conditions of low SES that lead to negative health conditions, but that the subjective psychosocial experience of living in poverty increases risk for diseases such as depression, cardiovascular disease and diabetes. In other words, the chronic stress and psychological suffering that comes with feeling poor leads to poor health. This is particularly acute in societies where income inequality is most disparate, where those in poverty live in close proximity to the wealthy, and thus the poor are made to feel poorer. Sapolsky's work further suggests that social capital, in terms of high levels of trust and efficacy in communities, contributes to better health. Masten and Reed (2002) catalog resilience-promoting environments such as effective schools, cohesive neighborhoods, religious institutions and health care/social service organizations, which can nurture resilience in youth, adults and communities who have endured substantial stress and trauma and buffer the adverse consequences of these stressors. This evidence suggests that in environments of support, stability and trust, social stressors do not necessarily penetrate the body, and do not automatically yield adverse physiological outcomes.

It is interesting to consider these dynamics in New York City, an urban microcosm of these global dynamics of dispossession and privilege. In our research, Polling for Justice, we are interested in theorizing and documenting how the retreat of the State from social welfare, mobilized since the Reagan years, has swollen the allostatic load on poor and working class youth while disabling the very relationships and institutions that might provide support for youth in crisis. The combination, we believe, heightens the load, diminishes young people's self-protective behaviors and encourages, instead, engagement in what public health psychologists might call *risk behaviors*. Our large scale survey allows us to probe the conditions under which dispossession affects social health, for whom and to identify the possible moderators that buffer youth from the policy onslaught.

Polling for Justice: Participatory Action Research for Studying Dispossession, Risk and Resilience

In the remainder of this essay we sketch a research project undertaken by urban youth and adults to test theoretical notions about dispossession, risk, and resilience-generating institutions and to generate data for youth justice social movements. In the tradition ►



Keynote article

Fine, Stoudt, Fox, and Santos (cont'd)

of Kurt Lewin's (1946) action research and drawing on Mort Deutsch's (1975) justice studies, we seek to document a history of the present; the ways in which shifting policies get "under the skin" of youth, particularly low income youth/living in poverty/youth of color/immigrant youth, and the ways in which public policy can be drafted so that it might be otherwise.

Polling for Justice is a large scale, participatory action research project designed by a research collective of youth and adults, focused on youth experiences of (in)justice in education, criminal justice, and health. An interdisciplinary collaboration among faculty and students at the City University of New York, a committed group of youth co-researchers, Brown University's Annenberg Institute for School Reform, and the Urban Youth Collaborative, our primary methodological instrument has been a survey co-constructed by youth and adults. This paper presents an outline of preliminary findings drawn from a large scale qualitative and quantitative survey of the human insecurity gap among a sample of 1,100 NYC youth, documenting the social health consequences of dispossession and privilege.

Polling for Justice began with an intensive research camp for a "contact zone" (Torre, 2010) of young people, university faculty, graduate students, community organizers and public health professionals. At our first gathering, more than 40 youth arrived, recruited from activist organizations, public schools, detention centers, lesbian/gay/bisexual/queer youth groups, foster care, undocumented youth seeking college and elite students from private schools, joined by educators, representatives of the NYC department of adolescent health, immigrant family organizers, lawyers, youth workers, psychologists, Planned Parenthood researchers, geographers, psychology and education doctoral students, in the basement at the Graduate Center of the City University of New York. From this expansive group, a participatory research team of youth, adult researchers and public health professionals collectively designed a large scale, citywide survey of standardized and home grown items to document youth experiences across various public sectors of the city. Fol-

lowing their first days of intensive work, the survey went through countless revisions, with input from the broad group of youth researchers, graduate students, faculty and also from youth organizers, community members, public health professionals, and city officials. A year later we had gathered more than 1,100 surveys, completed on the streets, in youth organizations and on the internet.

Preliminary Results: Testing Theory/Generating Research for Human Rights Campaigns

Polling for justice (PFJ) was designed by a collaborative of university and community researchers toward three ends: (1) to test theoretical relationships between state-sponsored dispossession and youth health, (2) to explore how youth organizing/social programs/schools/relationships can moderate the impact on dispossession on youth health, and (3) to generate research that can be mobilized for varied human rights campaigns. We present below some preliminary findings related to our key research questions.

1. Documenting the Landscape of Dispossession and Privilege on Youth Bodies:

We first wanted to document how circuits of dispossession and privilege heighten what neuro-psychologists call the allostatic load embodied by marginalized youth. To evaluate the accumulating circuits of dispossession, we developed an index ranging from 0 to 4 measuring levels of cross-sector dispossession from varied policy sectors, including low access to quality education, low access to health care, family/housing (in)stability and negative contact with police¹. Figure 1 provides the descriptive statistics for the Dispossession Index. While the most dispossessed youth (Groups 3 & 4) represented less than a third of the total sample (31%) they account for nearly two thirds (64%) of all the dispossessing incidents we measured.

¹ The Dispossession Index was derived by identifying four sectors heavily influenced by neo-liberal policy (education, police & prison, parents & home life, healthcare) and a series of questions representing potential consequences that youth may experience within these policy sectors. There were five survey questions addressing "education" (e.g. "Have you ever dropped out or been pushed out of school?"), five addressing "police & prison" (e.g. Have you ever been to jail or prison?), four addressing "parents & home life" (e.g. Have you ever been homeless?), and three addressing healthcare (e.g. "Do you pay for healthcare with methods other than family health insurance?"). Within each sector, youth were given a "1" if they experienced one or more of the potential consequences while youth who experienced none received a "0". The policy sectors were summed giving each youth who took the survey a dispossession score ranging from 0 to 4. A score of zero means that they experienced no negative consequences throughout the policy sectors. A score of four means they experienced at least one negative consequence in each of the four policy sectors. Therefore, increasing scores from 0 to 4 represents accumulating dispossession.

Keynote article

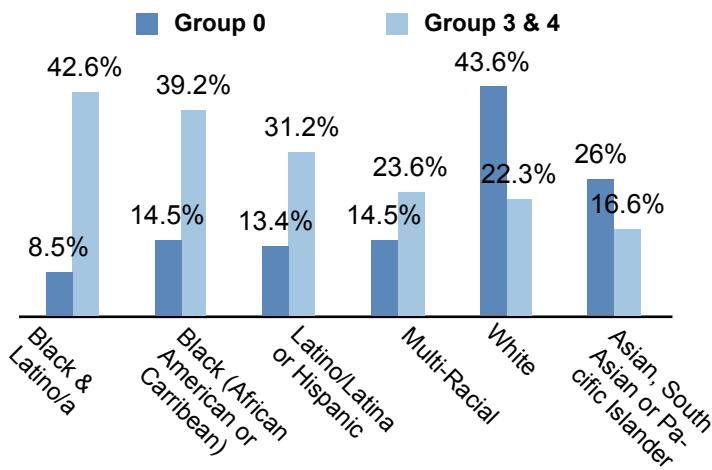
Fine, Stoudt, Fox, and Santos (cont'd)

Figure 1: Dispossession Index Descriptive Statistics

Dispossession Index	N	M	SD	Min	Max	Sum	% Total N	% Total Sum
Group 0	200	0.0	0.0	0	0	0	18.2%	0.0%
Group 1	286	1.2	0.5	1	4	341	26.0%	11.2%
Group 2	275	2.7	1.0	2	7	751	25.0%	24.7%
Group 3	233	4.8	1.6	3	10	1108	21.2%	36.5%
Group 4	107	7.8	2.7	4	15	838	9.7%	27.6%
Total	1101	2.8	2.6	0	15	3038	100.0%	100.0%

The landscape of dispossession stretches out unevenly across neighborhood and demographic groups. Highly dispossessed youth (Groups 3 & 4) are more likely to live in high poverty NYC community districts. A greater proportion of Youth of Color were highly dispossessed as compared to White and Asian youth. A similar disproportionate relationship was found for sexual identity. Youth who identified as Lesbian, Gay, Bisexual or Questioning (LGBQ) were more likely to experience greater dispossession than youth who identified as straight. Boys were also more likely to experience greater accumulation of dispossession than girls.

Figure 2: Circuits of Dispossession by Race/Ethnicity



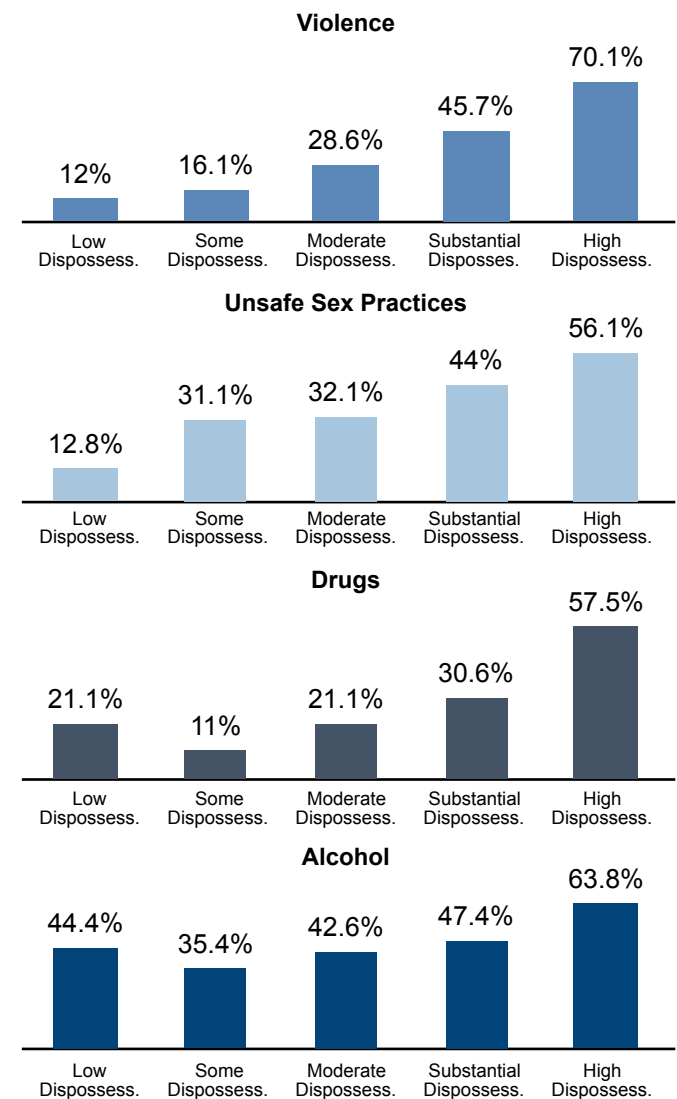
2. Theorizing the Social Psychological Impact of Dispossession for Health Risks:

Our next line of analysis was to document the extent to which cumulative cross-sector dispossession places youth in social psychological fields of vulnerability by which they seem, in the aggregate, to engage in fewer self-protective behaviors, or put differently, place themselves in harm's way/at risk. Operationally, we were interested in measuring the extent to which cumulative, cross sector dispossession is associated with youth in-

volvement with violence (e.g. carried a weapon in the last 30 days; injured someone in a fight in the last 30 days), unsafe sex practices (e.g. had intercourse without a condom; had an abortion), and use of drugs/alcohol (e.g. used illegal drugs in the last 30 days; had a drink of beer, wine or other alcohol in the last 30 days).

Figure 3 displays the linear relationships between circuits of dispossession and risk taking behaviors. Increasing levels of cumulative dispossession are associated with a greater probability of partaking in violence, unsafe sex practices, and using drugs/alcohol. In fact, youth in Group 4 were nearly six times more likely to engage with violence, more than four times more likely to engage in unsafe sex practices, and almost three times more likely to use illegal drugs than youth in Group 0.

Figure 3: Circuits of Dispossession by Risk Taking Behaviors





Keynote article

Fine, Stoudt, Fox, and Santos (cont'd)

The accumulation of dispossession is associated with a set of cumulative consequences for the NYC youth in our sample. However, it is also clear that this relationship is not perfectly predictive. While 70% of the youth with the most cumulative dispossession (Group 4) report engaging in violence, 30% did not; 44% did not engage in unsafe sex practices, 43% did not use drugs, and 36% did not drink alcohol. It is important to identify the conditions under which dispossession does not simply flow into risk behaviors.

3. Demonstrating the Policy and Institutional Moderators of Dispossession and Health Risk:

Interested in the conditions that moderate the effect of dispossession on youth health, we are beginning to explore the extent to which “resilience generating” environments can moderate the impact of dispossession on risk-taking behaviors and levels of depression.

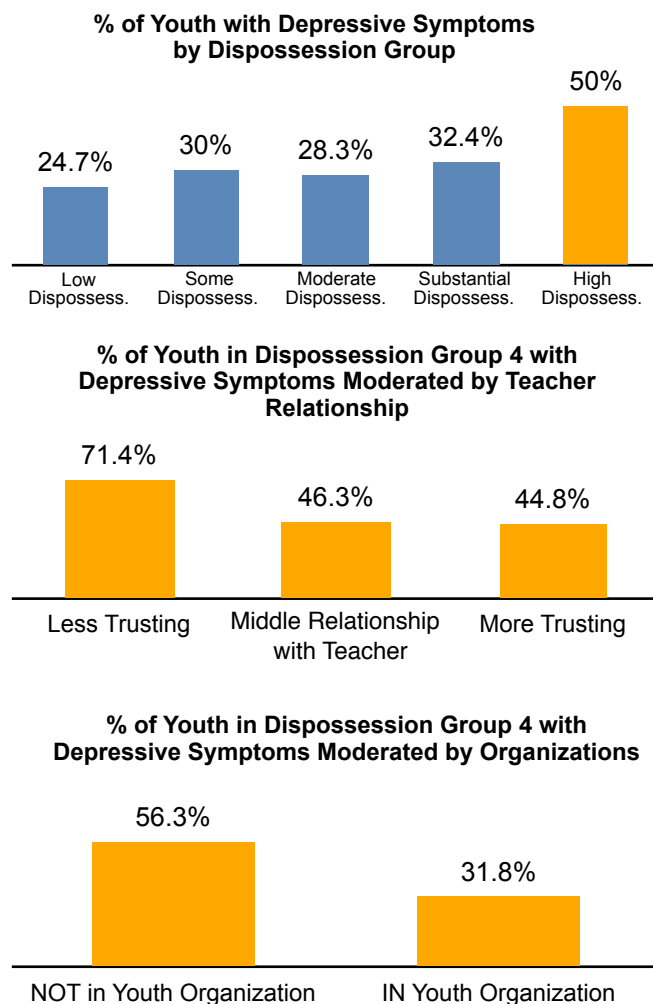
We used a modified version of the Center for Epidemiologic Studies Short Depression Scale (CES-D) where a score of 11 or greater indicates clinically meaningful depression (Radloff, 1977). Figure 4 displays the linear relationship between accumulating dispossession and severe depressive symptoms (e.g. score 11 or greater). Youth in the most dispossessed group (Group 4) were twice as likely to report clinical depression as compared to youth in the least dispossessed group (Group 0). However, 50% of the youth in Group 4 reported scores that suggested they were not clinically depressed. We wondered what conditions might buffer these youth from the adverse, emotional effects of structural dispossession.

To date, we have tested two moderators: involvement in youth organizing/organizations and high trust in educators. As we see in Figure 4, 71% of the most dispossessed youth who report low trust in teachers report clinically meaningful depressive symptoms; in contrast, 45% of the most dispossessed youth who report strong trust in teachers report clinical levels of depressive symptom.

Similarly, 56% of these youth who do not participate in youth organizations reported severe depressive symptoms compared to 32% of those youth in Group 4 who do participate in youth organizations.

While all of these data are gathered at a single point in time, it appears to be the case that engagement with youth organizing/organizations or trusting relations with educators can moderate the effects of serious dispossession on youth depressive symptoms. Put differently, the absence of these engaging relationships may exacerbate depressive symptoms.

Figure 4: Circuits of Dispossession by Depressive Symptoms and Moderators



Conclusion

In this short essay, we have tried to situate adolescent health in an interdisciplinary theoretical frame of circuits of dispossession and privilege, incorporating a dual recognition of the stressful impact of neo-liberal global and national policies on youth health and the potential buffering impact of deeply relational and respectful youth organizing and public institutions for youth.

Our story is both distressing and hopeful. Youth are indeed on the front lines of a globally shrinking public sphere, increasingly vulnerable to neo-liberal policy changes, denied opportunities for development and subject to varied technologies of criminalization and surveillance. And yet just as powerfully, our moderation analyses suggest that young people, despite the weight of political stress, carry both the desire and the capacity for resilience given sweet moments of social and institutional support. ■



Keynote article

Fine, Stoudt, Fox, and Santos (cont'd)

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Keynote article

Optimistic Expectancies and Immunity: Context Matters

Suzanne C. Segerstrom*

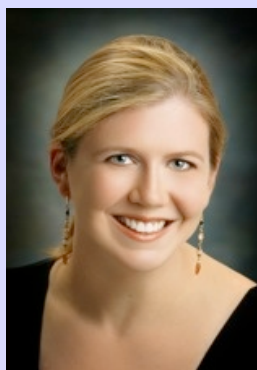
Department of Psychology, University of Kentucky, Lexington, KY, USA

Dispositional optimism – the belief that the future holds positive rather than negative events and outcomes – accompanies a number of adaptive psychological qualities. People who are more rather than less optimistic have less psychological distress, even when things don't go their way (see Carver, Scheier, & Segerstrom, in press, for a review). They cope with stressors more actively and more adaptively, using problem-focused strategies when those are likely to be effective (i.e., in controllable situations such as academic challenge) and emotion-focused strategies when those are likely to be effective (i.e., in uncontrollable situations such as trauma) (Solberg Nes & Segerstrom, 2006). In prospective studies, people who were more optimistic had more academic and professional success as measured by GPA and income (Segerstrom, 2007b; Solberg Nes, Evans, & Segerstrom, 2009). People who are more optimistic also have more successful social relationships (e.g., Srivastava, McGonigal, Richards, Butler, & Gross, 2006).

In light of these broad-ranging psychosocial successes, it seems that people who are more optimistic might also have better physical health. A large literature on the relationship between personality and health risk links adaptive psychosocial qualities to lesser morbidity and mortality, with effect sizes that rival biomedical interventions (Roberts, Kuncle, Shiner, Caspi, & Goldberg, 2007). In a recent meta-analysis, dispositional optimism also associated with lesser morbidity and mortality, including that from causes related to the functioning of the immune system such as HIV and cancer (Rasmussen, Scheier, & Greenhouse, 2009). However, these long-term, summary effects disguise a relationship between optimism and immune function, particularly cellular immune function, which actually varies significantly based on context. For the past 10 years, my research has illuminated this variability and the situations and people for whom optimism associates with stronger cellular immunity and those for whom the relationship may not be as strong – or even reversed.

Dispositional optimism

In my first study of optimism and immunity, I related dispositional optimism to changes in immune parameters over 8 weeks in first-year law students, a



Suzanne Segerstrom

Professor of Psychology, University of Kentucky,
Lexington, KY, USA

highly stressed population. In this study, there was not much evidence that dispositional optimism was related to immune parameters (cell numbers and natural killer cell cytotoxicity) at all. There was a small-to-medium positive relationship between dispositional optimism and number of CD8+ cytotoxic T cells, but no relationship between optimism and CD4+ helper T cells, CD19+ B cells, CD16/56+ natural killer cells, or cytotoxicity (Segerstrom, Taylor, Kemeny, & Fahey, 1998). (The results were more promising for situational optimism, discussed below.) As I prepared to pursue this line of inquiry, therefore, I had to consider whether there might be moderators of the relationship between dispositional optimism and immune parameters. Optimism is, of course, not the only potential buffer against stress; for example, social integration and social support are thought to be robust buffers. I therefore proceeded to use a proxy for social integration or disruption (staying home or relocating to attend law school) as a moderator. I expected that optimism would be most strongly related to immune parameters when the alternate buffer, social integration, was absent. This was in fact the case: dispositional optimism was positively related to immune parameters for students who moved away from home to go to law school, and this was true both in the initial sample and in a new sample (Segerstrom, 2001). It was unexpected, however, to find that students who ►

*Corresponding Author: Suzanne C. Segerstrom; email: ssegers@uky.edu

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did not move away from home yielded a negative relationship between optimism and number of helper T cells and, in the second sample, an *in vivo* measure of cellular immunity. In both samples, optimism correlated positively with immune cell numbers and function in students who moved away from home, but negatively with parameters in students who did not move away from home. Students who had a double buffer, high optimism and social integration, had lower cellular immune function than those who were integrated but not optimistic.

This was not the first study to report an interaction between dispositional optimism and situational factors in predicting immune parameters. In a sample of community women, optimism was associated with higher numbers of T cells when women experienced brief (< 1 week) stressors but with lower numbers of T cells when stressors were prolonged (> 1 week) (Cohen, Kearney, Zegans, Kemeny, Neuhaus, & Stites, 1999). In a laboratory study, optimism was associated with higher cytotoxicity when participants felt control over a loud noise stressor, but lower cytotoxicity when participants felt no control (Sieber et al., 1992). In both of these studies, the inverse relationships between optimism and immune parameters were attributed to expectancy violation. Stressor persistence and uncontrollability violated optimists' belief in a positive future, distressing them and perturbing their immune systems.

Empirically, however, this attribution did not hold up when I tested mechanisms by using cognate traits and affective pathways. First, I replicated the interaction between expectancies and stress in a laboratory study (Segerstrom, Castaneda, & Spencer, 2003). The relationship between optimism about academic qualifications and *in vivo* immunity was moderated by task type: When participants rested, optimism correlated with more robust immune responses, but when they performed an arithmetic task that was both difficult and impossible to master, optimism correlated with less robust immune responses. The study also tested whether this interaction would occur when optimism was replaced in the model with one of two related personality characteristics: neuroticism (predisposition to negative thoughts and feelings) or conscientiousness (predisposition to being hard-working and goal-oriented). Conscientiousness duplicated the optimism effect, but neuroticism did not. Therefore, these findings indicated that the aspect of optimism that has to do with positive thoughts and feelings (i.e., the inverse of neuroticism) was not responsible – the aspect that has to do with persistence and engagement (i.e., conscientiousness) was.

Second, in another naturalistic study with law students, optimism and relocation once again interacted, but affective states did not mediate the relationship (Segerstrom, 2006), further calling into question that idea that expectancy violation and disappointment were acting on optimists' immune systems.

These findings led me to a different interpretation of mechanisms occurring with first-year law students who did not relocate to attend law school: These students were experiencing conflict between their academic and personal lives. More optimistic students were attempting to engage and overcome this conflict, whereas their less optimistic counterparts were disengaging from goals (Segerstrom & Solberg Nes, 2006). Differences in responses to the *in vivo* immune test potentially reflected a cost of pursuing an optimistic but energetically demanding strategy (Segerstrom, 2007a; *in press*).

Situational optimism

It is interesting to note that dispositional optimism, the broad, characterological measure of outcome expectancy, seems to relate to the immune system differently than does situational optimism, the narrower measure of expectancy about a specific situation. Again using first-year law students, I have examined the effects of beliefs about one's own abilities and future outcomes specifically with regard to law school.

Situational optimism has stronger main effects on immunity, particularly measures of cellular immunity, than does dispositional optimism. In my first sample of law students, positive expectancies about law school correlated with higher numbers of helper T cells as well as higher cytotoxicity at mid-semester, controlling for baseline immune parameters (Segerstrom et al., 1998). This relationship was recently replicated in a within-person design, where changes in law school optimism covaried with changes in *in vivo* cellular immunity over the first 6 months of law school (Segerstrom & Sephton, 2010). Situational optimism also has different mediators. Although dispositional optimism's relationship to immune function is not mediated by affect, there was evidence that about half the relationship between situational optimism and immune function could be accounted for by affect, particularly positive affect.

One important characteristic of the within-person covariation between law school optimism and immunity was that this relationship had a significant random effect, that is, there was variability between ►



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people in the strength of this relationship. This variability was not related to dispositional optimism (i.e., law school optimism was not more or less strongly related to immunity based on levels of dispositional optimism), minority status, standardized test scores, or undergraduate academic performance. The only variable that approached significance was gender, with men having a stronger relationship between law school optimism and immune function than women did.

This was interesting in light of other findings in this sample with regard to gender that suggest that optimistic attitudes and behaviors might associated with better cellular immune function for men than women. Law school is a traditionally male environment, and although women are now equally represented in most US law schools, they still face both explicit and implicit sexism. The difficulty inherent in confronting and attempting to overcome sexism (an uncontrollable quality of the environment) might make active coping strategies less effective. As might be expected in this kind of environment, male law students had stronger immune responses than women, a gender difference that was not found in a control group. Furthermore, this difference was largely driven by the frequency and immune correlates of active coping. Men were more likely to report that they coped with law school stress by persisting or trying harder, and those men who reported coping strategy had more robust in vivo immune responses than those who did not. Women were less likely to report this coping strategy. Furthermore, those women who did report this coping strategy had less robust in vivo immune response than those who did not (Flynn, Schipper, Roach, & Seegerstrom, 2009).

Conclusion

The effects of optimism – and potentially optimistic modes of coping such as persistence and re-engagement – on the immune system appear to be exquisitely sensitive to the demands as well as the obstacles inherent in the situation. This sensitivity may indicate both benefits and costs and even a tradeoff between psychosocial and physiological benefits and costs. Limited resources may dictate that a person who chooses to exert the effort it takes to make progress on diverse goals cannot run all systems at full throttle, and the immune system may be a place from which resources can be diverted. Depending on the person's own psychological and physiological strengths and vulnerabilities, this "decision" may have positive or negative consequences for health. ■

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Keynote article

Health psychology in context

Michael Murray*

School of Psychology, Keele University, Keele, Staffordshire ST5 5BG, UK

Health psychology often traces its origins to developments in the 1970s with the establishment of the Division of Health Psychology within the American Psychological Association and the subsequent development of other national and international associations. This was followed by the publication of journals and textbooks and the delineation of what was meant by health psychology. Since then certain standard practices have evolved within the discipline which define what is acceptable and what is deviant. The purpose of this paper is to reflect on the forms of health psychology and the context within which these forms have become established.

The 1960s and 1970s was a period of great excitement and change in society internationally. The former colonies were asserting their independence and we had the rise of various social movements for change throughout the world. Psychology was not immune from these social movements and there was considerable debate within the discipline about its character and purpose. We had the growth of a range of critical debates within psychology as regards its methods and theories.

At the same time we had the growth of new sub-disciplines within psychology with different applied foci – the most important of which was health psychology. Thus health psychology was established at a time of sustained debate about the nature of the whole discipline of psychology. However, rather than engage in this debate health psychology moved rapidly to establish certain orthodoxies as regards theories and methods. In particular it adopted a limited range of theories (Health Belief Model, Theory of Reasoned Action, etc.) and methods (almost entirely questionnaire). If we look back through the pages of the main journals we will see that this was the case. This narrowing of vision is not unusual in the development of any discipline. There is a desire and an enthusiasm to assert the place of the new discipline in the range of other disciplines. In the case of health psychology this was particularly problematic at that time when other disciplines (e.g. sociology, anthropology) were vying for a place at the big health table traditionally dominated by medicine.

With so much disciplinary demarcation occurring there was little time for critical debate about the nature of health psychology. However, as the discipline



Michael Murray

Professor of Applied Social and Health Psychology

has grown so has the space for reflection. Over the past decade this debate is evidenced with the convening of specialist meetings and the publication of special journal issues and textbooks which attempt to develop a more critical approach to the discipline. Unlike much of mainstream psychology this critical approach is not unified but rather promotes a range of methods and theories. Underlying this critique, however, there is a broader concern with values – what is health psychology for and who does it serve.

Recently Michael Burawoy (2005) has developed an assessment of the character of much of contemporary sociology. He starts his analysis with a rather elegant model in which he distinguishes between the audience of our research and the character of our research or knowledge. As regards the audience he distinguishes between academics and non-academics and in terms of knowledge he distinguishes between instrumental and reflexive knowledge. Admittedly these two types of audience and of knowledge should not be considered distinct and it is also important to consider how one informs the other. Despite this caution it still provides a useful framework for considering the different forms of health psychology.

The traditional form of health psychology where it engages with an academic audience is premised upon instrumental knowledge which is especially concerned with the accumulation of facts and ►

*Corresponding Author: Michael Murray; email: m.murray@psy.keele.ac.uk



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answering clearly defined hypotheses. It frequently uses various quantitative methods to confirm the applicability of certain theories to explain certain health questions. The emphasis remains upon objectivity and distance. This so-called scientific approach can adopt all the trappings of natural science to assert its objectivity. It is particularly concerned with measurement of variables but more recently with describing the character of human experience. While the dominant method still relies upon the use of various standardised measures there has been the growing adoption of a range of qualitative approaches although the emphasis has been on ensuring that these new approaches are carefully proscribed and if possible follow the traditional rules of scientific inquiry. A particular focus has been on the character of the individual whether in terms of individual attitudes and beliefs or of human experience which are often described in terms of deficits. This focus on the individual has tended to separate health psychology from discussion about the importance of the social and political context and to promote a concern with individual change.

The engagement of the discipline with a non-academic audience is the concern of what has been termed applied health psychology. On the one hand there are clinical health psychologists who are concerned with using a variety of methods to enhance the quality of life of people with a range of health problems. On the other hand are those public health psychologists who insert various psychological theories into the broader public health practice. The focus of both is on developing individual change strategies to compensate for certain deficits and to rather ignore issues around the organisation of society and of healthcare. The aim is to apply the findings from scientific investigations conducted by the researcher. Thus rather than developing theory the practitioner is more concerned with refining practices. This form of health psychology follows the guidelines of the scientist – practitioner model defined by clinical psychology. It also presupposes access to specialist knowledge and skills which not only separate the health psychologist from the lay audience but more clearly aligns her/him with other health professionals. This distinction is accentuated by the adoption of various trappings of more established professional groups.

These scientific and scientist-practitioner approaches are the dominant approaches which have led to health psychology establishing itself as influential in a range of healthcare arenas. This preference for a narrow range of standardised approaches which do not challenge the ideas of the dominant discipline (in this case medicine) is not unusual in the early stages of any

discipline. It is a means by which a new discipline asserts its identity as distinct and as offering a particular contribution to both knowledge and practice. Part of this process of defining a discipline involves drawing up syllabi and establishing accreditation guidelines such that we can define who is qualified in health psychology. It also means policing the boundaries such that unacceptable theories, methods and practices are sidelined.

Admittedly, within any discipline there are always dissident voices which question the appropriateness of certain theories and methods. This brings us to the second form of knowledge identified by Burawoy – reflexive knowledge. As any discipline/profession grows in size it begins to reflect upon itself and its relationship with the broader society. Within health psychology these critical voices have become more sustained over the past decade and have begun to permeate the broader academic debate in terms particularly of methods. Thus whereas 15 years ago it was difficult to attract contributions to a textbook on qualitative health psychology, today most journals of health psychology contain articles using qualitative methods. Even the APA flagship journal *Health Psychology* has now published qualitative articles.

Admittedly, this does not mean that critical health psychology is just concerned with qualitative methods. Rather the debate goes beyond research methods to consider the processes of knowledge creation and values underlying the research. In its early days a critical approach is often fuelled by anger and frustration rather than a clearly detailed critique of the orthodoxy. But as it grows it becomes more theoretically informed and can more ably engage in the process of critique. A common aim of critical health psychology has been to reorient the discipline away from a focus on measuring individual characteristics to a concern with more dynamic social psychological, socio-political and socio-cultural processes. It has introduced ideas from discursive psychology on the one hand and other social science disciplines on the other. It has argued that health psychology exists in a certain socio-historical context which raises questions about how research questions are defined and how they are investigated. Of particular interest is the role of power in shaping health and illness and how power permeates our everyday relationships within various healthcare and social arenas. The increasing awareness of these ideas throughout the discipline illustrates how critical ideas can grow in influence as they chime with changing socio-historical circumstances.

A deliberate awareness of a discipline's role in these changing circumstances is the focus of the ►



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second dimension of reflexive knowledge which is concerned with the character of any discipline's engagement with the public. In the case of sociology, Burawoy articulates the need for a public sociology – one that is involved in an active form of social engagement with the public and not just with the established elites. In the case of health psychology this requires a more active form of public engagement rather than the more common traditional disinterested approach.

Here we can learn some lessons from community psychology which for the past 40 years has been concerned with various forms of emancipatory action with those groups with limited power in society. Admittedly, within community psychology there has been a tendency for some researchers to dispense with discussion about values and to assert a more technical approach. However, more recently there has been increasing challenge to this move towards supposed objectivity and a reassertion of a value informed social critique.

An example of this approach is the attempt to develop a community health psychology. This approach is quite explicit in its values orientation being concerned with social justice, concern for minorities and the excluded, and with challenging various forms of social oppression. There are of course risks involved in promoting this more activist form of health psychology. On the one hand it can be co-opted by mainstream agencies and as such lose its critical edge. Conversely it can become divorced from theoretical and methodological debate and become more self-serving. This tension is longstanding within the larger scholar-activist tradition which articulates the need for self-reflexivity such that the activist researcher brings together ideas from critical theory with involvement in broader movements for social change in an ongoing process of dialogue.

This form of collaborative activist health psychology is underpinned by the principles of participatory action research. It aims to work with collectives to reflect upon their circumstances and to consider strategies of change. Thus rather than imposing a change agenda from the outside the health psychologist as social activist works with the collective to understand their needs and to explore opportunities for change. Here the health psychologist brings together social psychological ideas on the nature of society and of social change together with a commitment to the values of human emancipation.

These different approaches within health psychology have changed over the history of the discipline and reflect the importance of the wider socio-political context within which any discipline works. Back in the 1970s when health psychology was developing there

was sustained debate about giving people responsibility for their own health. In the UK there were classic reports about social inequalities in health which identified the importance of structural factors. However, changing the structure of society was not something acceptable to dominant interests who preferred to focus on changing individual behaviour - if people did not change then it was not the government's responsibility.

Forty years later as we enter a much more extensive world economic crisis these debates are coming to the fore again only this time the response of health psychology can be more sophisticated. Within a world of widening social inequalities, war, mass migration, and religious fundamentalism it is increasingly difficult for health psychology to maintain a disinterested stance. At times like this it is increasingly important for any discipline to both engage in critical reflection about our theories, methods and values but also to engage in the broader public debate about the nature of our work.

The use of Burawoy's classification scheme is a means to consider how different forms of health psychology have developed and evolved. This scheme should not be considered exclusive but one within which there is movement as old ideas and methods wane and new ideas are accepted. As such critical health psychology plays an essential role in fostering this debate as does the idea of a more public health psychology. Both can challenge established orthodoxies in the academic and non-academic domains and reassert the importance of emancipatory values underpinning both our research and practice. ■

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Health Psychology in Member Countries

Health Psychology at the University of Stirling, Scotland

Gerry Molloy*, Rory O'Connor, Ronan O'Carroll, Vivien Swanson

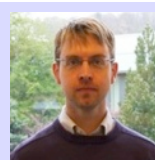
Health Behaviour Research Centre, Department of Psychology, Cottrell Building, University of Stirling, FK9 4LA, Scotland.

University of Stirling - the place

There are few academic settings more tranquil and picturesque than the University of Stirling in the heart of central Scotland. Overlooking Airthrey Loch and surrounded by lush woodland, the former Airthrey estate provides an environment for research, teaching and living that is the envy of many. The expression 'outstanding beauty' is often applied to the Stirling campus and anyone who has visited will know that this is certainly not the inevitably effusive hyperbole of the University press office. It is simply a statement of fact.

Although Stirling is relatively small when compared to Universities in the major UK urban centres, the modest size of the University affords a number of important benefits. These include more personal working relationships with other research, teaching and administrative staff and easier access and a greater opportunity to engage with all levels of governance in the University. The benefits of making more meaningful connections with all those in the working environment can offset the challenges that are presented by competing against the larger research powerhouses for research funding and attracting the best students. The University has received a number of accolades over the last year, which indicates that it is not just the physical beauty of the place that is noteworthy. The Sunday Times awarded the University the Scottish University of the Year in 2010¹. This award was based on the University's performance on a range of indices, but particularly student focused outcomes. The Department of Psychology at Stirling's recent rating as 8th out of 101 departments in the UK² in the 2011 Guardian University Rankings suggests that smaller institutes like Stirling are capable of punching well above their weight when competing against larger institutes on performance indicators.

Finally an intriguing observation from data derived from the Scottish Neighbourhood Statistics³ shows that the University postcode has the lowest percentage of the population receiving mental health treatments in Scotland. While it remains unclear what exactly is driving this finding, although it is likely to be partly socio-demographic, the University is happy to accept that the exceptional environment and experience that the University provides may account for part of the unusually good mental health profile for the couple of thousand living in FK9 4LA.



Gerry Molloy

Lecturer in Psychology



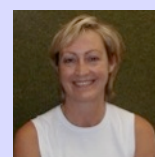
Rory O'Connor

Professor of Psychology



Ronan O'Carroll

Professor of Psychology



Vivien Swanson

Senior Lecturer in Psychology

Health Psychology in Scotland

Scotland has a very strong tradition in Health Psychology with leading figures in the European Health Psychology Society being based at various Scottish universities over the last 25 years including Professors Derek and Marie Johnston (University of St Andrews and University of Aberdeen), Professor Charles Abraham (University of Dundee), Professor Paschal Sheeran (University of Dundee), Professor Sheina Orbell (University of Dundee and St Andrews) and our very own Professors Ronan O'Carroll and Rory O'Connor. The group in Stirling builds on this tradition and is now taking a leading role in shaping Health Psychology in Scotland and throughout the UK and Europe. The Health Psychology group at Stirling has strong research links both within the University and with academic and clinical colleagues in the main research centres in Aberdeen, Dundee, Edinburgh and Glasgow. There are many challenges to the health of the population in Scotland, and health psychologists at Stirling have developed important collaborative working links with the National Health Service via their research, and also through involvement in a unique government-funded pilot to train stage 2 health psychologists working in health im- ►

*Corresponding Author: Gerry Molloy; email: g.j.molloy@stir.ac.uk

Health Psychology in Member Countries

Molloy, O'Connor, O'Carroll, and Swanson (cont'd)

provement in public health settings.

Health Psychology in Stirling - Research Profiles

The Health Psychology group at Stirling is now the largest core funded Health Psychology research group in Scotland with two full time Professors, a senior lecturer and a lecturer. There are over 20 affiliated staff in the recently established Centre for Health and Behaviour Change, including post-doctoral researchers, research assistants and PhD students and project funding comes from a range of sources including the Chief Scientist's Office in Scotland, Medical Research Council, NHS, British Academy, European Commission, Scottish Government and the Economic and Social Research Council. The department has a leading BPS accredited MSc in Health Psychology. The MSc course includes a short placement in a health care or organisational setting to carry out an evaluation of service provision. This gives students first hand invaluable experience of how health services work in practice and gives a clear advantage in securing employment following graduation. This has been running for several years and there are also a wide range of modules offered to undergraduates on topics related to Health Psychology. We also have a dedicated Health Psychology laboratory in the Department. This is a well equipped facility with a range of features dedicated to laboratory based Health Psychology. The teaching staff are Chartered Psychologists with the British Psychological Society and registered Health Psychologists with the Health Professionals Council.

Professor O'Carroll, who is the current vice-president of the United Kingdom Society of Behavioural Medicine and a practising clinical and health psychologist, has a diverse portfolio of research that encompasses behavioural medicine (e.g. adherence, organ transplantation, prediction of outcome following medical and surgical interventions), memory and emotion and clinical neuropsychology. Ronan has recently been the chair of the thriving British Psychological Society Division of Health Psychology – Scotland. He currently holds a number of project grants as Principal Investigator supporting his work.

Professor Rory O'Connor is broadly interested in self-regulation processes and health outcomes and he leads the Suicidal Behaviour Research Group at Stirling, the only dedicated suicide/self-harm research group in Scotland. The overarching aim of the research conducted within the group is to apply theoretical models derived from different areas of psychology (including health and clinical psychology) to enhance our understanding of self-harm and suicide. He applies health psychological models (including Theory of Planned

Behaviour, Self-regulatory Model, Transtheoretical Model) to enhance our understanding of suicide/self-harm. Rory's work has been funded by both UK and European sources.

Dr Vivien Swanson, who is the director of the MSc in Health Psychology, conducts research on a range of topics including stress and health, infant feeding (including applying psychological models of behaviour change to breastfeeding and developing self-efficacy in parents of premature infants) diet and obesity and diabetes. Over the last 10 years Dr Swanson has sat on several governmental advisory groups in relation to infant feeding and diabetes, and is the current chair of the British Psychological Society, Division of Health Psychology – Scotland.

Dr Gerry Molloy is the most recent member to join the team taking up a lectureship in April 2009 after posts as post-doctoral research fellow at University College London and the University of Aberdeen. His research focuses on the health effects of providing and receiving social support and issues relating to informal care for older adults with activity limitations due to cardiovascular disease. In particular he is interested in the question, 'How do others in our immediate ongoing social environment influence health and illness?' particularly in older age and in adaptation to chronic illness.

This rich and diverse portfolio of Health Psychology research provides a stimulating academic environment for PhD students, early career researchers and Professorial research leaders alike. The department hosts many visiting researchers and welcomes applications from those that can contribute to and benefit from the various programmes of research to become official visiting scholars. Indeed potential PhD students are encouraged to contact the academic staff to discuss potential PhD topics and potential funders.

Health Psychology in Stirling - the future

The field of Health Psychology increasingly acknowledges that the discipline has now reached the point in its development where it has to prove its worth in terms of delivering and evaluating theory-based interventions that aim to improve health and well-being, and with this in mind The Centre for Health and Behaviour Change has this as a key objective for new programmes of research over the next 5-10 years. Our current and planned studies in this area include the following:

- Interventions to improve self-efficacy in parents of premature babies and to motivate mothers to initiate and maintain breastfeeding.
- Interventions to enhance adherence to medica- ►



Health Psychology in Member Countries

Molloy, O'Connor, O'Carroll, & Swanson (cont'd)

tion in patients with cardiovascular disease by modifying beliefs about medications and improving self-regulatory skills⁴.

- Increasing sign-up on the organ donor registry via tackling emotional barriers to registration.
- Using brief psychological interventions e.g. volitional health sheets, to reduce self-harm⁵.

We believe that the discipline of Health Psychology has an important role to play in improving population health and that the University of Stirling can be an internationally leading centre for science and practice in this area. Later in 2010 the University of Stirling will formally launch The Centre for Health and Behaviour Change. The Centre will provide the foundation and structure for the long term future of the discipline at the University and play a key role in demonstrating that Health Psychologists have the knowledge and skills to make a difference to public health.

For more and up-to-date information on Health Psychology at Stirling and The Centre for Health and Behaviour Change, please visit our web pages which can be found at:

<http://www.psychology.stir.ac.uk> ■

1. http://www.timesonline.co.uk/tol/life_and_style/education/sunday_times_university_guide/article6831996.ece
2. <http://www.guardian.co.uk/education/table/2010/jun/04/university-guide-psychology>
3. <http://www.sns.gov.uk/default.aspx>
4. <http://www.biomedcentral.com/1471-2377/10/15>
5. <http://www.psychology.stir.ac.uk/research/SBRG/index.php>

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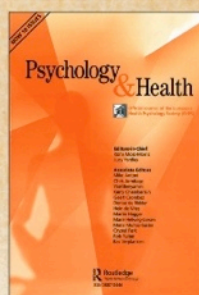
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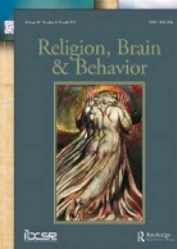
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