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EHPS president's message

Paul Norman
President - European Health Psychology Society

Dear Colleagues,

It was a great pleasure for me to welcome members of the new EC to an albeit wet and windy Sheffield for our winter EC meeting earlier this month. These winter meetings have become an established feature in the calendar of the EC as they allow us to have a concentrated time to meet face-to-face to review recent activities, brainstorm new ideas and plan for the future. Many of the new initiatives in recent years, such as the Create Tandem and Visiting Scholar Grants as well as the Networking Grant, have stemmed from initial ideas discussed at the winter EC meeting. In addition, the first meeting of a new EC provides an opportunity to take a fresh look at our current activities and a new input of ideas and energy. As you can imagine, our two days were very full. I have tried to highlight some of the key issues we discussed below.

Membership and Finances

I am pleased to report that our membership reached 500 for the first time in 2010! Members have been sent renewal reminders and most have already renewed their membership for 2011. We will be sending out further reminders in the next few weeks (please renew soon if you haven't done so already!) as well as encouraging non-members who have attended our conferences in recent years to join the society. We are hopeful that these activities, coupled with the expected increase in membership around the time of the Crete conference, will maintain our membership above the 500 mark.

Despite introducing a number of new initiatives last year, our financial position is very sound, due to the success of our conferences and the increase in our membership. As a result, we are well positioned to continue to invest in the development of the society and expand the range of actives that we can support. However, on the downside, the increase in membership also places a burden on the workload of the Treasurer/Membership Secretary, particularly at this time of year. At our meeting we discussed ways in which the processing of membership applications and renewals could be automated in order to make the process more efficient both for the Treasurer/Membership Secretary and for members. In addition, an automated renewal system could also be used to update members' details on the membership directory which could be organised/searched by keywords (e.g., research interests). This may, in turn, facilitate networking and the development of specialised interest groups within the society. At our meeting we decided to explore a number of avenues for developing an automated renewal system that could serve various purposes and to commit funds to ensure its implementation.

On a related matter, we plan to introduce electronic voting for future EC elections. This change has two main benefits. First, it will reduce the workload of the Secretary and the Election Scruntineers as we would no longer need to send out and receive voting forms. Second, it will make voting more convenient for members which may increase participation. In order to instigate this change, we will need to make a small change to the society's Bylaws which will need to be agreed by the Members Meeting at the Crete conference. Members will be receiving a draft of the proposed changes to the Bylaws in the near future, so that they can be commented on (and potentially revised) before the Members' Meeting.

Journals

I would like to welcome the new Editors-in-Chief of Psychology & Health, Mark Conner and Daryl O'Connor, who started their term at the beginning of the year. The journal continues to grow, attracting an increasing number of high-quality submissions each year. However, there has also been an increase in the size of the publication backlog which the new editors have highlighted as one of their key goals to reduce. To this end, from this year the journal will include 12 issues per volume (up from 10). In addition, we have negotiated with the publishers (Taylor & Francis) to publish an additional (supplementary) issue this year to further reduce the size of the backlog, which will be jointly funded by Taylor & Francis and EHPS. The additional issues this year will make a significant dent in the size of the backlog which will ensure that authors' work is published more quickly and will have a positive impact on the journal's impact factor.

Health Psychology Review continues to grow. The EC would like to acknowledge the exceptional time and energy the Editor, Martin Hagger, has put into the journal. It is now published on time, twice a year, and has a steady flow of new submissions. The journal has applied to be indexed in SCCI which would provide it with an impact factor. The unofficial impact factor for Health Psychology Review is already 1.3. This will

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undoubtedly increase once the journal is indexed and further establishes itself as the only review journal dedicated to health psychology.

In our EC meeting we also discussed the possibility of extending online access to Psychology & Health and Health Psychology Review to student and reduced fee members who do not have online access to the journals through institutional subscriptions. We felt this would be a good investment in the future of the society by further encouraging student membership and expanding our membership particularly in Eastern Europe. We will be negotiating with Taylor & Francis regarding the feasibility and cost of such an initiative.

Health Psychology Provision in Europe

A recurrent theme in the National Delegates' Meetings at recent conferences has been the wish for EHPS to develop a 'core minimum curriculum' that we would expect Masters courses in Health Psychology to cover. There are now many Masters courses in Health Psychology available across Europe, some of which are detailed in the National Delegates' pages on our website. The development of some general guidelines would encapsulate current practice across Europe and provide a framework for the development of new courses. We therefore plan to invite a small working group to consider this issue in more detail at a pre-conference meeting in Crete. This working group would then report back to the EC and the National Delegates Meeting to consider whether and how this initiative can be taken forward.

EC Meeting in Sheffield, February 2011

EHPS Grants

Over the past two years we have introduced a number of small grants to encourage networking and collaboration between our members across Europe. These have included the Create Tandem and Visiting Scholar Grants which were introduced in 2009 as well as the Networking Grant which was introduced in 2010. We are committed to continuing these grants. At present, the Tandem and Visiting Scholar Grants are awarded yearly, whereas the Networking Grant is awarded every two years. Feedback from the recent survey conducted by the Synergy group indicated that members would like more opportunities to engaging in networking activities and to develop research collaborations across Europe. The EC will therefore be discussing with Synergy ways in which this can be achieved. In the immediate future we plan to offer the Networking Grant every year, providing we have sufficient funds.

EHPS Conferences

At our EC meeting we looked back at last year's conference in Cluj-Napoca and forward to our upcoming conferences in Crete (2011), Prague (2012) and Bordeaux (2013). Last year's conference in Cluj-Napoca was very popular, with over 600 delegates. We are indebted to the hard work of the local organisers for producing such an excellent conference. Delegates' feedback on the conference was very positive and a summary of this feedback is reported in this issue of EHP. One issue that was highlighted by respondents to the survey was the number of no-shows. This issue has been noted and we will be discussing with future conference organisers ways to ensure that this is minimized.

Our next conference takes places in Crete (20-24 September, 2011). Preparations are well under way and the deadline for the submission of abstracts has just closed. Over 1,000 abstracts were submitted to the conference organisers. We are anticipating that the conference will be one of our largest to date. The conference will represent a special moment for the society as it will be the 25th Conference of the EHPS. To mark this occasion the local organisers will be organising a special celebration, which will be combined with the opening ceremony, on the evening before the first day of the conference. When making your travel please arrangements please try to ensure that you can arrive in Crete in time for the opening ceremony and celebration on the Tuesday evening! I look forward to seeing you in Crete.

As you see, the EC has a number of plans for the coming year which will hopefully contribute to the continued growth and development of health psychology in Europe. As ever, we are keen for members to contact us with comments and ideas for future developments.

Best wishes for 2011 from myself and the Executive Committee,

Paul Norman, EHPS President

ask the expert

Social Justice: What has Health Psychology Contributed?

Anthony Montgomery

University of Macedonia, Greece

The current economic crisis in Europe behoves all organisations to re-examine the contribution that they make to society. Put simply, society wants to know if it is getting value for money from the services and organisations they fund. The EHPS is predominately populated by university employees whose salaries are (typically) funded by taxpayers. Thus, the need for Health Psychology to be relevant has never been more important. The present article was prompted, in some part, by the thought provoking keynote speech by Prof. Michael Murray (EHPS Cluj; 2010), whereby Michael suggested that Health Psychology has a weak ego and challenged us all to ruminate on how our activities impact upon society. This is a good question, and deserves an answer.

With all the aforementioned in mind, I have approached a sample of senior health psychologists to ascertain their personal experiences of how their own careers have contributed to social justice in the world. The following article represents their responses to the following question:

"Looking back on your career, in what way has your own work contributed to social justice in the world?"

Prof Susan Michie

University College London

What is social justice? Social justice involves creating a society based on principles of equality and solidarity, that understands and values human rights, and that recognises the dignity of every human being. At its 2007 World Summit for Social Development, the United Nations proclaimed 20 February as World Day of Social Justice. Governments pledged to promote the equitable distribution of income and greater access to resources through equity and equality and opportunity for all. The day aims to consolidate the efforts of the international community to eradicate poverty, and promote full employment and decent work, gender equity and access to social well-being and justice for all.

Health psychology in relation to social justice: The aims of Health Psychology, according to the British Psychological Society, are:

1. To study scientifically the psychological processes of health, illness and health care
2. To apply psychology to:
   - the promotion and maintenance of health
   - the analysis and improvement of the health care system and health policy formation
   - the prevention of illness and disability and the enhancement of outcomes of those who are ill or disabled
3. To develop professional skills in research, consultancy and teaching/training

How do these aims match the aims of social justice? Psychology is the scientific study of the interaction of behaviour, cognition and emotion with each other, and with the environment. Although environmental context is crucial to psychology, its role is often a secondary rather than primary focus. Applying psychology to the promotion of health and reduction of disability has the capacity to increase social well-being, but this does not automatically translate into increasing equity and equality. Improved health services can lead to increased inequality, due to unequal access to services, with those from low income and ethnic minority groups underserved by services. Population health interventions, such as persuasive mass media marketing, can also increase inequality if not targeted to the more deprived sections of the population.

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Social Justice: What has Health Psychology Contributed?

Social justice will not be increased by the application of psychology without a sophisticated analysis and awareness of its political context and consequences. This will require self-conscious policy changes and leadership from our scientific and professional societies. One possibility would be to organise annual Health Psychology events on the World Day of Social Justice.

My work: My first scientific publication (Michie, 1980), 30 years ago, followed a visit to the psychiatric hospital in Cuba, one of the most equal societies in the world. As a newly qualified clinical psychologist, I was inspired to communicate their therapeutic model which embodies the principles of social justice. This experience made me realise the limitations of our own therapeutic approach, which was more individualistic, separated from social values and lacking dignity compared to that in Cuba. It also made me reflect on the role psychologists played in society more generally and our missed opportunities to work towards a more just and equitable society. The following year I wrote an article for Bulletin of the *British Psychological Society*, (Michie, 1981) entitled "The clinical psychologist as agent of social change".

As a Health Psychology researcher, I am active at a policy level to work to maximise the likelihood that our scientific knowledge is applied in the most effective way to maximise social justice, as well as to increase the general health of the population. I will give two examples of my work aimed at reducing inequalities, one translating scientific research into a health service and one aimed at lobbying politicians to support equality-promoting social interventions.

NHS Health Trainers was a new service set up in the UK in 2004 with the aim of reducing health inequalities by targeting interventions to change behaviours in relation to health. About 1500 Health Trainers, mainly drawn from and based in their local communities, currently provide this service. Along with Policy Leads in Government, I designed the evidence-based intervention and, together with Prof. Nicky Rumsey and a small team of Health Psychologists, have supported its implementation, development and evaluation. It includes behaviour change techniques that are relatively straightforward to train and use, such as goal-setting, action-planning and self-monitoring. To support the health trainers to maintain evidence-based practice as much as possible, we wrote a Behaviour Change Handbook which was distributed to the services and is available on the UK Department of Health website (Michie et al., 2006). The evaluation has demonstrated success, both in engaging low income and ethnic minority groups within the population, and in showing improvement in self-reported health behaviours and Body Mass Index (Smith, Gardner, & Michie, 2010).

The Coalition Government elected in the UK in 2010 has rapidly moved away from the previous Government's health policies of attempting to reduce inequalities. In an effort to preserve as much of the UK's world-leading tobacco control strategy as possible, two Health Psychologists (myself and Prof Robert West) have helped the health charity, Action on Smoking and Health (ASH), to present evidence on effectiveness and public acceptability of components of that strategy and the moral arguments for maintaining it (Featherstone et al., 2010) to the All Party Parliamentary Group on Smoking and Health. This formed a key part of their evidence to the UK Government's 2010 Comprehensive Spending Review.

Future perspectives: The world faces serious threats to social justice in the coming years. There is a global economic crisis, largely created by short-term profiteering by the banking sector. The consequent national debts are overwhelmingly being paid for by the mass of the population, rather than by those who caused the crisis. In the UK, the brunt of the "austerity cuts" to income, jobs and services is being borne by the lowest paid. The financial crisis is being used as an excuse by the UK's government to achieve the Conservative Party's long-standing political goals of minimising the public sector and reducing the constraints on private companies to exploit their markets. Increased inequality within societies has been shown to reduce social cohesion, health and well-being (Wilkinson & Pickett, 2009). Now, more than at any time in my lifetime, it is time for Health Psychology to recognise, and act on, the interrelationships between social justice and our professional aims.

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ask the expert

Social Justice: What has Health Psychology Contributed?

Prof Adriana Baban
Babes-Bolyai University, Romania

Before I graduated, I knew that I couldn't practice psychology in the lab or in the office exclusively, as so many acts of injustice were happening all around me, including sufferance, trauma and health disparities. I learned that my way to do psychology is to give voice to vulnerable people who cannot speak for themselves. I also learned that they should not be seen as individuals lacking good resources to cope with adversities, but human beings caught in the middle of unfortunate socio-economic circumstances. Listening and publishing the stories of Romanian women who had to pass through the experience of one of the most draconian pronatalist policy in the world, stories which gave voice also to more than 10,000 women who died because of a regime which strictly prohibited them access to contraceptives and legal abortion, carried the hope that their traumatic experiences will never again be repeated. The central argument of a study on the psychosocial-health systems dimensions of cervical screening is that the health status of women from countries experiencing tremendous political, economic, social and institutional changes are more vulnerable to different diseases, including cervical cancer. Individual risk factors such as beliefs, attitudes and behaviors should be interpreted through the perspective of the social context. The question of what are the factors which can limit or encourage women to be active agents in health promotion and disease prevention is particularly relevant in the current situation of many countries in Eastern Europe. My research interests also involved psychological consequences of domestic violence and women's ways of coping with it; with a study carried out in Albania I highlighted the fact that the silence around domestic violence makes it the most pervasive, yet least recognized form of human rights abuse. Several other research projects, in which I was involved, have aimed to bring forward the practices that would prevent the social exclusion of young people in residential care, diminish violence in the residential system and facilitate equal opportunities and their social inclusion. The theme of the 24th EHPS Conference in Cluj, Romania, "Health in Context" represented an invitation to participants to become more reflexive researchers, driven by social justice in making decisions that can impact the life of others, in an attempt to validate health psychologists as agents of social change for the benefits of populations, communities and individuals.

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Prof Teresa McIntyre
University of Houston, USA

Early on in my education, I became painfully aware of inequalities in wealth, educational opportunities and health. I transitioned to college at the time of the Portuguese Revolution, a peaceful coup d'etat that overthrew a 50 year dictatorship which also ended the Portuguese colonial wars and occupation. To fulfil a 1-year community service requirement for college admission, I was placed in a school at a fishing village where children were poor and had alcoholic parents, suffered from poor nutrition, poor hygiene and most of all, were starving for affection. This experience and my personal beliefs in the value of life and solidarity, shaped my career interest in health and psychology, and left a lasting impression that my scientific endeavours should help "solve real problems" and alleviate suffering among people that needed the most help.

A career in health psychology offers great opportunities to contribute to social justice. My career contribution to social justice has spanned the areas of service provision, education and training, consultancy and professional leadership.

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As a service provider and clinical supervisor, I had the opportunity to impact diverse underprivileged populations. In the U.S., I developed behavioural medicine services for Portuguese-speaking immigrants who suffered from tremendous victimization, an experience that taught me that contextual factors are key in understanding health behaviour and implementing effective interventions (McIntyre & Augusto, 1999). The health psychologist's role and credibility also relies on expanding beyond the clinical role to the social advocacy arena. In Portugal, I pioneered several theory-based psychosocial interventions in the context of public health services, where more than half of the patient population have less than four years of education (e.g. McIntyre, Fernandes, & Araujo-Soares, 2000). Effective practice requires combining cultural sensitivity with innovation in applying traditional methods of assessment and intervention.

As an educator, I pioneered the development of health psychology in Portugal, training many generations of health psychologists. They have brought the biopsychosocial perspective to an environment where the medical model is still dominant, which empowers patients and fosters more equality in health care delivery (e.g. Sousa & McIntyre, 2008). My teaching often transposed national boundaries. I was privileged to train the first clinical psychologist in Angola, and conduct research on the impact of war trauma on health in young civilian populations (e.g. McIntyre & Ventura, 1996). This work inspired two other important research initiatives. The first one was to co-author the first comprehensive study of PTSD and health consequences of combat stress in Portuguese veterans of the colonial war, a study that became a reference for health policy (Maia, McIntyre, Pereira, & Ribeiro, in press). The second is an outcome study of a psychosocial intervention for women with high HIV-risk, at the province of Beira, in Mozambique, conducted by my PhD student (Patrao, McIntyre, & Veiga-Costa, 2009). All these experiences are examples of how health psychologists can move from local to global focus in unexpected ways as well as to contribute to social justice beyond their immediate milieu.

My role as a consultant produced the most potential for direct impact on policy, fostering social justice by giving voice to different actors in the health care delivery process (patients, professionals, administrators). As a consultant to the northern Regional Health Administration (RHA), I led the first region-wide studies on patient satisfaction, the impact of programs to reduce wait lists for surgery, and professional satisfaction (e.g. McIntyre et al., 2002). I was also a consultant in a matter that is close to my heart, providing a scientific basis for the selection process of adoptive parents and personnel training for the Portuguese National Adoption Agency. The program sought to make the process of adoption more transparent and credible as well as expeditious, thus reducing the social injustice towards the children that await adoption and those that are eager to parent.

Participation in international scientific or professional associations offers great opportunity to contribute to social justice beyond national boundaries. I believe that a scientific society can be a powerful instrument of social justice. Through over 10 years of executive roles at the European Health Psychology Society and with many EHPS Executive Committee colleagues, we worked towards this goal in several ways: (a) by promoting increased equity in health psychology education and training, thus contributing to reduce the great asymmetries in health psychology development that characterize this continent, (b) by promoting local health psychology development through the strategic selection of sites for annual conferences, executive meetings, and other initiatives, (c) by increasing access to conferences, specialty workshops/groups and publications to members from countries that are economically disadvantaged (e.g. reduced fees), (d) by providing leadership opportunities to members from countries that are not mainstream in the EHPS, and (e) by liaison with and representation in regional and world organizations that are advocates for social change.

There is an increasing recognition that health psychology and health psychologists have a social and moral responsibility to contribute to social justice both through the advancement of scientific knowledge and through social action (e.g. Campbell & Murray, 2004). Health psychologists in Europe have the opportunity to demonstrate that health psychology can make a difference to improve equity in health and well-being in Europe and beyond.

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ask the expert

Social Justice: What has Health Psychology Contributed?

Prof Gerjo Kok
Universiteit Maastricht, The Netherlands

Social justice is often seen as an absolute norm: equality (outputs for everyone, independent of inputs). In social psychology, social justice relates not to an absolute norm but a subjective one: people want to be treated in a way they see as representing equity (inputs reflect outcomes). One typical result of equity studies is that people dislike being over-benefitted. Another more negative result of equity studies is blaming of the victim (Jost & Kay, 2010). Equity and equality are not similar.

Social psychologists are merely people. They like to assume that their work contributes to equality. Has our own work contributed to social justice in the world? Social psychologists working in applied research often refer to Kurt Lewin. Mostly because of his remarks on the practicality of theories, but also for this quote:

> "*I am persuaded that scientific sociology and social psychology ... can do as much, or more, for human betterment as the natural sciences have done.*" (1948, p. 83).

In that tradition, we have in our research team contributed to a more energy saving driving style of professional drivers, an improved quality of life of patients with diabetes, improved primary prevention of HIV/Aids, less medical consumption in children with asthma; more effective smoking cessation programs; improved environmental conditions for healthy eating; better stress management in children, less stigmatization of people living with HIV/Aids, and etcetera. Some of that work was carried out in developing countries, empowering the target population and training faculty. We also have contributed to the state of the art of understanding and changing behaviour, for example by showing that fear appeals are almost never effective, and that promising alternatives are available. And, finally, we have contributed by diffusing that kind of knowledge (Bartholomew et al., 2011).

Have we done enough? Being familiar with the human tendency for self-justification, we had better not even try to answer that question. Suffice to say that our outcome expectations (as well as our experiential attitude) while doing this work are positive.

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Dr Wendy Lawrence
University of Southampton, UK

There is no social justice where health inequalities exist. My work within the Southampton Initiative for Health focuses on improving the health of disadvantaged women. They are more likely to have poor quality diets (Robinson et al., 2004), and we know poor maternal nutritional status leads to poorer growth and development of the fetus and infant, increasing the risk of chronic conditions such as cardiovascular disease and obesity in adulthood (Barker, 1997). My work offers me the opportunity to make a difference by improving the diets of disadvantaged women and their children, thus breaking this cycle of disadvantage and inequality in which generations of UK citizens have been trapped.

I lead the delivery of a training intervention developed from evidence gathered from a programme of research undertaken by myself and colleagues (Lawrence et al., 2009; Lawrence et al., 2011; Lawrence & Barker, 2009). We recognise that the most efficient way of improving disadvantaged women's diets is to support frontline health and social care practitioners who work with them on a daily basis. We are training them to have 'healthy conversations' with the women they meet, modelling what we want to see in their practice post-training (Barker et al., 2011). Practitioners are encouraged to explore their clients' worlds and em-

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power them to find their own solutions to their problems. As well as empowering the women and increasing their sense of self-efficacy, this approach raises the self-efficacy of practitioners as they see the change in their clients. The training liberates them from feeling they have to find solutions to everyone's problems. Staff working in these settings are frequently drawn from the population with whom they work, further enhancing the ability of the intervention to reduce inequalities.

Supporting change in practitioners will in turn support change in women. A quote from one trainee illustrates the power of the training:

"It's changed my life as well. It made me sit down and think about my life and things I have to change in my life. It certainly has helped me."

From our evaluation work, I know that we have changed the relationship they have with their clients. One trainee reports:

"It got me thinking that people can make up their own minds and have their own ideas; just by asking them open questions, rather than bombarding them with suggestions and ideas yourself, they realise what they can do."

I believe that "a little and often, by many, over time makes a difference". This training is making a difference and in a small way is my contribution to social justice.

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Prof Michael Murray
Keele University, UK

Integrating concern for social justice into research can take place at both the empirical and the conceptual level. A few examples from different stages of my career can illustrate some of this work. In the early 80s I coordinated a large project on smoking among young people. For this I used both qualitative and quantitative methods with the aim of developing an understanding of smoking as being socially and materially located. In articles on this work (e.g., Murray & Jarrett, 1985) I argued against the individualistic victim-blaming approach and for a more social and materialist approach to health promotion to address inequalities in health practices. I referred to Bertolt Brecht's famous poem:

"Too much work and too little food/makes us feeble and thin/Your prescription says/put on more weight/You might as well tell a bullrush/not to get wet."

In a summary volume on this study of smoking (Murray et al., 1988) we further challenged the victim-blaming approach that was commonplace in the newly emerging health psychology. I thought it is useful to quote extensively from this report to give some idea of my thinking at that time:

"In designing our research we criticised the traditional psychological approach adopted by many previous investigators of smoking behaviour. Instead, we preferred a more social psychological approach which concentrated on the character of young people's social interaction and on how they viewed smoking within the context of their own lives. However, in drawing conclusions we cannot ignore the wider societal context within which the young people live and within which smoking occurs. Indeed, as Corrigan (1978) states: '*in so far as we construct our problems apart from society then our conclusions are located outside the political process of change in that society.*'"

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In the following years I and many others have attempted to different degrees to locate our research on psychological understandings of health and illness within a societal context of increasing social inequalities and also to develop strategies of change within this context (e.g. Murray, 2004). In the early 2000s I helped to convene a working party to develop a more community action approach to health psychology. The basic principles underlying this approach have the desire for social justice as a central theme coupled with a desire to involve health psychologists in various forms of social action (e.g., Murray et al., 2004; Murray & Campbell, 2003). This was taken up further in a recently edited special journal section on poverty and health psychology (e.g., Murray & Marks, 2010). One of our current projects is concerned with promoting greater quality of life among older residents of a disadvantaged urban community through a range of community actions (Murray & Crummett, 2010). While these projects are informed by a desire to promote health and well-being by engaging marginalised groups in a challenge to social exclusion they have illustrated the difficulties of working at a community level and the need to further expand the role of critical health psychology. Elsewhere I discuss this issue further (e.g., Murray, 2011).

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Prof Marie Johnston
University of Aberdeen, UK

Health psychology can contribute to or detract from social justice – we may increase inequalities or fail to benefit the least advantaged by our choices for research and practice. Or we may enhance social justice by developing theory and methods to address behavioural aspects of health and healthcare where there are inequalities of stigma, prejudice and access. I have chosen to focus my applied practice and my research on populations that are relatively neglected by both healthcare and science, especially in the area of disability.

Practice: At an early stage, I chose to deliver psychological services in an area of high deprivation (Johnston, 1978), to people who are dying (Honeyburn, Johnston, & Tookman, 1992; Jones, Johnston & Speck, 1989) and to patients ostracised in the healthcare community (Johnston, 1987). Currently, I supervise two government funded health psychology trainees to develop improved services for behaviour change for people in area of high deprivation; and, for Scottish Government, Diane Dixon and I are developing a framework for defining professional competencies to deliver behaviour change interventions to all populations (Dixon & Johnston, 2010).

Theory: The theories we use can add to social injustice. I have argued that, in health research, explanations for the behaviour of healthcare providers and users differ in a prejudicial way: Healthcare professional behaviour tends to be explained in terms of education and environment whereas patient behaviour attracts deficit and distress theories (Johnston, 2005). In the area of disability, I proposed models of function and activity limitations that could be applied to everyone, elite athletes and people who have severe impairments alike, rather than having stigmatising models of behaviour exclusively for those already disadvantaged by their health condition (Johnston, 1996). Tests of these models demonstrate that the same processes that drive activities in people without impairments are also instrumental in determining activities in people with impairments (Dixon, Johnston, Rowley, & Pollard, 2008). Based on this theoretical approach, we have developed an effective intervention to reduce activity limitations following stroke (Johnston et al., 2007), which has been incorporated into guidelines for the management of stroke (Scottish Intercollegiate Guidelines Network; 2010) and is currently being rolled out throughout the Scottish National Health Service.

While there is ample evidence that gender, social deprivation, age etc. account for variance in health outcomes, the causal processes are poorly theorised. Hannah McGee and I have proposed at least three mechanisms: biological, psychological and environmental and have found evidence for environmental processes associated with social deprivation and gender influencing recovery from activity limitations following MI (Johnston, McGee, Graham, & Macleod, 2002).

Measurement of health outcomes: Assessment of health and healthcare outcomes may introduce inequalities. ▶

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For example, women or people who are socially deprived may appear to have poorer health if the measures assess activities which may depend on access to transport. It is important that the measures do not exaggerate – or obscure – disadvantage. Recent statistical developments allow investigation of differential functioning of items within questionnaires and our work, led by Beth Pollard, demonstrates that even well-accepted measures like the SF-36 may introduce such biases (Pollard & Johnston, 2010).

Intervention: Advances in healthcare interventions frequently result in increased inequalities: Typically the more advantaged are more likely to access the new treatments. Several explanations have been proposed: For example, there is a persuasive case for social identity discouraging access by the more disadvantaged (Oyserman, Fryberg, & Yoder, 2007). Others have argued that health may not take priority in the hierarchy of goals over safety, hunger, social acceptance, etc. Nevertheless, it is possible that some kinds of interventions are more likely to accentuate disadvantage and this remains to be investigated. Dual-processing theories (Strack & Deutsch, 2004) contrast reflective processes with non-reflective, automatic, environmental prompts or cues, methods which are more universally accessible and which have the potential to influence everyone's behaviour. In the context of behaviour change for health, we have identified a wealth of behaviour change techniques which use automatic, prompted or cued methods. However, analysis of methods currently used in health services shows that healthcare staff are trained to deliver many more of the reflective, reasoned behaviour change techniques (Dixon and Johnston, 2010).

Given biases in the delivery of healthcare, enhancing evidence-based practice increases the likelihood that the more disadvantaged will access effective care. Financial incentives used to manage primary care in the UK (Quality Outcomes framework, QOF) have reduced social inequalities in the receipt of healthcare (Ashworth, Medina, & Morgan, 2008). Our recent trial of financial incentives increased the delivery of evidence-based dental practice for children living in deprived areas (Clarkson et al., 2008) and was immediately implemented into policy for the National Health Service in Scotland.

On Reflection: Reducing inequalities has been a major theme for me throughout my career but, like others, I have also had other goals and distractions. In particular I would mention the draw of high tech, innovative medicine. While I have always worked on disability (Williams, Johnston, Willis, & Bennett, 1976), I have also done work in more high tech areas including IVF and surgery, but made a conscious decision to reduce that area of my research to focus more on the less popular, under-researched area of disability. When asked to give keynotes I have always had disability as a major theme, hoping to enhance the status of this area by giving it a prestigious platform. Also, when interviewed by journalists, I have frequently managed to introduce issues of social injustice e.g. the disabling architectural design of homes. There are key points in one's career when choices are made, many at an early stage, but one may also have opportunities to refocus in line with one's values at later stages.

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Some reflections

Dr Anthony Montgomery
University of Macedonia, Greece

The contributions reflect a rich diversity of answers. Our "grey beards" have demonstrated that the answer to how we can all contribute to social justice lies in different places; the political, the personal, the economic, the civic and the ability to seize an opportunity when presented with one. The contributions should be mandatory reading for the next generation of health psychologists. "Doing" social justice is not easy, and this is as it should be. Questions of social justice force us to answer questions about values, and it's easy to lose sight of values when we are struggling to be tenured or publish in good journals. That said, social justice will fail to capture the imagination of the next generation of health psychologists unless it is associated with a significant incentive. Personally speaking, I would like to suggest that we need to chain social justice to the bigger question of why we keep failing to show ethical leadership in public about psychology. We either allow psychology to be sold cheaply by non-psychologists or, in extreme cases; we allow psychology to become the tool of governments for interrogation and

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ask the expert

Social Justice: What has Health Psychology Contributed?

torture (Pope and Gutheil, 2009). Maybe this is what Michael Murray meant when he suggested that we have a weak ego?

Let's look forward. At the beginning of the 21st century, social network sites have replaced news and media as the authentic voice of people. Facebook, if it were a country would be the 3rd most populous country on the planet. Increasingly, Facebook and Twitter probably do more for social justice than we can, simply by giving individuals a voice that they control and regulate. Obviously, social justice is not their vision, but they offer people the first steps to feelings of equality and equity. Social network sites are designed so as to maximise the positive projections that individuals can receive from others, which is quite an incentive. Recently published research about Facebook usage showed that doctors, with profiles on Facebook, are being contacted (poked/tweeted) by their patients (Jain, 2009; Moubarak, Guiot, Benhamou, Benhamou, & Hariri, 2011). Such technology changes the doctor-patient relationship beyond recognition. It would be interesting to ask where such behaviour fits in the illness perception continuum or Theory of Planned Behaviour! But seriously, the success of online social networks tells us something very important; people can be highly motivated to disclose, regulate and self-manage information about themselves without significant behavioural interventions. At present, it may be mostly about their cat and their 21st Birthday party, but industry and business has already seen the potential. When will we?

Finally, I haven't answered the question that I posed myself. This reflects my humility. However, rather than wondering what social justice is, I would be very curious to ask our contributors the follow-up question:

"How would the world have to change for your vision of social justice to be realised?"

...but that is probably a question for a sandy beach, good wine and a Greek sunset. ■

References:

Ashworth, M., Medina, J., & Morgan, M. (2008). Effect of social deprivation on blood pressure monitoring and control in England: A survey of data from the quality and outcomes framework. *BMJ: British Medical Journal*, 337(7680), 1-10. doi:10.1136/bmj.a2030

Barker, D. (1997). Fetal nutrition and cardiovascular disease in later life. *British Medical Bulletin, 53*, 96-108.

Barker, M., Baird, J., Lawrence, W., Jarman, M., Black, C., Barnard, K., & ... Cooper, C. (2011). The Southampton Initiative for Health: a complex intervention to improve the diets and increase the physical activity levels of women from disadvantaged communities. *Journal Of Health Psychology, 16(1)*, 178-191. doi:10.1177/1359105310371397

Bartholomew, L.K., Parcel, G.S., Kok, G., Gottlieb, N.H. & Fernández, M. E. (2011). *Planning health promotion programs: an Intervention Mapping approach* (3rd edition). San Francisco, CA: Jossey-Bass.

Campbell, C., & Murray, M. (2004). Community health psychology: promoting analysis and action for social change. *Journal of Health Psychology, 9*(2), 187-195. doi:10.1177/1359105304040886

Clarkson, J., Turner, S., Grimshaw, J., Ramsay, C., Johnston, M., Scott, A., & ... Pitts, N. (2008). Changing clinicians' behavior: a randomized controlled trial of fees and education. *Journal Of Dental Research*, *87*(7), 640-644. doi:10.1177/154405910808700701

Dixon, D. & Johnston, M. (2010). Health Behaviour Change Competency Framework: Competencies to deliver interventions to change lifestyle behaviours that affect health. *NHS Scotland*. http://www.healthscotland.com/learning/index.aspx

Dixon, D., Johnston, M., Rowley, D., & Pollard, B. (2008). Using the ICF and psychological models of behavior to predict mobility limitations. *Rehabilitation Psychology, 53(2)*, 191-200. doi:10.1037/0090-5550.53.2.191

Featherstone, H., Reed, H., Jarvis, M., Michie, S., Gilmore, A., West, R., & ... Scally, G. (2010). APPG Inquiry into the effectiveness and cost-effectiveness of tobacco control: Submission to the Spending Review and Public Health White Paper Consultation process. ISBN 978-1-872428-84-0.

Honeybun, J., Johnston, M. & Tookman, A. (1992). The impact of a death on fellow hospice patients. *British Journal of Medical Psychology, 65*, 67-72.

Jain, S. (2009). Practicing Medicine in the Age of Facebook. *New England Journal of Medicine, 361*, 649-651. doi:10.1056/NEJMp0901277

Johnston, M. (1978). The work of a clinical psychologist in primary care. *The Journal Of The Royal College Of General Practitioners, 28*(196), 661-667.

Johnston, M. (1987). Frequent attendance/anxiety in a primary care setting. In J. West & P. Spinks (Eds). *Clinical Psychology in Action* (pp 195-199). Boston: Wright.

Johnston, M. (1996). Models of Disability. *The Psychologist, 9*, 205-210.

Johnston, M (2005). Keynote presented at the European Society of Health Psychology, Galway, Ireland.

Johnston, M., Bonetti, D., Joice, S., Pollard, B., Morrison, V., Francis, J., & Macwalter, R. (2007). Recovery from disability after stroke as a target for a behavioural intervention: results of a randomized controlled trial. *Disability And Rehabilitation, 29*(14), 1117-1127. doi: 10.1080/03323310600950411

Johnston, M., McGee, H., Graham, E., & MacLeod, M. (2002). Commentary: Beyond the sociodemographics: From prediction to explanation of the effects of gender and social deprivation in recovery from myocardial infarction. In K. Schaie, H. Leventhal, S. L. Willis, K. Schaie, H. Leventhal, S. L. Willis (Eds.), *Effective health behavior in older adults* (pp. 105-116). New York, NY US: Springer Publishing Co.

Jones, K., Johnston, M. & Speck, P. (1989) Despair felt by the patient and the professional carer: a case study of the use of cognitive behavioural methods. *Palliative Medicine, 3*, 39-46. doi:10.1177/026921638900300107

ask the expert

Social Justice: What has Health Psychology Contributed?

Jost, J.T., & Kay, A.C. (2010). Social justice: History, theory, and research. In S.T. Fiske, D. Gilbert, & G. Lindzey (Eds.), *Handbook of social psychology* (5th ed., Vol. 2, pp. 1122-1165). Hoboken, NJ: Wiley.

Lawrence, W. & Barker, M. (2009). A review of factors affecting the food choices of disadvantaged women. *Proceedings of the Nutrition Society, 68*, 189-194. doi:10.1017/S0029665109001013

Lawrence, W., Schlotz, W., Crozier, S., Skinner, T., Haslam, C., Robinson, S., & ... Barker, M. (2011). Specific psychological variables predict quality of diet in women of lower, but not higher, educational attainment. *Appetite, 56*(1), 46-52. doi:10.1016/j.appet.2010.11.003

Lawrence, W., Skinner, C., Haslam, C., Robinson, S., Inskip, H., Barker, D., & ... Barker, M. (2009). Why women of lower educational attainment struggle to make healthier food choices: the importance of psychological and social factors. *Psychology & Health, 24*(9), 1003-1020. doi:10.1080/08870440802460426

Lewin, K., 1948. Experiments in social space. In: K. Lewin (Ed.), *Resolving social conflicts* (pp. 71-83). New York: Harper (Original work published 1939).

Maia, A., McIntyre, T., Pereira, M., & Ribeiro, E. (in press). War exposure, Post-traumatic Stress, and Psychopathology as Predictors of Portuguese Colonial War Veterans' Physical Health. *Anxiety, Stress and Coping*.

McIntyre, T., & Augusto, F. (1999). The martyr adaptation syndrome: Psychological sequelae in the adaptation of Portuguese-speaking immigrant women. *Cultural Diversity and Ethnic Minority Psychology, 5*(4), 387-402. doi:10.1037/1099-9809.5.4.387

McIntyre, T., Fernandes, A., & Araújo-Soares, V. (2000). Intervenção psicológica na reabilitação pós-enfarte do miocárdio: Um esforço interdisciplinar [Psychological intervention post-myocardial infarction: a multi-disciplinary effort]. P*sicologia, Saúde e Doenças, 1*(1), 53-60.

McIntyre, T., & Ventura, M. (2003). Children of War: Psychosocial sequelae of war trauma in Angolan adolescents. In S. Krippner & T. McIntyre (Eds.), *The psychological impact of war trauma on civilians: An international perspective* (pp. 39-54). Westport, CT.: Praeger Publishers.

McIntyre, T., Pereira, G., Silva, N., Fernandes, S., Correia, M., & McIntyre, S. (2002). A satisfação dos utentes dos serviços de saúde na Região Norte: Avaliação e Divulgação [Patient satisfaction with health services in the northern region: evaluation and marketing]. Porto, Portugal: Ministério das Cidades, Ordenamento do Território e Ambiente – CCRN - Comissão de Coordenação da Região Norte.

Michie, S. (1980). A therapeutic community in Cuba. *International Journal of Therapeutic Communities, 1*, 92-99.

Michie, S. (1981). The clinical psychologist as agent of social change. *Bulletin of the British Psychological Society, 34*, 355-356.

Michie, S., Rumsey, N., Fussell, S., Hardeman, W., Johnston, M., Newman, S., & Yardley, L. (2006). *Improving Health - Changing Behaviour: NHS Health Trainer Handbook*. London: Department of Health and British Psychological Society. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085779

Moubarak, G., Guiot, A., Benhamou, Y., Benhamou, A., & Hariri, S. (2011). Facebook activity of residents and fellows and its impact on the doctor-patient relationship. *Journal Of Medical Ethics, 37*(2), 101-104. doi:10.1136/jme.2010.036293

Murray, M. (Ed.). (2004). *Critical health psychology.* London: Palgrave.

Murray, M. (2011). Toward a social and political health psychology. In N. Edwards & L. MacLean (Eds.), *Creating a research career: setting your program compass*. Ottawa: University of Ottawa Press.

Murray, M., & Campbell, C. (2003). Living in a material world: Reflecting on some assumptions of health psychology: Comment. *Journal of Health Psychology, 8*(2), 231-236. doi:10.1177/1359105303008002665

Murray, M., & Crummett, A. (2010). 'I don't think they knew we could do these sorts of things': Social representations of community and participation in community arts by older people. *Journal of Health Psychology, 15*, 777-785. doi:10.1177/1359105310368069

Murray, M. & Jarrett, L. (1985). Young people's perceptions of smoking at work. *Health Education Journal, 44*, 22-26. doi: 10.1177/001789698504400106

Murray, M., & Marks, D. F. (2010). Health psychology, poverty and poverty reduction. *Journal of Health Psychology, 15*(7), doi: 10.1177/1359105310378386

Murray, M., Jarrett, L., Swan, A.V., & Rumun, R. (1988). Smoking among young adults. Aldershot: Avebury.

Murray, M., Nelson, G., Poland, B., Maticka-Tyndale, E., & Ferris, L (2004). Assumptions and values in community health psychology. *Journal of Health Psychology, 9*(2) 315-326. doi:10.1177/1359105304040897

Oyserman, D., Fryberg, S. A., & Yoder, N. (2007). Identity-based motivation and health. J*ournal of Personality and Social Psychology, 93*(6), 1011-1027. doi:10.1037/0022-3514.93.6.1011

Patrão, A. L., McIntyre, T., & Veiga-Costa, E. (2009). *Effectiveness of an education-based and a negotiation-based intervention to promote sexual health and prevent HIV/AIDS in Mozambican women: a pilot study*. Paper presented at the V International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention, Cape Town, South Africa, July 19, 20, 21 and 22.

Pollard, B., & Johnston, M. (2010). Papers presented at UKSBM and ISOQOL conferences.

Pope, K. & Gutheil, T. (2009). The interrogation of detainees: how doctors' and psychologists' ethical policies differ. *British Medical Journal, 338*, 1178-1180.

Robinson, S. M., Crozier, S. R., Borland, S. E., Hammond, J., Barker, D. J. P., & Inskip, H. M. (2004). Impact of educational attainment on the quality of young women's diets. *European Journal of Clinical Nutrition, 58*, 1174-1180. doi:10.1038/sj.ejcn.1601946

Scottish Intercollegiate Guidelines Network (2010). http://www.sign.ac.uk/guidelines/fulltext/118/index.html

Smith J., Gardner, X., & Michie, S. (2010). Health Trainers: National End of Year Report (2008-2009). Commissioned by the Health Inequalities Unit, Department of Health, UK.

Sousa, M., & McIntyre, T. (2008). Conhecimento do diabético sobre a doença e a repercussão no tratamento. [Diabetic´s knowledge of the disease and its impact on treatment], *Revista Brasileira em Promoção da Saúde, 21*(4), 281-289.doi:10.5020/18061230.2008.p281

Strack, F. & Deutsch, R. (2004). Reflective and impulsive determinants of social behavior. *Personality and Social Psychology Review, 8*, 220-247. doi:10.1207/s15327957pspr0803_1

Wilkinson, R., & Pickett, K. (2009). *The Spirit Level: Why Equality Is Better For Everyone*. Penguin Books, UK.

Williams, R.G.A., Johnston, M.., Willis, L. & Bennett, A.E. (1976) Disability: a model and a measurement technique. *British Journal of Preventive & Social Medicine, 30*,71-78.

original article

Behavioural Medicine and the EHPS

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Introduction to The International Society of Behavioural Medicine (ISBM)

Behavioural medicine is an interdisciplinary field concerned with the development and integration of socio-cultural psychosocial, behavioural and biomedical knowledge relevant to health and illness and the application of this knowledge to disease prevention, health promotion, aetiology, diagnosis, treatment and rehabilitation. ISBM (http://www.isbm.info/) is a federation of national societies, whose goal is to serve the needs of all health-related disciplines concerned with issues relevant to behavioural medicine. Each national society includes both biomedical and behavioural scientists. Europe is very well represented in ISBM, with many member national societies for behavioural medicine e.g. member societies in Denmark, Finland, Germany, Hungary, Italy, Netherlands, Norway, Portugal, Romania, Slovakia, Spain, and UK, the Central and Eastern European Society of Behavioural Medicine, and nine member societies outside Europe (Australia/New Zealand, Chile, China, Japan, Korea, Mexico, Thailand, USA and Venezuela). Both the most recent past-President of ISBM (Hege Eriksen from Norway) and the current President-Elect (Joost Dekker from the Netherlands) are from Europe. All member national societies develop and maintain liaison with the ISBM and other related local and international professional organisations. Health Psychology is very well represented as a discipline within Behavioural Medicine, for example, in the UK, Health Psychologists comprise approximately one-third of the UKSBM membership.

The goals of ISBM are to encourage and promote exchanges of scientific information and professional experience between social, behavioural and clinical scientists, as well as practitioners, to stimulate research and the development of research capacity through formal meetings and collaborative undertakings. Each ISBM national society also aims to raise the profile of behavioural medicine within national science and health policy. This is particularly important as Governments are increasingly recognising that behaviour is a key determinant of many chronic diseases, via poor diet, inactivity, smoking and alcohol intake. It is vital that we all try and influence our politicians regarding the requirement for a strong empirical evidence-base in behavioural science and medicine, otherwise expedient "ad hoc" public health campaigns are likely to be rolled out, at great expense, with little in the way of formal evaluation. When such enterprises produce disappointing results, this can be used as evidence of the lack of efficacy of behavioural approaches. As Marteau et al. (2006) concluded in their BMJ Editorial announcing the formation of UKSBM; "*Progress in understanding and changing behaviour to improve health is modest but real. Potential gains from the wider application of effective interventions are large and include reduced costs for healthcare systems and increased autonomy and health for individuals. We need to challenge ambivalent attitudes towards behavioural medicine among those who develop science and health policy*" (p.438).

The *International Journal of Behavioral Medicine* (IJBM) is the official journal of ISBM. It presents original research and integrative reviews on interactions among behavioural, psychosocial, environ-

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mental, genetic and biomedical factors relevant to health and illness. The scope of IJBM extends from research on bio-behavioural mechanisms and clinical studies on diagnosis, treatment and rehabilitation to research on public health, including health promotion and prevention. IJBM publishes research originating from all continents, inviting research on multi-national, multi-cultural and global aspects of health and illness. It is a quarterly journal, publishing approximately 50 papers per year.

ISBM also publishes a *Newsletter*, with news on developments in ISBM, developments in national societies, and interviews with prominent members.

How does ISBM differ from the EHPS?

The EHPS is an excellent society for exchange of Health Psychology expertise, research and practice in Europe. EHPS has a clear focus on how the discipline of psychology can aid our understanding of health. ISBM and the national societies are characterised by their *multidisciplinary membership*, e.g. Medicine, Public Health, Sociology, Nursing, Psychology and Physiotherapy. Thus ISBM provides an exciting opportunity for interdisciplinary cross-fertilisation and exchange of ideas between behavioural scientists working in different disciplines. ISBM has a clear focus on the importance of behaviour in health and medicine. The national meetings and the International Congress of Behavioral Medicine (ICBM) provide excellent opportunities for this kind of inter-disciplinary interaction. ICBM offers the opportunity to meet colleagues from different disciplines and countries, who may have different approaches, and to be able to learn from them. ICBM also offers the potential of fostering important interdisciplinary relationships and collaborations. Implementation science is a good example of multidisciplinary behavioural medicine. This is the scientific study of methods to promote the uptake of research findings into routine healthcare in both clinical and policy contexts. For example, systematic reviews may conclude that there is unequivocal evidence regarding the best way to manage a clinical condition, and this intervention may be recommended for clinicians, (e.g. by the National Institute of Clinical Evidence (NICE) in the UK). However, it is not unusual to find out that "best practice" is often not followed. Implementation research aims to identify barriers to implementation and strategies to overcoming them. The scope of behavioural medicine extends from research efforts to understand *fundamental bio-behavioral mechanisms*; to *clinical diagnosis and intervention*; to *disease prevention and health promotion*. ISBM is intended to serve the needs of all health-related disciplines concerned with the integration of behavioural (psychological and social) and biomedical sciences. Biomedical factors are important, both as determinants and as outcomes, in the context of clinical care and public health. ISBM aims at the integration of biomedical factors and behavioural (psychological and social) factors. Finally, ISBM is a truly *international society*: its membership originates from five different continents. This brings a huge variation in cultural values, societal contexts and economic resources among the ISBM members. This variation brings challenges, but it offers opportunities for exchange as well. A recent example is a paper in IJBM on the Chinese 'yu' syndrome, characterized by a cluster of mind/body obstruction-like symptoms such as pent-up emotions, feeling something stuck inside the head, throat, and chest, indigestion, bowel dysfunctions, and abdominal distension (Ng et al, 2011). This is of course very close to the Western concept of somatoform disorder.

The boundaries between health psychology and behavioural medicine are not always sharp and clear. In fact, there is significant overlap between papers in journals and conference themes, with many participating in both health psychology and behavioural medicine conferences. Nevertheless, there are clear-cut differences, related to scientific disciplines, the focus of research and practice, and cultural diversity. Behavioural medicine and health psychology are complimentary to each other, instead of being in competition. While respecting and valuing differences, we believe that the ISBM and EHPS can and should work together as effective allies in lobbying for increased investment in basic and applied research in behavioural science, medicine and practice.

Why should EHPS members join their National Society for Behavioural Medicine?

- Many have already done so!
- ISBM is complimentary to, not in competition with, EHPS
- The focus is on multidisciplinary behavioural science in relation to health and medicine. ISBM aims to promote the exchange of scientific information and experience between different professional groups.
- ISBM aims at the integration of biomedical and behavioural (psychological and social) science.
- The variation in cultural values, societal contexts and economic resources among ISBM members offers opportunities for exchange.
- National societies help raise the profile of behavioural medicine within national science and health policy. These societies have excellent multidisciplinary scientific meetings.

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O'Carroll & Dekker (cont'd)

- Members of national societies receive free electronic access to both the International Journal of Behavioral Medicine and the Journal of Behavioral Health Services and Research.
- The International Congress of Behavioral Medicine (ICBM) is an excellent biennial meeting – usually held in August each year. Recent venues have included Bangkok, Tokyo, and Washington. The next ICBM meeting will be held in Europe, in Budapest, Hungary 29th August - 1st September 2012.
- Membership of national societies of behavioural medicine usually represents excellent value for money. For example, in the UK the cost is £35 for full membership and £10 for students (see http://uksbm.org.uk/). The next UKSBM conference will be held at the University of Stirling in Scotland on 13th and 14th December 2011.

To conclude, in this brief article we hope to have provided sufficient information to persuade readers that ISBM is complimentary to EHPS, and to seriously consider the benefit they would derive from joining their national society of behavioural medicine. ■

References:

Marteau T., Dieppe P., Foy R., Kinmonth A.-L., Schneiderman N. (2006). Behavioural medicine: changing our behaviour. *British Medical Journal, 332*, 437-438

Ng, S.-m., Fong, T., Wang, X.-l., & Wang, Y.-j. (2011). Confirmatory Factor Analysis of the Stagnation Scale—A Traditional Chinese Medicine Construct Operationalized for Mental Health Practice. *International Journal of Behavioral Medicine*, 1-6. doi: 10.1007/s12529-011-9146-9

2010 conference evaluation

Delegate Feedback about the 2010 Conference of the EHPS, Cluj-Napoca, Romania

The 2010 Conference of EHPS took place in early September, in the city of Cluj-Napoca in Romania. It was hosted by the Babeş-Bolyai University, the oldest University in Romania, and by the Romanian Association of Health Psychology. The overarching theme of the Conference was *Health in Context*, underscoring the importance of community, social, cultural, economic and historical contexts for health. This was our most eastern location yet, and the EHPS expresses our gratitude to the local organizers for their hospitality and a very successful conference.

After the conclusion of the conference, the EHPS Executive Committee asked delegates to evaluate different aspects of their visit and participation in the 2010 EHPS annual event. We developed an evaluation survey, and are very grateful to Natalie Schüz for setting up the online technology and processing the data. We now have a section on the EHPS website, which can also be used in the future for online surveys. Here are some of the results of this evaluation:

The survey was filled out by 288 delegates of the conference, of which 43.4% were EHPS members and 54.9% from a total of 640 delegates were not members. The overall quality of the conference was well evaluated, with 23.6% of the delegates stating it was good, 51.4% stating it was very good, 17.7% that it was excellent. On a 5-point scale, the quality of the symposia was rated as 4.0, of the keynote lectures as 4.02, and the quality of chairing as 4.13. The overall quality of the workshops was rated highly at 4.14, and in the open-ended question people commented on the excellence of the workshops. The quality of the poster sessions was rated a little lower at 3.69. For the 2010 conference the Scientific Committee had decided to have poster sessions without poster presentations. Half of the delegates stated that they prefer to have poster presentations (50%), while 29.9% stated that they prefer without presentations, and the rest had no preference. Many delegates (35.8%) felt that this year there were too many posters for the room. While 57.6% felt they were the right number. This is compared to, for example 2.8% who felt the symposia were too many, while 86.5% felt that they were the right number.

For the 2010 conference the EHPS Executive Committee introduced an online only abstract book, in order to save funds and paper. While 55.5% of the delegates had accessed it before the conference, a full 40% had not, for different reasons. Ultimately 55% support the idea of an online only abstract book, while 28% do not, and others would like to see both an online and a printed abstract book. We will be using an online only abstract book again in Crete 2011 and we will take into account what we have learned from the 2010 experience and make sure information and access is clearly and easily available in advance and during the conference at computers.

Irina Todorova & Natalie Schüz

In response to the open ended question regarding what aspects of the conference would delegates change for the future, the common answers were related to limiting the number of posters at each session, more information about the online abstract book, and reducing the number of absent presenters. Some people felt that the dinner had a slow start or that preferred food choices were not available, but many commented that after that the celebration was very enjoyable. These are issues which the EC is considering in detail in preparation of the 2011 Conference in Crete. In response to which aspects of the conference worked well, the responses were very positive, stating that it offered a high quality of presentations, representing a diversity of themes, methodological approaches and international representation. "The keynote topics were very well chosen"; "I would like to commend the organizers for including a wide range of approaches, including critical and qualitative." Delegates felt that the conference offered a unique opportunity and settings to meet colleagues and other PhD students. Delegates were very impressed by the hosts and local organizers, stating that they were always available, proactive, dedicated and extremely helpful.

"The hosting of the local organizing committee was excellent. The conference was very well organized and the atmosphere was welcoming."

"I would like to congratulate the organization for choosing this city for a conference called Health in Context. *It was really interesting to get to know Cluj and some of its particularities and grow with them. Also I would like to thank the local team."*

"The attention before, during and after the conference was impressive. They were very helpful, answering all your questions, making changes and everything I needed. Congratulations to the organization team!" ■

Irina Todorova
EHPS Past President and Conference Officer

EHPS grants

EHPS Networking Grant Initiative 2010

The EHPS launched a new Networking Grant initiative in 2010. The aim of the Networking Grants is to support collaboration across EHPS countries and members in their research endeavours. It is hoped that these grants will catalyze initial stages of the development of collaborative research projects involving EHPS members in different institutions/countries (e.g., a small pilot study/meeting or a first part of a larger project).

In 2010 a full Networking Grant (5,000 Euros) was awarded to a team that aims to set up a European network of researchers to explore the potentials and mechanisms behind self-affirmation. In particular, moderators of the effects of self-affirmation on health cognitions (e.g., risk perceptions, intentions) and health behaviours will be examined. Funds were requested to support a series of pilot studies based on the expertise of the applicants and research meetings to discuss results and write a competitive European wide grant proposal. The collaborators on this project include Richard Cooke (Aston University, UK), Peter Harris (University of Sheffield, UK), Guido van Koningsbruggen (University of Utrecht, NL), Urte Scholz (University of Zurich, CH), and Benjamin Schüz (German Centre of Gerontology, D). Benjamin and the team will write a short report about the outcomes of this award later in 2011 in the European Health Psychologist.

CREATE Visiting Scholar Grants/Tandem Grants

In 2009, the EHPS decided to fund two new initiatives with the purpose of promoting collaboration and networking across countries: 2 tandem grants for a maximum of 2000 Euros each, and 2 visiting scholar grants for a maximum of 1000 Euros each (which gives a total of 6000 Euro). In 2010, we ran these schemes for young researchers for the second time.

In 2009, we had many, very high quality applications for both types of grants. In 2010, however, we only received applications for the visiting scholar grants. The grants committee evaluated the applications and then proposed to award grants to 6 visiting scholar projects. The Executive Committee agreed to transfer the money from the tandem grants to the visiting scholar grants. The projects covered a wide rage of topics, such as "mindfulness interventions in healthcare professionals who suffer from burnout", "psychological health and wellbeing of women who have had instrumental intervention during childbirth", "grief of healthcare professionals and how it affects patient care", "social exclusion in chronic pain patients", "the role of social identity in shaping sexual behaviour of men who have sex with men", and "impact of training delivered to volunteer walk leaders". Recipients were Asimina Lazaridou from Greece visiting Ellen Lager, Ingrid Rowlands from Australia visiting Maggie Redshaw, Leeat Granek from Canada visiting Michelle Fine, Adriana Banozic from Croatia visiting Jessie Dezutter and Jos Corveleyn, Kasia Banas from the UK visiting John de Wit, Katerina Kassavou from the UK visiting Kerry Chamberlain. All 6 recipients have been asked to send a short abstract that will be published on the EHPS website and to write a report for the EHP as well. ■

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