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editorial

Men's health: Exploring vulnerabilities and maximizing opportunities

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Considerable research in health psychology has focused on women and women-specific health issues, leading to health sometimes being considered a feminized domain where men are often seen as passive actors (Seymour-Smith, Wetherell, & Phoenix, 2002). Nevertheless, interest in men's health is growing and there is an ongoing debate about the advantages and risks associated with masculinity. Statistics indicate that men are at a disadvantage in terms of mortality and morbidity (Lipsky, Cannon, & Lutfiyya, 2014). For instance, life expectancy for men is lower than for women, and men are at greater risk of developing major diseases that affect both sexes (White & Cash, 2004; Ferlay et al., 2010). Such findings may be rooted in the fact that men engage more in risk behaviors such as poor dietary habits (Gough, 2007; Wardle et al., 2004), inappropriate alcohol consumption (de Visser & Smith, 2007) and smoking (Hitchman & Fong, 2011). Men engage in more physical activity, as a means to cope with stress (Davis et al., 2000). However, men tend to engage in more high-risk or aggressive sports that have a greater potential for injury and even death (Sloan, Gough, & Conner, 2010). Thus, even potential health protective behaviors may turn out to be harmful for some men.

Social constructions of masculinity may have an impact on health in terms of certain risk behaviors like heavy drinking, smoking, fighting or driving at high speed, which are considered 'manly' and part of the hegemonic masculinity (Edwards & Jones, 2009). However, contemporary notions of masculinity suggest a more complex concept, as certain aspects might build a "masculine capital" for health (de Visser & McDonnell, 2013) or be used in health promotion. Having masculine capital implies that a man may engage in both masculine (e.g. working in jobs that ensure financial power and prestige) and nonmasculine or feminine behaviors (e.g. caring for physical appearance), the latter still being consistent with his masculine identity such as in the case of the metrosexual man (de Visser, Smith, & McDonnell, 2009). Also, one may use healthy masculine behaviors to compensate for 'manly' risk behaviors. For instance, a man may compensate for not drinking alcohol (considered a masculine risk behavior) with engagement in sports (considered a masculine health behavior). Since they are considered part of contemporary notions of masculinity, nonmasculine behaviors like caring for physical appearance may be used to promote health behavior such as healthy diet, giving up smoking, engaging in physical activity or going to medical check-ups. Ideas concerning masculinity can both make men more vulnerable and/or be protective in terms of health. For example, 'being a man' can be expressed through being strong and being caring, which can both hinder and help men (Elliot, 2015). Masculinity/femininity are evolving constructs, made more complex by the fact that they represent a continuum rather than a dichotomy. The present special issue features papers that bring out the complex interplay between masculinity and health and offer insights for further research and interventions.

The current issue

Paul Southworth (2016, this issue) applies the theory of hegemonic masculinity to the study of suicide and reviews the relevant literature on the topic. Rates of suicide and attempted suicide are highly gendered, with males being more likely to take their own lives while females being more likely to attempt suicide. The author points out that a hegemonic masculine ideal was found to be deleterious to men's mental health with traits of independence, strength and stoicism identified frequently within the suicide literature. Findings show that previous literature examined masculinity mainly as a single concept, counter to the multiple masculinities upon which the idea of hegemonic masculinity is built. Masculinity was seen as a homogenous, oppositional counterpart to femininity rather than a relational hierarchy of competing masculinities, while subordinate or marginalized masculinities were rarely considered.

Marianne Cense and colleagues (2016, this issue) present the example of the Dutch campaign *Beat the Macho*, developed to challenge boys to explore how social norms about masculinity affect their lives and which conflicts they experience due to social pressure to perform stereotypical masculine behavior. The campaign offers a good example of how masculinity norms can be challenged, changed and inform health behavior interventions.

Greg Decamps and colleagues aim to improve the understanding of muscle dysmorphia, a special form of body dissatisfaction, typically suffered by males, and associated with intense physical activity. The researchers report on the results of research conducted among a sample of male sportsmen. Implications for its prevention are discussed.

HIV rates among South Africans remain among the highest in the world. Therefore, effective health education programs aimed to protect people against STIs/HIV are urgently needed. The standard recommendation for preventing STIs, including HIV, remain abstinence from sex, being faithful to one's partner (serial monogamy), having a limited number of life time sexual partners, consistent condom use with all partners, and both partners having an STI/HIV test with a negative test result before quitting condom use. Anam Nyembezi and colleagues (2016, this issue) describe the application of Intervention Mapping in the development of an STI/HIV health education program, which can be integrated into the traditional male circumcision practices in the Eastern Cape Province of South Africa.

Men's heath starts with boys' health. Alina Cosma (2016, this issue) examines the Health Behavior in School Children (HBSC) study findings regarding the differences between boys and girls in terms of social context, health and risk behaviors and health outcomes. Recommendations for policy and practice are provided, and Cosma highlights the fact that boys represent a heterogeneous population with different strengths and vulnerabilities concerning physical and mental health.

Finally, our last paper examines the problem of what is the best way to research men and their health behaviours. Methodological aspects are important when considering how to conduct research in the domain of men's health. Katarzyna Wojnicka (2016, this issue) delineates how we can best employ qualitative research when conducting interviews with men. Wojnicka introduces us to the emerging, but insufficiently explored, issue of methodology in research concerning men and masculinities. The paper is based on the author's considerable experience in conducting research projects with male participants and presents important observations concerning the theoretical, analytical and methodological issues that need to be addressed when research men and masculinity.

We hope you enjoy the special issue!

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original article

Hegemonic masculinity and suicide: A review of the literature

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There is a gender paradox within suicide statistics: suicide rates are almost universally much higher in males, while rates of suicidal ideation and attempted suicide are much higher in females (Canetto & Sakinofsky, 1998). While men tend to use more fatal methods than women (Schrijvers, Bollen, & Sabbe, 2012), this does not adequately explain the difference (Cibis et al., 2012; Mergl et al., 2015), and still begs the question of why methods differ between genders.

The idea of "hegemonic masculinity" emerged as an alternative to sex role theories which divided gender into two homogenous and complementary or oppositional kinds, omitting inequalities of power between and within these categories (Connell, 1987). A social constructionist structure of power was proposed with multiple masculinities, one of which is hegemonic over subordinated masculinities as well as women. Within each context, the hegemonic masculinity is the normative masculine ideal to which men are most commonly expected to strive. Through this hegemony men gain and retain power and domination over women and other men. All men thus gain a "patriarchal dividend" even if they do not conform to the hegemonic masculinity (Connell, 1995).

Hegemonic masculinity is generally considered to have a deleterious effect on men's health in those contexts studied, contributing to men's underutilisation of services (Jeffries & Grogan, 2012; O'Brien, Hunt, & Hart, 2005); excessive drinking (Dempster, 2011; Joseph, 2012; Peralta, 2007); and poor diet (Gough, 2007; Nath, 2011). However, there is evidence that in some contexts hegemonic masculine ideals can have positive effects on men's health by encouraging healthy behaviours (Sloan, Gough, & Conner, 2010). This narrative overview of the literature aims to assess how the idea of hegemonic masculinity has been used to understand suicide.

Methods

Medline, EMBASE, CINAHL, Pubmed and PsycInfo databases were searched using the following terms on 20/01/2016:

1. hegemonic masculin*
2. dominant masculin*
3. subordinate masculin*
4. subordinated masculin*
5. marginalised masculin*
6. marginalized masculin*
7. 1 or 2 or 3 or 4 or 5 or 6
8. suicid*

English language, peer-reviewed articles were included with no restriction on date. 11 articles were identified. Two were excluded which did not use hegemonic masculinity to study suicide. References from identified articles were reviewed for relevant articles. One was identified. Thus ten articles were subject to review. These are summarised in table 1.

Results

Hegemonic Masculine Traits

A similar masculinity was identified in all articles as being hegemonic; one characterised by competitiveness and honour, independence,

Table 1
Summary of identified articles

Year	Country	Population	Summary	Reference
2008	Australia	Rural "farm men"	In-depth interviews with members of rural farming communities looking at mental health outcomes for men in the context of protracted drought. The paper argues that a rural hegemonic masculinity has been beneficial to the men in good times but is harmful in times of stress.	(Alston & Kent, 2008)
2008	UK	Men with depression	A review of literature demonstrating different approaches to men with depression. The paper discusses theories of sex differences, gender roles and hegemonic masculinity in this context.	(Branney & White, 2008)
2011	USA	Current and former military servicemen	A discussion of dominant masculinity norms among current and former servicemen in the US military. Based on available literature as well as composite, fictionalised case studies from the authors' experience. The paper argues that adherence to dominant masculine norms put servicemen at exceptional risk of suicide.	(Burns & Mahalik, 2011)
2012	Ireland	Young men (18-30) who had made suicide attempt	In-depth interviews with young men who had made an attempt at suicide. The paper argues that hegemonic masculinity norms increased men's risk of suicide by discouraging disclosure of emotional vulnerability and encouraging the use of alcohol and drugs to cope.	(Cleary, 2012)

(continued)

strength and stoicism. Social change in communities was identified as a perceived threat to men's hegemony and "honour"; e.g. when women take on a breadwinner role (Alston & Kent, 2008; Oliffe & Han, 2014). Work and an ability to provide were thus identified as key to a masculine sense of honour, with a clear association between unemployment and male suicide rates (Oliffe & Han, 2014; Scourfield, 2005) and financial instability dominating motivation for domestic murder-suicides (Oliffe et al., 2015). One article compared male and female suicides (Niehaus, 2012) in a South African village, similarly finding that male suicides were perceived as a means of escape from situations where masculine hegemony was insecure. However, female suicides were also seen as protest at their subordinated position, thus implicating male hegemony in both male and female suicides.

In mass shootings involving suicide, honour was seen as a key determinant, with a "warrior-supportive" hegemonic masculinity in the US encouraging men to perform masculine acts of extreme violence to avenge perceived slights against their masculinity (Kalish & Kimmel, 2010; Oliffe et al., 2015). The perceived control over others or the need to establish control over others was also seen as a key motivator for homicide-suicides (Oliffe et al., 2015) and potentially in suicides used to punish others, e.g. following relationship breakdown (Scourfield, 2005).

Independence, strength and stoicism were thought to restrain men from seeking help and encourage acceptance of worsening circumstances (Alston & Kent, 2008). Depression was frequently perceived as a feminine trait. Men believed they should be less expressive of emotion than women; that men with depression are seen as weak; and that women expected and needed strong masculinities (Cleary, 2012). Thus they could not use discussion as an outlet for distress, instead seeking methods such

Table 1 (continued)
Summary of identified articles

Year	Country	Population	Summary	Reference
2006	UK	Men with depression	In-depth interviews with men with depression, exploring associations between men's gender identities and their depression. The paper discusses ways in which men adopted hegemonic or alternative masculinities in their recovery from depression. They also observed the contribution to suicidal behaviour made by pressures to conform to hegemonic masculinity.	(Emslie, Ridge, Ziebland, & Hunt, 2006)
2010	USA	Mass murderer suicides	An examination of three cases of mass school shootings in the US which ended with suicide of the shooter. The paper argues that these cases elucidate a culture of hegemonic masculinity which creates a sense of "aggrieved entitlement" which can lead to violence.	(Kalish & Kimmel, 2010)
2012	South Africa	Male and female suicides	Analysis of ethnographic narratives of male and female suicides in a village in South Africa. The paper argues that male suicides are normally preceded by thwarting of attempts towards dominant masculine status; while female suicides represent a protest at their subordinate position, both to men and other higher ranking women.	(Niehaus, 2012)
2014	Canada	All men	A discussion of men's work-related depression and suicide, specifically in the context of gendered analysis. Based on previous literature, the paper discusses how masculinities, including hegemonic masculinity, are connected with work-related depression and suicide.	(Oliffe & Han, 2014)
2015	Canada/ USA	Murderer suicides	Analysis of newspaper articles describing North American murder-suicide cases. The paper argues that marginalised masculinities and alignment to hegemonic masculinity emerged as key themes in these incidents.	(Oliffe et al., 2015)
2005	UK	Male suicides	A critical review of the suicidology literature. Analysis is performed using concepts of hegemonic masculinity and subordinated masculinities.	(Scourfield, 2005)

as alcohol, drugs or suicide (Cleary, 2012). Subjects in recovery from depression sought independence by reducing dependence on medication and healthcare, deriding any emphasis on interpersonal dependence in the recovery process (Emslie et al., 2006).

A lack of emotional competence was also identified in two articles, with rational objectivity seen as superior to emotion. Men who had attempted suicide were found to have little experience in expressing or exploring their emotions (Cleary, 2012). This could cause tensions with others and a restricted ability to cope when new emotions were encountered. Furthermore, by establishing emotional distance from others, the feelings of these others (such as children) could be discounted in consideration of whether to take one's own life (Scourfield, 2005).

Some who attempted suicide found motivation by persuading themselves of the courage required to act or mocking themselves for the cowardice of

inaction (Emslie et al., 2006). The US military was identified as having a "masculine warrior" hegemonic masculinity which rewards strength, stoicism and independence, and punishes deviation. Servicemen displaying these attributes were considered competent while those lacking were thought to jeopardise others' safety. Extreme independence was encouraged with a sense of invincibility and a disavowal of weakness and vulnerability, reducing utilisation of mental health services among servicemen (Burns & Mahalik, 2011).

Positive Aspects of Hegemonic Masculinity

A minority of articles also identified positive effects of hegemonic masculinity. Responsibility to others was seen as a key barrier to suicidal behaviour, helping men to contemplate ways in which they may be needed by loved ones (Emslie et al., 2006; Oliffe & Han, 2014). However, this could become a motivator to suicide if men felt their families would be better off without them (Emslie et al., 2006). Subjects recovering from depression were found to reconstruct their masculinities according to hegemonic norms, finding strength in male company. They highlighted the importance in re-establishing independence, e.g. through medication. Others framed their recovery in hegemonic masculine terms, e.g. as battle. However, it should be noted that such subjects were a minority (Emslie et al., 2006).

Within the US military, Burns and Mahalik posit that emphasising self-reliance may help some servicemen retain some control over mental illness and encourage deliberate acts to overcome depressive symptoms. They argue that physicians can reduce feelings of shame by highlighting such possibilities which do not discard hegemonic masculinity (Burns & Mahalik, 2011).

Subordinate or Marginalised Masculinities

Subordinated or marginalised masculinities were rarely discussed, with only two articles explicitly addressing the concepts. Emslie et al. found a minority of those recovering from depression emphasised their differences with hegemonic masculinity, constructing a separate masculinity. They emphasised that depressed men may have more intelligence or sensitivity than others. Two ethnic minority gay men identified depression as just another difference and took pride in their differences; their distance from hegemonic masculinity helped them to construct a separate masculinity (Emslie et al., 2006).

Scourfield further suggests a subordinate mentally ill masculinity, suggesting that by aspiring to masculine rationality we identify the "irrational" as mentally ill (Scourfield, 2005). Branney and White also propose that differing behaviours in men with depression may be seen as the performance of a depressed masculinity; that aggression, substance misuse and suicide are ways of "doing depression" (Branney & White, 2008).

Homosexual masculinities were also discussed very briefly. The marginalisation of homosexual masculinities is established at a young age through homophobic insults (Emslie et al., 2006), and coming out as gay was a key factor in two suicide attempts (Cleary, 2012) reflecting higher suicide rates for homosexual men (Scourfield, 2005).

Discussion

Connell's concept of hegemonic masculinity hinges on the idea of multiple masculinities defined not only by their content but by power relationships between them. Most articles identified here mention these concepts, but go on to examine masculinity as a single form, albeit renamed hegemonic masculinity. As with sex role theory, variations from this normative masculinity are seen as deviant, with alternative masculinities rarely considered. Masculinity is thus a homogenous, oppositional counterpart to femininity rather than a relational

hierarchy of competing masculinities. Only two articles explicitly discussed subordinated or marginalised masculinities and this is very brief, leaving little recognition of intersectionality. There is, for instance, no discussion about different constructions of masculinity in different socioeconomic contexts despite the known relationship between deprivation and suicide rates (McLean, Maxwell, Platt, Harris, & Jepson, 2008). There is also no discussion of the power relationships between masculinities. Without this discussion, theories of multiple masculinities risk being reduced to a mere typology.

Another drawback in the literature is the small range of contexts within which hegemonic masculinity and suicide has been studied. While the greater proportion of suicides occur in low- and middle-income countries (World Health Organization, 2014), most research has taken place in high-income countries. This may explain why hegemonic masculinities were found to be similar in all the identified articles.

Future research in this area should focus on the power relationships within and between genders and the importance of subordinated or marginalised masculinities. Before such research is undertaken, the implications of theories of multiple masculinities for policy makers and mental health workers are unclear. The current literature may be useful in providing a deeper understanding of some hegemonic masculine traits within Western contexts and how these traits are performed in the context of suicidal ideation and behaviour. However, without greater understanding of alternative masculinities, the degree to which such traits can be subverted, resisted, co-opted or adapted will remain unclear.

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original article

Activating boys to reflect on masculinity norms: the Dutch campaign *Beat the Macho*

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Traditional norms of masculinity can lead to many problems in society for both men and women. In his book Real Boys (1998) psychologist William Pollack argues that masculinity norms emphasizing stoicism have harmful consequences for boys growing up, such as depression, anger and aggression, and the risk of suicide. Other studies reveal that masculinity norms negatively effect the development, health and wellbeing of boys (Barker, 2000; Connell, 1995; Jackson, 2002; Smith, 2003) and the quality of friendships and romantic relationships (Connell, 1995; Kroeper, Sanchez & Himmelstein, 2013; Pollack, 1998). Moreover, men with hostile, suspicious and dominating attitudes towards women are more prone to commit physical and sexual violence against women (e.g. Hines, 2007; Malamuth, Linz, Heavey, Barnes, & Acker, 1995; Ward & Beech, 2006). Reason enough for the Dutch Ministry of Emancipation to finance a pilot project aimed at changing traditional norms of masculinity amongst boys, the campaign *Beat the Macho*.

Methods

Development of the Campaign Beat the Macho

The campaign Beat the Macho was built upon four key elements of successful programmes aimed at transforming inequitable gender norms (Pulerwitz, Michaelis, Verma, & Weiss, 2010). Pulerwitz et al. concluded in their review that engaging men to think critically about gender inequality is the first key element, for instance by using group education sessions and social marketing campaigns to prompt men to reflect on how gender inequality plays out in their own lives. Secondly, a focus on younger men is most effective. Adolescence is a time when gender role differentials start to widen, creating advantages and vulnerabilities for young men. Interventions that reach young men can provide a counterbalance to peer pressure. Thirdly, a combination of interactive, small-group, male-only education sessions and community-based activities (e.g. a social marketing campaign) appears to be the most effective strategy. Fourthly, media can play a big role in social change, for instance addressing gender inequity in soap operas and radio shows.

The campaign Beat the Macho contained three phases:

1. In seven towns workshops were held with adolescent boys between 14 and 20 years old. Mostly male trainers worked with seventy boys on the issue of masculinities using gender transformative methods. The trainers received a training manual and a two-day course. After exploring their concepts of masculinities, boys were asked to recount situations in which they felt pressured to conform to specific male gender norms. Together the group of boys concluded on a collective storyline that represented the experiences of many of them. This led to seven storyboards that formed the starting point for the next phase.

2. The storyboards were transformed into comics and posted online. Popular online YouTube artists ('vloggers') asked boys to visit the internet page and comment on the comics, and to make suggestions

how to solve the situation in the comic appropriately. Almost 7000 boys commented on the comics. They also voted which comic was most relevant to their lives.

3. The content of these online discussions formed the basis for a hip-hop song, made by two popular Dutch artists. The song 'Luister naar jezelf' (Listen to yourself) was posted online and boys were asked to submit a short clip of themselves singing part of the song, to be included in the final video. The final song and video were also posted online and received media coverage via popular radio shows. Some groups of boys were so enthusiastic that they made a song of their own and performed it at a local festival.

Research design

The research had two aims. Firstly we wanted to gain insight into the lived realities of boys when it comes to masculinity norms: how do they experience masculinities, what are their experiences with social pressure and how do boys cope with this pressure? Secondly we wanted to look at the process of gender transformative work: do boys open up to it, under what circumstances does it work for them, what can we achieve with it? Five different research methods were used: (1) participatory observation during the workshops, (2) semi structured interviews with the trainers, (3) content analysis of the story boards, (4) thematic analysis of the comments online on the storyboards and (5) retrospective interviews with boys who participated in the campaign.

Results

Boys and masculinity norms

The aforementioned research methods allowed us to identify key overarching experiences of boys with masculinity norms. In most groups the boys recognized the theme 'social norms to behave like a real man' immediately. The workshops contained different methods to explore the concept of masculinity. For example boys were asked to make a sequence of photographs of different men, lining them up from very masculine to not so masculine. The explanations about their choices clarified their

Table 1

Key elements of masculinity for the participating boys with negative and positive forms of expression

Negative (for self or others)	Aspect of masculinity	Positive (for self or others)
Bragging, bluffing, lying, not coping with losing	Wanting to win	Winner' s mentality, perseverance, guts, wanting to excel
Mobbing, wanting too much attention, vanity	Seeking attention	Being funny, an entertainer
Peer pressure, rearing, being bossy	Dare to be yourself	Being sincere, having the guts to be different
Being a player, chasing women, having to have a big car	Acquire social position	Looking after your girlfriend and your family
Indifference towards school, nonchalance	Performance	Respect for craftsmanship, men who are successful in what they do
Negative self-image because you have a migrant background or are discriminated against	Perseverance	Respect for men who overcome setbacks, like successful football players who grew up in slums
Anti-social behaviour, aggression, intimidating others	Autonomy	Enjoying life and making others enjoy it too; don't bother, just do your own thing
Fighting against somebody or something	Fighting spirit	Fighting for an ideal, a dream

concepts of masculinity. In some subgroups the photograph of a man carrying his child was on top, as fatherhood was seen as the ultimate form of masculinity. Others preferred football players that performed very well, stating they showed perseverance. Nelson Mandela was a popular role model as well; boys stated he had the guts to stand up against the regime. During the workshops boys showed positive and negative feelings towards the concept of masculinity. Many opinions reflect two sides of the same coin. 'Having guts' for instance is highly appreciated, but bragging is not appreciated at all. Both behaviours are connected to a characteristic that is viewed by boys as typical masculine: a winner's mentality. Table 1 displays the key aspects of masculinity for the participating boys, and their negative and positive forms of expression.

After their reflection on masculinities boys were invited to come up with their own life experiences with social norms of masculinity. The participants expressed many occasions in which they felt pressured into doing things they did not feel comfortable with. Their stories can be clustered in two themes: (1) peer pressure to cross boundaries and join activities such as stealing, mobbing, fighting, using drugs and alcohol and harassing girls and (2) fear to be rejected for exhibiting gender non-conforming behaviour, for instance by not wearing the right clothes, not liking football or R&B music, not being assertive. The seven storyboards the boys developed collectively combined their own stories to a story they could all identify with.

After the seven scenarios were posted online most boys advised the main character in the scenario that either he should have the guts to do his own thing or he should point out to his peers to behave themselves (with remarks like 'get a grip on yourself' and 'are you crazy?'). A smaller group reacted to the social pressure on the main character by saying he should comply with his peers, act out in an aggressive way or outdo the others. The third smallest category contained reactions that served to establish the masculine status of the respondent, by displaying dirty language and jokes, suggesting they did not take the scenarios seriously but felt a need to express that nonetheless. Boys were asked to vote which scenario was most relevant to their lives. The two scenarios about girls were chosen most (together 66% of the votes).

Gender transformative work

With regard to the second research aim, the workshops illuminate the conditions needed to create a safe space for boys to reflect on masculinities. Peer pressure amongst boys remained an obstacle for an open exchange of experiences. If the atmosphere was not safe, boys easily slipped back to performing macho behaviour, making jokes and showing off, to ensure their social position in the group. This was contra-productive in the process of reflection and transforming gender norms. The traditional norms of masculinity were confirmed,

Table 2
Content of the seven storyboards

Peer pressure	Rejection because of gender non-conform behaviour
Your friends challenge you to touch the breasts of a girl who is dancing in front of you	Your friend is laughed at because he is afraid of dogs
You are with your girlfriend and your friends ask you to come to hang out together	You are laughed at because you like ballet
Your friends pressure you to rob a shop together	
Your friends are about to beat somebody up	
Your friends steal something from the shop	

weakness was punished, and homosexuality was taboo. This happened for instance during a workshop when one of the boys explained his attitude towards homosexuality. He said everybody has the right to be who he is, but he did not felt comfortable with men displaying explicitly that they were gay, such as an actor in a well-known TV 'soap opera'. The other boys laughed at him for watching soap television and called him a 'faggot'.

The competences of the trainers are absolutely crucial. Important elements are the use of humour, being authentic, playful, taking the boys seriously and daring to show their own vulnerability. Although there were also good workshops leaded by a combination of male and female trainers, the participants spoke out more openly when the trainers were male. Male trainers could open up the discussion by using examples from their own experience. Other conditions for safe spaces are trainers who are clear about the rules and who do not hesitate to intervene when boundaries are crossed, in a friendly, respectful way.

Discussion

The campaign confirms the conclusion of Pulerwitz et al. that a combination of interactive, small-group, male-only education sessions and a social marketing campaign is an effective strategy. The concrete task of making storyboards that would be published online and the chance to be part of a song by famous artists stimulated the active involvement of boys during the workshops. We also found that adolescent boys are really open to talk about the issue when a safe space is offered. Boys reflect in the retro perspective interviews that it was the first time they could freely and openly exchange these experiences. Adolescence seems a good moment to invite boys, as in this period many boys feel insecure and lost. As one of the participants stated: "Beat the Macho helped me to open up. When you go to high school nobody prepares you. Big chance that you do not feel comfortable. Big chance you do not dare to be yourself. You become very introverted. Beat the Macho is a good instrument to help you reflect, connect and open up."

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original article

Boy's health- what may be learned from three decades of HBSC Survey

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Adolescence constitutes a critical period in a person's development when many health-related behaviours are formed or consolidated. Considering current knowledge about development and health, it has been acknowledged that even if the endpoint of pubertal development appears to be similar for both genders, the trajectories that boys and girls follow are quite different. Gender is often considered a determinant of health which moderates the impact of social determinants of health (Keleher, 2004). Using a selective understanding of gendered health by which the health outcomes and behaviours are compared between genders, the Health Behaviours in School-aged Children (HBSC)[1] Survey has since the early 1990s managed to gather important information on gender specificity of key health related behaviours in adolescence (Currie, 2008, 2012).

For 30 years the HBSC Survey has been a pioneering cross-national study gaining insight into young people's well-being, health behaviours and their social context. This research collaboration with the WHO Regional Office for Europe is conducted every four years among school children aged 11, 13 and 15-years old. Currently, 44 countries and regions in Europe and North America take part in the study. With adolescents making about one sixth of the world's population, HBSC uses its findings to inform policy and practice aimed at improving the lives of millions of young people.

Below, the key findings related to boys' health from the past 30 years of HBSC research on school-aged children's behaviours are summarised. Four main domains will be focused on: social context, health outcomes, health behaviours, and risk behaviours.

Social context. The HBSC Study examines young people's views on their interactions with family, peer and school. We find that boys are likely to find it easier to communicate with their fathers than with their mothers, a finding that is consistent across countries and age-groups. HBSC evidence also indicates that boys are more likely than girls to spend evenings (after 8pm) with friends. Older adolescent boys (15-year olds) report the highest prevalence of evening peer contact, as well as having a larger number of close friends than younger boys or similar girls. Boys are less likely than girls to report good academic performance or that they like school a lot, but they appear to feel less pressured by schoolwork. Some of the aforementioned outcomes are associated with socio-economic status. For example, boys from higher socio-economic families are more likely to find it easy to talk to their parents; indicate having better academic performance, as well as having a larger number of close friendships or using more frequent electronic means to communicate with their peers. These associations are seen across all participating countries in the HBSC 2010 survey, as well as among both genders (Currie et al., 2012).

Health outcomes: This dimension encompasses measures about perceived health status, well-being, body image, and medically attended injuries (having had at least 2 injuries in the past year that needed it

[1] At present, membership of HBSC is restricted to countries and states within the WHO European region, and it comprises of 44 countries (all the EU member states and regions, plus Albania, Armenia, Georgia, Iceland, Israel, Luxembourg, Norway, Macedonia Malta, Republic of Moldova, Russian Federation, Switzerland, Turkey, as well as Canada and the USA).

to be treated by a doctor or a nurse). Extensive academic publications and international reports using HBSC data indicate that boys are less likely to perceive poor health or have multiple health complaints (Cavallo et al., 2006; Ottová-Jordan, Smith, Augustine, et al., 2015; Ottová-Jordan, Smith, Gobina, et al., 2015). As they grow older, these gender differences are seen in almost all countries included in the study, and they seem to grow with age (Ottova-Jordan, Smith, Augustine, et al., 2015). Similar findings have been reported using longitudinal (Resnick et al., 1997) or cross-sectional studies (Bolognini, Plancherel, Bettschart, & Halfon, 1996). Boys tend to report higher levels of injuries requiring medical treatment. A significant increase in this prevalence has been seen over time (2002-2010) in most of the countries included in the survey (Molcho, Walsh, Donnelly, de Matos, & Pickett, 2015). The gender difference in reporting medically-attended injuries may be explained, in part, by boys' higher level of engagement in physical activities (Molcho et al., 2015). Even though boys from all three age categories report higher levels of obesity than girls, they are less likely to indicate that their body is too fat or that they engage in any weight-reduction behaviours (Currie et al., 2012). Some of these indicators are associated with family affluence. For example, across all countries boys from higher affluence families are more likely to report high life satisfaction, to have lower levels of health complaints or to rate their health as being poor.

Health behaviours. This dimension includes indicators on: eating behaviours, physical activity and sedentary behaviours. According to the HBSC 2010 International Report, even though boys are more likely than girls to have breakfast daily, they tend to have higher levels of overweight/obesity and unhealthy eating habits (eating less fruits and vegetables and more frequently consuming sweets, chips, crisps or soft drinks). Across all countries boys tend to report higher levels of engagement in moderate-to-vigorous physical activity (MVPA), with younger boys reporting higher levels. Boys have shown a greater increase than girls in MVPA rates in recent years, a trend which is consistent across all participating countries (Kalman et al., 2015).

Risk behaviours. Within HBSC framework, several risk behaviours are taken into account: substance use (alcohol, tobacco, and cannabis), sexual experiences, and violence (fighting, bullying perpetration and victimization). Boys tend to have earlier onset of tobacco use, alcohol consumption or cannabis use, as well as higher levels of weekly alcohol consumption across all countries included in the HBSC 2010 Survey (Currie et al., 2012). In a minority of countries, boys had higher levels of weekly/lifetime tobacco and cannabis use compared to girls. Boys tend to have higher levels of involvement in violent behaviours (fighting and bullying perpetration) across all countries and age groups (Molcho et al., 2009; Molcho et al., 2015). With increasing age, the prevalence of these externalising behaviours tends to decrease. The report of being bullied by peers tends to be less gendered polarized, whereas boys are reporting higher levels of victimization in a minority of countries (Chester et al., 2015). No consistent pattern of associations has been observed between these behaviours and family affluence.

Lessons learned- implications for practice and public health policies

To summarise, HBSC findings highlight internationally-consistent gender differences in adolescent health behaviours and health outcomes. The 2014 HBSC International Report will expand upon these findings and focus on gender and socio-economic differences in young people's health and well-being. Special attention may need to be paid to boys' well-being at school, as they are systematically worse-off than girls when considering the holistic school experience. Previous research indicates that school performance and school connection are protective factors against health risk behaviours such as substance use, risky sexual behaviour or suicidal

ideation (Resnick et al., 1997). It is important to note that similar to previous findings (Kuntsche et al., 2011), gender equalization of the prevalence for some risk behaviours (e.g. smoking and drinking) has been observed in recent years. Even though in western societies, tobacco and alcohol use has been widely associated with masculinity and men had higher prevalence of reporting such behaviours, this gender gap has become less evident for both adults and adolescents in the past decades (Pitel, Geckova, van Dijk, & Reijneveld, 2010). Changing social norms and expectations about gender specific behaviours, as well as the changes seen in women's social position might explain this emerging tendency (Lyons & Willott, 2008).

These results point out to a need for adopting a gender-specific viewpoint when analysing health behaviours and outcomes, as well as when designing specific health promotion interventions. In domains such as violent behaviour, school engagement or mental health promotion, practitioners and policy makers should consider these gender differences in terms of prevalence and specific risk and protective factors. It is important to note that *adolescent boys like adolescent girls are a heterogeneous population. Some are faring well in their health and development. Other boys face risks and have needs that may not have been considered* (World Health Organization, 2000, p. 7).

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original article

The application of intervention mapping in developing STI/HIV health education program for traditionally circumcised men in the Eastern Cape Province of South Africa

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South Africa faces challenges in reducing the incidence of human immunodeficiency virus (HIV) infections. In 2012, approximately 5.5 million persons reportedly lived with HIV, with an infection rate of 11.6% in the Eastern Cape Province (Shisana et al., 2014). Heterosexual intercourse is reported as the primary mode of HIV transmission in South Africa. Several studies demonstrated that well-designed HIV/AIDS education programmes have positive effects on reducing risky sexual behaviours among young people including delaying sexual debut, reducing the number of sexual partners, increasing condom negotiation skills and use (Gallant & Maticka-Tyndale, 2004; Johnson, Carey, Marsh, Levin, & Scott-Sheldon, 2003; Kaaya et al., 2002;).

Health promotion programs have been found to be the most effective when developed and implemented in a systematic manner following a proper planning and evaluation model. Nowadays, the commonly used planning model is Intervention Mapping (Bartholomew, Parcel, Kok, & Gottlieb, 2006). Intervention Mapping (IM) is a framework that provides a systematic approach for the development of health education programs that are based on evidence and theory and it consists of six fundamental steps (see Figure 1). IM has been used in South Africa to create health promotion interventions (Draper et al., 2014; Aaro et al., 2014; Kolbe-Alexander et al., 2012). To our knowledge, there is no STI/HIV health education program designed for men who have undergone initiation and traditional male circumcision (ITMC).

ITMC is a cultural practice that has evolved over centuries in different parts of the world including South Africa. It is practiced as a rite of passage that marks the transition from boyhood to manhood in the Eastern Cape Province. During the rite of passage, young males are taught by men who have also undergone the same ITMC processes about appropriate sexual behaviours including the dangers of promiscuity, marriage, starting a family and taking responsibility within the community (Meissner & Buso, 2007; Vincent, 2008), which contributes to the development of ethnic identity. Ethnic identity has been described as the degree to which a person identifies with and is involved socially, politically, emotionally, behaviorally or spiritually in cultural beliefs and practices of one's racial/ethnic group (Langford et al., 2010; Saylor & Aries, 1999).

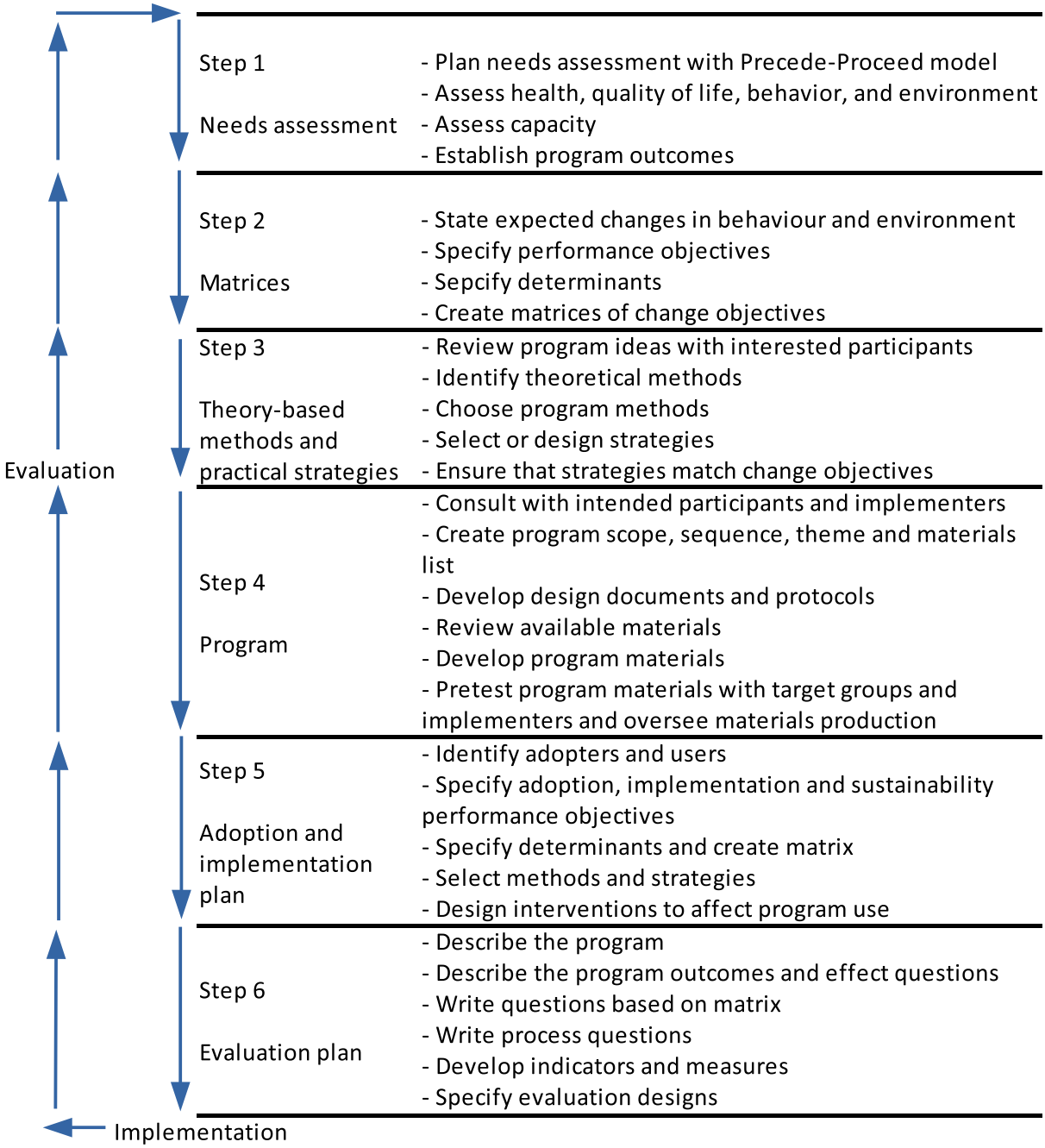
Aim

In this paper we describe the application of the IM in the development of an STI/HIV health education program, which can be integrated into the ITMC practices in the Eastern Cape Province of South Africa.

Step 1: Needs assessment

This step involves an analysis of the health problem, associated behavioural and environmental

Figure 1. Intervention Mapping Protocol



conditions, and determinants of these conditions for the population at risk. In this paper, we reviewed sexual behaviours that place traditionally circumcised men at risk of STIs/HIV. A cross-sectional study among initiates found that 79% of the participants were already sexually active before ITMC (Nyembezi at al., 2010). A study among traditionally circumcised men in Cape Town reported participants engaging concurrent sexual partnerships and unprotected sex (Eaton, et al., 2011). Nyembezi at al., (2012) study also showed that 41.4% of the participants were in concurrent sexual partnerships;

and the intention to reduce the number of sexual partners was associated with the intention to be a responsible man, attitudes towards gender based violence, attitudes towards sexual coercion, subjective norms towards gender based violence, subjective norms towards responsible man's family welfare, self-efficacy towards having one sexual partner and positive self-esteem. A cross-sectional study conducted by Nyembezi, Ruiter, et al. (2014) revealed that about 49% of the participants reported consistent condom use; which was positively associated with the knowledge of condoms, positive attitudes towards condom use with main and casual sexual partners, positive subjective norms towards condom use with the main sexual partner, perceived self-efficacy towards condom use, positive self-esteem, positive beliefs about male circumcision and STI protection, positive attitudes towards gender based violence and ethnic identity towards cultural alienation. In another study, participants who expressed high as opposed to low cultural affiliation were significantly more likely to use condoms consistently and correctly when having sex, especially if they reported to have more than one sexual partner (Nyembezi, Resnicow, et al., 2014). Low levels of HIV testing are not unusual among young men of South Africa. A study among traditionally circumcised men revealed that 35.1% tested for HIV, of those 46% reported inconsistent condom use; the intention to test for HIV was positively associated with the perceived probability of getting an STI, positive attitudes towards gender-

Figure 2. Proposed Matrix of change objectives for condom use behaviour among initiated and traditionally circumcised men in the Eastern Cape Province (continued)

Performance objectives	**Personal Determinants**					**External Determinants**
	Knowledge	**Attitudes**	**Perceived norms**	**Self-efficacy**	**Risk perception**	**Social support**
Plan high quality condom use (Government provided)	Describes the benefits of using quality condoms in preventing STI/HIV and pregnancy	Expresses feeling good for being prepared for condom use			Describes how lack of planning increase risks of STI/HIV and pregnancy	Supported by sexual partner in planning for condom use
Obtain good quality condoms	Identifies places where government provided condoms can be obtained	Expresses importance of obtaining good quality condoms		Expresses confidence in obtaining quality condoms		Sexual partner supports obtaining quality condoms
Check expiration date	Mentions that condoms deteriorate with time			Expresses confidence in checking condom expiration date before use	Recognises risks of use of bad quality condoms	
Always have quality condoms accessible	Lists effective places to keep condoms accessible and in good conditions				Describes why not having quality condoms is risky for STI/HIV and pregnancy	Sexual partner supports and checks availability of quality condoms

(continued)

Figure 2. Proposed Matrix of change objectives for condom use behaviour among initiated and traditionally circumcised men in the Eastern Cape Province (continued)

Performance objectives	Personal Determinants					External Determinants
	Knowledge	Attitudes	Perceived norms	Self-efficacy	Risk perception	Social support
Discuss benefits (prevention of STI/pregnancy) of using quality condoms with sexual partner and peers	Mentions importance that sexual partner and peers also understands benefits of using condoms					
Negotiate condom use with sexual partner	Lists steps on negotiating use of quality condoms	Recognises negotiating condom use as important for responsible man		Expresses confidence in negotiating condom use with sexual partner		Sexual partner reacts positively when discussing condom use
Demonstrate correct use of condoms	Names all steps in correct use of condoms	Recognises safe outcomes of correct use		Feels confident in showing correct condom use	Describes how incorrect condom use increase risks of STI/HIV and pregnancy	Sexual partner helps in correct use of condoms
Consistent condom use for every sexual encounter	Describes why correct condom use with every sexual contact is needed	Feels good towards using quality condom every time when having sex	Expects that sexual partner, peers and significant others want you to use condoms every time when you have sex	Feels confident in using quality condom with sexual partner every time when having sex	Mentions risks of inconsistent condom use	Sexual partner peers and significant others support decision of using quality condom every time when having sex

based violence, received general teachings about being a responsible man and highest grade passed (Nyembezi at al., 2013). This evidence provides justification for the development an STI/HIV health education program. Behavioural objectives should focus on promoting the delay of sexual intercourse, reducing multiple concurrent sexual partnerships, increasing consistent and correct condom use for those who are already sexually active and increasing HIV testing.

Step 2: Matrices

In this step, the problem-increasing behaviors and environmental conditions are transformed into problem-reducing behaviours and environmental conditions. This step requires a specification of objectives that include explicit descriptions of the targeted population's behaviour, performance objectives and the personal and external determinants of those behaviours. In this paper, we will provide an example of performance objectives for condom use. We developed a matrix by combining eight performance objectives for condom use and associated determinants to create change objectives (see Figure 2 for a proposed matrix).

Step 3: Methods and applications

In step 3, change objectives should be linked to

practical strategies derived from theoretical methods for behavioural change. A method is a general theory-based technique to accomplish change in behavioural determinants; a practical strategy is the specific application of a method, in such a way that it fits the targeted group and the intervention in context. In the last three decades, social cognitive theories have been developed to understand the determinants of health behaviours, among which the Theory of Planned Behaviour (Ajzen, 1991), Social Cognitive Theory (Bandura, 1986), and Protection Motivation Theory (Rippetoe & Rogers, 1987) are the most commonly used frameworks to explain health behaviour (for integrative approaches, see Fishbein et al., 2001; Montano & Kasprzyk, 2008). For example, the Theory of Planned Behavior proposes that individual behaviour is determined by intention. The strength of intention in turn is determined by attitude, subjective norms and self-efficacy.

Step 4: Program development

The product of step 4 is the actual development and delivery of the program on the basis of the preceding steps. The planners should specify the scope and sequence of the components as well as channels of delivery (interpersonal), delivery system (a lesson delivered during the ITMC processes), program materials and language. This program should be fully designed in close collaboration and consultation with the House of Traditional Leaders, health promoters, research institutions and popular opinion leaders such as chiefs, traditional surgeons, traditional guardians, initiates and men that have undergone the rite of passage, striving for cultural sensitivity. All components of the intervention should be pilot tested for effectiveness before final production and implementation.

Step 5: Adoption and implementation plan

This step requires the planner to delineate what decision makers need to do to assure program adoption and what individuals who are implementing the program need to do to assure reliable and appropriate implementation. The traditional guardians could be chosen as implementers of the program (i.e. teach messages aimed to promote consistent and correct condom use) because of the pivotal role they play in teaching traditionally circumcised men essential responsibilities and appropriate sexually behaviours. The best way to improve appropriate adaptation and implementation of the intervention would be working with a linkage system, collaborating with traditional guardiansfrom the start of the planning process. All the implementers should be trained. The program should be piloted to determine the feasibility and also to allow the implementers to gain experience.

Step 6: Evaluation plan

The objective of this step is to design an evaluation plan that focuses on process and effect of the program. Information from the previous steps can be used to develop questions and measurement instruments. The evaluation should be based on research methods and instruments that will be useful for examining the fidelity and completeness of the program implementation. It should also evaluate the impact on behavioural determinants, environmental conditions and quality of life outcomes. The team might decide to use mixed research methods such us in-depth interviews and survey among implementers and targeted groups to evaluate the program. The effectiveness of the program and implementation could be evaluated in a randomised control trial. One group can receive specific teaching and training on condom use whilst undergoing ITMC, while the other continues with the normal teachings taught to every traditionally circumcised man.

Conclusion

This paper highlights some important aspects about sexual behaviours that put young people at risk of STIs/HIV. As South Africa works to consolidate gains in STI/HIV prevention, it is vitally important that men who have been undergone ITMC are fully involved. We propose that the STI/HIV health education program development should be based on sound theoretical models, use an IM framework and be designed in collaboration with the various stakeholders.

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original article

The influence of body-related-beliefs on sportsmen's body image and muscle dysmorphia: The role of body malleability

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Recent studies on body image have focused on male body dissatisfaction (Baghurst, Hollander, Nardella, & Haff, 2006; Blond, 2008; McCabe & Ricciardelli, 2004; Mosley, 2009). In this area, Pope, Phillips, and Olivardia (2009) suggested muscle dysmorphia as a specific kind of dysmorphophobia centered on body shape, including ideas that the body is not shaped or thin enough, with excessive involvement in physical activity and preoccupations with dieting. This trouble, sometimes described in terms of bigorexia (Mosley, 2009) has been reported in more than 10% of bodybuilders (Pope et al., 2000), and is explained by the high prevalence of unrealistic male body images (Baghurst et al., 2006; Blond, 2008; Jonason, Krcmar, & Sohn, 2009). This result also led Pope et al. (2000) to propose the concept of the 'Adonis complex'. Contrary to women, whose body dissatisfaction is generally related with weight concerns (especially weight loss), the specificity of muscle dysmorphia described in the Adonis complex in men relies more on the desire to improve body shape and to increase muscle size rather than to lose fat (McCabe & Ricciardelli, 2004; Olivardia, Pope, Borowiecki, & Cohane, 2004). Thus, involvement in sport should be considered as both a consequence and a predictor of body dissatisfaction.

However, the links between sport and body dissatisfaction remains unclear, which some research suggesting it is associated with greater body satisfaction (Hausenblas & Fallon, 2002; Weaver & Byers, 2006) whereas others showed that it might be linked with negative perceptions of the body (Davies, Kennedy, Ravelski, & Dionne 1994; Olivardia et al., 2004). Such inconsistencies might be explained by social or motivational factors (Baghurst et al., 2006), while the body weight literature also suggests that body-related-beliefs, and especially implicit theories, should be taken into account. (Schunk, 1995). Burnette (2010) reports that individuals can form entity (fixed) or incremental (fluid) beliefs about their weight and their body. According to Burnette (2010) people with entity beliefs are less likely to be involved in attempts to diet in order to lose weight. Conversely, people who view their bodies as malleable can be involved in excessive physical activity and experience muscle dysmorphia, even while holding negative body perceptions. Then, this study aims at testing the relationship between body image, body malleability and muscle dysmorphia amongst sportsmen.

Methods

Participants were 137 male sportsmen (mean age = 27.4, SD = 1.8) involved in 26 different sport disciplines and recruited from two regional sports training centers located in the south-west of France. Sampling was based on previous agreement of the heads the training centers before presenting the objectives of the study to the sportsmen during annual systematic medical examination. No randomization was used in the sampling procedure, but sportsmen had to be eighteen years old or older to be involved in the study. Athletes who decided to participate signed a consent form and the researchers ensured that the anonymity regarding

Table 1
Descriptive statistics and correlation coefficients for Body Image, Body Malleability and Muscle Dysmorphia

	Descriptive statistics				Correlation coefficients (p.value)		
	Mean	Stand. Dev	Min	Max	BI	BM	MD
Body Image BI	70.8	8.62	43	90	1.00		
Body Malleability BM	35.45	7.11	17	48	.211 (.013)	1.00	
Muscle Dysmorphia MD	44.96	15.18	6	95	-.085 (.325)	.271 (.001)	1.00

the collected data was fully respected. Then, participants were presented with a questionnaire containing standardized measures of body image, body malleability beliefs and muscle dysmorphia and completed the measures during medical examination. According to the French legal system, ethical approval is not required in studies using non-invasive methods, such as self-report surveys.

The body image questionnaire from Koleck, Bruchon-Schweitzer, Cousson-Gélie, Gilliard, and Quintard, (2002) was used to measure general body perceptions. Participants responded to the 19 items[1] on a 5-point Likert-type scale proposing two opposite body descriptors. High scores correspond to positive perceptions of the body. The alpha reliability for this scale was satisfactory (α = 0.87).

Implicit theories about the body related to the concept of malleability were assessed with Burnette's questionnaire (2010) adapted from Dweck's, Chui's and Hong's measure for intelligence implicit theories (1995). The 8 items[2] of the questionnaire are scored on a 6-point Likert-type scale ranging from 1 (really not agree) to 6 (totally agree), high scores corresponding to incremental beliefs (body malleability). This scale exhibited high internal consistency (α = 0.94).

The Male Body Dissatisfaction Scale (Ochner, Gray, & Brickner, 2009) was used to measure participants' scores of muscle dysmorphia. The Cronbach alpha calculated across the 25 items[3] (5-point-Likert-scales) was satisfactory (α = 0.90).

[1] Items such as : "Physically attractive vs Physically unattractive" or "Bad health vs Healthy"
[2] Items such as : "Your body weight is something about you that you can't change very much" or "No matter who you are, you can significantly change your body weight"
[3] Items such as : "I worry about being more muscular" or "I am hesitant to take my shirt off in public because people will look at my body"

Results

Descriptive statistics and correlation coefficients for Body Image, Body Malleability and Muscle Dysmorphia (MD) are provided in Table 1. Moderated hierarchical regression analysis was used to test the influence of body image on muscle dysmorphia and the moderation of that relationship by body malleability. Prior to analysis, independent variables were standardized in accordance with the recommendations of Aiken and West (1991) to avoid the multicolinearity associated with using interaction terms in regression equations. With muscle dysmorphia as the dependent variable, the scores of body image and body malleability were entered as predictors in the first step of the analysis. In the second step, an interaction term representing the multiplicative composite of body image and body malleability was included as a predictor.

Results indicated that body malleability (β = 0.302, p < .001) was a significant predictor of muscle dysmorphia in the first step of the analysis. In the second step of the analysis, a significant negative interaction between body image and body malleability on muscle dysmorphia (β = -0.167, p < .05) was found. These results, including β values, t test statistics, p. values and adjusted R squared are presented in Table 2.

Simple slopes analyses (Aiken & West, 1991) were

Table 2
Results of the moderated hierarchical regression analysis

Step		β	t	p-value	Adjusted R^2 for model
1	Body Image BI	-.149	-1.766	.080	.081
	Body Malleability BM	.302	3.595	.000	
2	Interaction BI x BM	-.167	-2.011	.046	.101

used to decompose the nature of these interactions and are presented in Table 3. We computed slopes for the regression of body image on muscle dysmorphia at three levels of body malleability: the mean and one standard deviation above and below the mean. Then considering the moderation of the body image-muscle dysmorphia relationship by body malleability, unstandardized regression coefficients for muscle dysmorphia were significantly different from zero for high levels of body malleability alone ($\beta = -0.286$, $p < .01$), but not low and medium levels. The slopes illustrating this result are presented in Figure 1. For people with high body malleability beliefs, a negative perception of the body predicts muscle dysmorphia, whereas this is not the case for low and medium levels of body malleability.

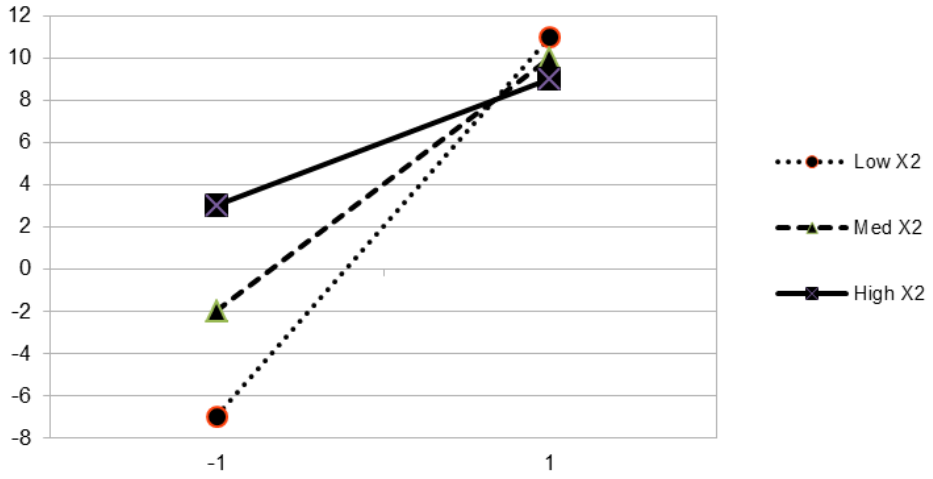
Discussion

These results suggest that body malleability should not be considered as a systematic protective factor against health issues (Dweck et al., 1995): if its positive influence has been demonstrated in the context of weight loss (Burnette, 2010), our findings show that body malleability might also be considered as a vulnerability factor when considering the risks for body image disorders such as muscle dysmorphia. However, our findings support Burnette's results (2010) concerning the influence of specific beliefs on diet intentions, and can be extended to other activities such as excessive physical activity. Nevertheless, this association merits further investigation. One possible avenue would be to examine the relations between body image, body malleability and several measures referring to the principal consequences related to muscle dysmorphia such as addiction to sport practice (Hausenblas & Down, 2001), self-esteem and depression (Olivardia et al., 2004) or specific eating disorders (Davis, Kennedy, Ravelski, & Dionne, 1994). Moreover, if our findings are helpful when considering the predictive factors of muscle dysmorphia, further research remains necessary in order to determine if other psychological variables can explain the relationship. Integrative models including psychological, medical and social factors would provide a more comprehensive picture. The results suggest that specific interventions should be offered to sportsmen with high levels of body

Table 3
Results of the Simple slopes analysis for the regression of body image (X1) on muscle dysmorphia (Y) at three levels of body malleability (X2)

X2 Label	X2 value	Slope between X1 and Y at this value	Slope standard error	t statistic	df	p-value
Low	-1	9	1,612	5,581	96	2,21E-007
Medium	0	6	1,414	4,242	96	5,09E-005
High	1	3	1,483	2,022	96	0,045

Figure 1. Illustration of the Simple Slopes Analysis for the three levels of Body Malleability (X2): Low, Medium, High



malleability who are unsatisfied with their own body. Such a treatment should focus on cognitive and/or behavioral interventions in order to change negative body perceptions to positive and minimize the risks of muscle dysmorphia. The positive benefits of such interventions would merit further examination in longitudinal studies based on different specific sports. The results of this study contribute to a better understanding of male body image disorders including beliefs and self-perceptions.

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original article

Researching men: Main issues and challenges in qualitative research

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While research on men (but not masculinities) has a long history as the majority of contemporary social science refers to the male experience (Tosh, 2011; Yarrow, 2001) the lack of adequate methodology for researching men's lives from a gender studies perspective is still visible. Despite the dynamic development of (critical) studies on men and masculinities within the last 20-30 years (Hearn, 2004) we still "have been struck by the relative lack of interrogation of the epistemologies and methodologies involved in the study of men and masculinities" (Pini & Pease, 2013). Therefore, the main goal of this short paper is to enhance a discussion on men and methodologies by examining the most crucial issues from the field. The paper is based on the author's experiences in conducting gender-sensitive research on men and masculinities from the critical, feminist perspective.

According to Schrock and Schwalbe "qualitative methods provide the best insight into how men present themselves as gendered beings" (Schrock & Schwalbe, 2009) and this is why the paper focuses on this type of scholarly investigations. However, one acknowledges that research on men is also conducted in the quantitative paradigm but "quantitative researchers less commonly examine the more abstract social aspects of masculinities, such as gender differences and inequalities in social connection and exclusion within national populations" (Patulny & Pini, 2013) and therefore, the number of quantitative studies on men and masculinities is still rather low.

One of the most common issues in research on men and masculinities concerns the problem with the recognition that men have a gender and their lives, experiences, problems etc., can and should be analyzed from the (critical) gender perspective as its inclusion (both on theoretical, analytical and methodological level) leads to a comprehensive understanding of the nature of problems that men deal with. Another challenge is connected to the ways in which the gender perspective is being used in such investigations. In other words, the simple inclusion of gender as a category will not shed light on the problem as long as men are viewed as a homogeneous group of individuals, who share the same position in the social structure, experiences, problems and privileges. Only a critical analysis of both men's privileges and the costs of masculinity as well as differences among men (Messner, 1997), preferably with the intersectional approach (Berger & Guidroz, 2009; Cershaw, 1989; Phoenix, 2008), can lead to the full understanding of the character of contemporary masculinities and men's lives. Focusing on just one of these issues is unsatisfactory and such an approach is not recommended. It is important to underline that in men and masculinities studies (e.g., in the research on men's health) one needs to be careful and does not focus exclusively on men who are stigmatized. Researchers should not treat them only as victims of the system since the notion of traditional, hegemonic masculinity (Connell, 2005) plays an important role also when it comes to the cost of masculinity. In other words, it is important to critically analyze the impact of dominant and often toxic forms of masculinity construction on the health status of certain groups of men.

However, the main challenges in research on men and masculinities cannot be limited only to

theoretical dimensions as they are visible also on the analytical and methodological levels. In the process of analysis, one of the most crucial issues is the role of researcher and her/his positioning within the research. Such positioning depends on her/his gender, social class, ethnicity, migration background, nationality, sexuality, age, (dis)ability etc., which can all impact on the process of analysis and may result in drawing different conclusions. Depending of the social background, researchers can be more or less distant and critical regarding certain male practices, behaviors and narratives, which may influence their analysis and knowledge production in various ways. Therefore, in-depth reflection on his/her position in the research process, her/his motivation with regard to conducting research on this particular topic as well as the goal of her/his scientific intervention should be always part of the analytical process.

Several crucial challenges can be also identified at the methodological level, especially in the context of the face-to-face interviews. Firstly, researchers should be aware that what they hear from interviewees is strongly contextualized. Men might decide to perform different narrations when they talk to other men and different narrations when in presence of a female researcher. Many researchers claim that in the case of interviews on sensitive issues it is easier for men to express their closeness or emotions in front of women rather than men. In front of men, male interviewees often try to present themselves as 'real' men and not to reveal too much sensitivity (Williams & Heikes, 1993). Moreover, in some cases, men might be resistant to talk about certain problems with other men and avoid discussing their emotions, vulnerability, fear, sicknesses, body weakness etc. while it might be easier for them to open up in front of women.

Nevertheless, aside from the advantages of being female researchers there are also disadvantages, with power challenges and safety issues.

This is especially challenging when the research participants are men who represent rather traditional and dominant forms of masculinities, usually based on the assumption that the male gender dominates over the female one. In such situations, a female researcher is not able to create a partnered, non-hierarchical relation with the research participant which results in various implications - both for further analysis and for the researcher herself. Finally, female researchers deal with issues such as the impact of physical appearance on the interview process, body and safety issues as well as the problem of flirting or even the threat of harassment and therefore, women need to elaborate individual strategies that enable them to conduct research.

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report

Using N-of-1 methods to study or change health-related behaviour and outcomes: A symposium summary

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N-of-1 methods are increasingly attracting attention as a viable and innovative set of methods in health psychology science. N-of-1 methods focus on changes within an individual (or individual unit e.g. family, hospital) over time and involve repeated measurements to draw conclusions about the individual. N-of-1 methods are advocated by the UK Medical Research Council as methods that can be used to test theories and interventions (Medical Research Council, 2008). They can be used to investigate patterns of individual behaviour and determinants over time and, in contrast to group-based designs that focus on the effect of an intervention *on average*, N-of-1 methods can be used to understand the effect of an intervention on the individual.

Since 2011, the European Health Psychology Society (EHPS) annual conference has featured a symposium dedicated to methods in health psychology. The '5th Methods in Health Psychology Symposium', held at the EHPS annual conference in Cyprus (2015), was on the topic of using N-of-1 methods to study or change health-related behaviour. The symposium aimed to highlight the key features and advantages of N-of-1 methods and how they can be used to address key questions in health psychology science. The purpose of the symposium was to create an interest in the method and discuss areas which currently lack clarity and consensus in regards to the application of N-of-1 methods to health psychology research.

Wayne Velicer (University of Rhode Island) opened the symposium with a strong emphasis on how N-of-1 methods can be used to address research questions that traditional group-based designs cannot. N-of-1 methods provide information about changes in individual behaviour over time which is not well represented in studies using group-based designs. Wayne presented the findings from a study that examined smoking behaviour for a period of 40 days in a group of individuals (Hoeppner, Goodwin, Velicer, Mooney, & Hatsukami, 2008). Analysis of the data at the group level showed that, on average, smoking behaviour decreased over time. However, analysis of the data at the individual level showed that only 12% of the group displayed this smoking pattern. In fact, some smokers had increased their smoking behaviour over time. Wayne highlighted the need for statistical methods for analysing N-of-1 data that can account for potential autocorrelation (i.e. dependency between the data points due to repeated and frequent measurements from the same individual) within the data. Ignoring the existence of autocorrelation in N-of-1 data can have major implications because it results in inaccurate tests of significance and effect size estimates. Furthermore, the study of autocorrelation itself can provide important insights into the function of behaviour over time such as daily and cyclical patterns in health-related behaviours. The dependency in the data can sometimes lead to large autocorrelations, and these have implications for the selection of the statistical method(s) used to analyse N-of-1 data, because the presence of dependency in the dependant variable violates the assumptions of many traditional statistical techniques. Although specialised statistical techniques may be required there is currently no 'gold standard' method of analysis. Wayne concluded that replicating N-of-1 studies across individuals, contexts and settings can

help to identify homogeneous subgroups of individuals with similar health behavioural patterns.

Next, Suzanne McDonald (Newcastle University) presented a summary of findings from a systematic review of N-of-1 methods applied to health behaviour research (McDonald, Quinn, Hobbs, White, & Sniehotta, 2013). The review identified a number of studies using N-of-1 observational and experimental designs to study or change various behaviours including physical activity (PA), treatment adherence, sleep, alcohol consumption, smoking and drug use. Suzanne also presented the findings from a series of N-of-1 natural experiments conducted to understand how PA patterns change during the retirement transition. An N-of-1 design was appropriate because of the considerable heterogeneity in PA trajectories and PA determinants during the retirement transition (McDonald, O'Brien, White, & Sniehotta, 2015). PA, measured continuously by tri-axial accelerometry, and ecological momentary assessments of potential cognitive and affective determinants of PA were collected daily for seven participants approaching retirement. Additional variables of interest were selected by participants and added to the design as potential predictors of their PA. Participants provided data for a continuous period of 4-6 months covering the retirement date and the data were analysed using Auto-Regressive Integrated Moving Average (ARIMA) models (Box & Jenkins, 1970). In this study PA trajectories were found to differ considerably between individuals, with some individuals showing increases in PA levels pre- to post-retirement and others showing decreases in PA levels or no change. The predictors of daily PA also differed between participants and for some individuals predictors of PA changed pre- to post-retirement. The findings showed that the direction, magnitude and predictors of PA change may vary considerably between individuals. At the end of the study the participant's data were discussed with the participant and they were encouraged to take an active role in the interpretation of their data. This resulted in a shared understanding of the data and facilitated a process of knowledge co-creation about individual behaviour change.

Nicola O'Brien (Newcastle University) presented the findings from a series of N-of-1 studies comparing a biomedical, a psychological, and an integrated model of activity and activity limitations to predict walking within individuals with osteoarthritis (O'Brien, Philpott-Morgan, & Dixon, 2015). Most theories of behaviour describe the behaviour of an individual yet are rarely tested at the individual level using N-of-1 designs (Johnston & Johnston, 2013). The study also tested the effectiveness of a data-driven walking intervention. Diary methods were used to assess impairment (pain, pain-on-movement, joint stiffness), cognitions (intention, self-efficacy, perceived controllability) and walking (pedometer step count) in four individuals with osteoarthritis twice-daily over 12 weeks. An AB intervention design was used, where the A phase represented a six week period of measurement prior to the implementation of the intervention and the B phase represented a six week period of measurement after the implementation of the intervention. The intervention was a walking intervention individually tailored to target the factors which were found to predict the individual's walking behaviour during the A phase. Simulation modelling analysis tested relationships between predictors and walking behaviour using cross-correlations and the effect of the intervention for each individual was evaluated by testing differences between the means of the two phases while accounting for identified autocorrelation. Multiple regression analyses examined the predictive ability of the three models. Cognitions were better, more consistent within-individual predictors of walking than impairment. More specifically, the integrated and psychological models, which recognise a role for cognitions in predicting behaviour, accounted for substantially more variance in walking than the biomedical model. In this case the individually-tailored intervention did not significantly increase

walking in any participant. However, the study demonstrated the possibility of using N-of-1 methods as a tool to personalise interventions to individuals based on the unique determinants of their behaviour.

Finally, Falko F. Sniehotta (Newcastle University) presented the findings from a series of N-of-1 randomised controlled trials (RCTs) investigating differential response to interventions targeting increased bouts of PA or reduced sedentary time in individuals with Type II Diabetes. The study design was informed by a previous study which investigated the differential effects of two distinct behaviour change techniques (self-monitoring and goal-setting) to increase walking in normal and overweight adults (Sniehotta, Presseau, Hobbs, & Araujo-Soares, 2012). Intervention and control phases were randomly allocated to different days. Seven participants wore an accelerometer measuring PA for 6 months. The intervention conditions included either a daily prompt designed to increase PA, a prompt designed to reduce sedentary time or a control condition. No prompts were delivered on days following either PA or sedentary prompts to examine the nature of carryover effects (i.e. the effect of an intervention condition carrying over into subsequent days). Participants were also prompted daily to complete ecological momentary assessments of potential cognitive and affective determinants of PA and sedentary behaviour. Bootstrapped time series analyses assessed the effect of each type of prompt for each individual over time and tested for the presence of carryover effects in non-intervention days. Each participant varied in their response to the interventions targeting PA and sedentary time with some responding better to intervention days targeting PA and others responding better to intervention days targeting sedentary time. This study demonstrated how N-of-1 RCT designs can provide a rigorous test of interventions at the individual level. Using methods that provide information about individual response is important, particularly if intervention response is likely to be heterogeneous (Davidson, Peacock, Kronish, & Edmondson, 2014). N-of-1 RCTs can also be used to test specific intervention components (e.g. behaviour change techniques) and can help to identify the most effective combinations, sequences and doses of intervention components for achieving sustained behaviour change (McDonald, Araujo-Soares, & Sniehotta, 2016).

Karina W. Davidson (Columbia University) closed the symposium with a message about how important N-of-1 methods are to the field of health psychology. Specifically, she discussed that although between-subject RCTs are the sine qua non of causal inference, they are not without limitations. Health psychology or behavioural treatments tested in a conventional RCT offer the same treatment to all participants in the intervention group. And, we regularly find that while some benefit from the treatment, others derive no benefit and yet others may even be harmed. And, such a finding can occur even when the average treatment effect is large, and of clinically meaningful and significant benefit—to the hypothetical 'average' participant. This range of benefit (or in some cases harm) available for the actual participants is called the heterogeneity of treatment effect. N-of-1 RCTs offer a low-cost, more precise means by which to overcome some of these limitations, particularly by allowing for the quantitative examination of heterogeneity of treatment effects, and by allowing for individualization of treatment. They can only be used when a treatment is reversible, and the outcome is varying, and can be assessed on a regular basis. This, it turns out, are conditions that are true for many of the symptoms health psychology seeks to treat. Testing our behavioural and psychological reversible interventions first inside an N-of-1 RCT design is a vital methodological advance for health psychology. It allows us to determine for whom a treatment works, and if it should be tailored, rather than presented generically. Only when the heterogeneity of treatment effect is small—a rare occurrence in our field—should we move back to conventional,

between-subjects RCTs.

Summary

The 5th Methods in Health Psychology symposium highlighted the key features and advantages associated with N-of-1 methods and underscored a number of novel opportunities for future research. N-of-1 methods can be used to test theories about individual behaviour and to identify the best interventions for individuals. Furthermore, N-of-1 methods can be used as a tool to develop highly tailored and personalised interventions which are adapted to address the specific needs and preferences of individuals. N-of-1 research can capitalise on the rapid developments in technology and sampling methods that enable investigators to obtain reliable, valid and unobtrusive measurements of behaviour and symptoms from individuals over time (Dallery, Cassidy, & Raiff, 2013; Shiffman, Stone, & Hufford, 2008). The use of N-of-1 methods can make a substantial contribution to many debates within the field and we hope that the symposium sparked interest and enthusiasm for the use of N-of-1 methods in future health psychology research.

Further reading

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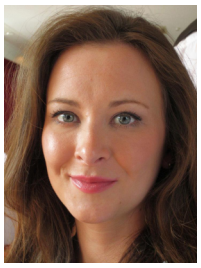

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report

Annual Report - Greece

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Academic development

Besides the post graduate program in Health Psychology at the University of Crete, modules concerning health psychology are also offered in post graduates courses in Clinical Psychology, as well as in Medical Schools and Public Health Institutes. Moreover, there are plans for establishing at least one more post-graduate program in health psychology within the next few years. Additionally, health psychologists are appointed to Universities and the already appointed colleagues obtain higher levels of academic rungs/ positions. Finally, during the last years, a fast growing number of young scientists are applying for PhD programs in Health Psychology.

At present, there is no national law regulating the role of a Health Psychologist, although the title and the practice of a Psychologist are regulated. In general, tasks and responsibilities depend on a complex array of national or setting-related needs and customs. However, a close collaboration between the Hellenic Association of Hospital Psychologists and the Division of Clinical and Health Psychology of the HPS has been established. This collaboration aims at determining the appropriate conditions and procedures regarding the training and supervision of post-graduate students in Health and Clinical Psychology, as well as professionals in the field. In this regard, a leaflet that includes relevant suggestions made by a joint committee was published. Also, an informal task force has been created in order to promote the implementation of these suggestions.

Applied developments - Research

Several research teams exist across Greek Universities. The research work in health psychology carried out in Greece is noteworthy considering the short history of health psychology in the country and the shortage of resources. At the same time, a significant number of Greek health psychologists work as educators and researchers at academic and research institutions overseas:

1) Dr. Evangelos Karademas, Associate Professor in Clinical Health Psychology, Psychology Department, University of Crete

Two large studies are now taking place. The first is a longitudinal study conducted by the University of Crete, Departments of Medicine and Psychology, aims in examining the long-term psychological, cognitive and biological adaptation of patients with autoimmune disorders. The second one, is a clinical trial of a new programme for the psychological management of chronic pain. It is conducted by the University of Cyprus, Department of Psychology and the University of Crete, Department of Psychology.

2) Dr. Christina Karamanidou, MSc Program Leader in Organizational Psychology, the MSc in Psychology (conversion course) and the MA in Counselling and Psychotherapy, the University of East London (UEL) in Greece.

She also teaches at the Health Institutions and Policies Master's course offered by the Social and Educational Policy Department, University of Peloponnese. Furthermore, she is a guest lecturer in various postgraduate programs organized by the University of Athens (MSc in Research into Female Fertility and Reproduction) and the National School of Public Health in Athens (MSc in Hospital

Management, MSc in Public Health, MSc in Applied Public Health).

Since 2008 she has been involved in several European research projects in the areas of health, education and science communication (e.g. AVSA: Audio Visual Science Audiences concerned public's representation of science in 5 European countries and was funded by the E.C as part of the 7th framework Science in Society, EUGATE: European Best Practices in Access, Quality and Appropriateness of Health Services for Immigrants in Europe conducted in collaboration with the National School of Public Health and concerned health services and migrants in 16 European countries and was funded by the E.C., WEBWISE: conducted in collaboration with the National School of Public Health and concerned the evaluation of innovative educational methods and tools e.g. WEB 2.0, e-learning, in public health professional's training). She has established scientific collaborations with the Department of Psychology and the Quality of Life programme in Eginition Hospital, University of Athens and the Infectious Diseases department of the Alpha Institute of Biomedical Sciences, in Athens.

In 2012, she received a post-doctoral research grant from the General Secretariat for Science and Technology, Greek Ministry of Culture, Education and Religious Affairs for her project: 'Knowledge, attitudes and communication preferences of different segments of the Greek public with regards to cervical cancer and the HPV vaccine', which was successfully completed in 2014.

This year, she developed an e-learning course on Health Promotion within the School Context hosted by the University of Athens.

3) Dr. Antonia Paschali, Ass. Professor, Faculty of Nursing, Department of Mental Health and Behavioral Sciences, National & Kapodistrian University of Athens.

Funded Research Projects (2013-2014): "The role of patient-physician communication illness representations and coping behaviors with chronic patients suffering from diabetes mellitus. Special Account for Research Grants of the National and Kapodistrian University of Athens. Grant no: 1896/4-4-2013. "Empathy & the Theory of mind in bipolar patients and their families" Special Account for Research Grants of the National and Kapodistrian University of Athens, Grant no: 1921/10-4-2013. (2014-2015): Principal Investigator: Vassilatis, D. (Biomedical Research Foundation of the Academy of Athens). Collaborator: Paschali, A. (National & Kapodistrian University of Athens) "Behavioral analysis of Parkinson's disease models". The Michael J. Fox Foundation for Parkinson's Research (pending).

She is a reviewer of the official journal of the Hellenic Psychological Society: "Psychology" (http://www.elpse.gr/el/periodiko.html), for the Hippokratia Journal and for the Journal of Health Psychology.

For 2014, she was coordinator of the Clinical & Health Psychology Scientific Society, a division of the Hellenic Psychological Society (ELPSE); she is a member of the scientific committee of the Journal of Cognitive Behavior Research & Treatment (http://ibrt.gr/edu/sites/default/files/profil_periodikou.pdf); from 2014 to date she is member of the Editorial Board, for the Journal "Health Psychology Research".

4) Dr. Cleo Protogerou, CPsychol AFBPsS. Senior Research Fellow, Liverpool Reviews & Implementation Group, Health Services Research, University of Liverpool, UK.

Research has focused on the investigation of factors and psychosocial determinants shaping HIV-risk behavior (especially non-condom use) among young people across cultural settings - South Africa (University of Cape Town), UK (Universities of Bath and Liverpool), the States (University of Connecticut), and Greece (PANTEION). She is currently involved in an international project, with the Universities of Sydney and Botswana, investigating the impact of personal and parental religiosity in young Botswana Pentecostal Church

goers. She conducts primary, review, and 'meta-review' research, combining quantitative and qualitative methodologies. She has also worked for the Greek Organization against Drugs, training teachers into delivering substance prevention interventions for school students

5) Dr. Natasha Soureti, Organisational Health Psychologist, Department of Defense, Part-time lecturer (Cardiff University; Greenwich University). Coordinator of a smoking cessation clinic (www.quit-smoking.gr).

Research interests include: a) use of social cognition models in changing health behaviours in an online or offline setting; b) application of self-regulatory strategies in getting individuals at high risk of developing heart-disease (i.e. overweight, smokers) to eat more healthily and to increase the performance of special populations such as elite athletes; c) testing the impact of different type of risk communication messages on motivation to change; d) at the current job at the police, studying the protective effects of personality traits on depression, anxiety and post-traumatic stress disorder; e) comparison of different type of therapies in helping out unemployed, Greek individuals with elevated levels of depression and anxiety.

Selected Health Psychology Publications

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Protogerou, C., Flisher, A. J., & Wild, L. G. (2014). Factors shaping condom use among South African university students: A thematic analysis. *Journal of Psychology in Africa, 24,* 215-224. doi:10.1080/14330237.2014.906081

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report

Annual Report - Italy

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In Italy, the official scientific society in Health Psychology is the Italian Health Psychology Society (Società Italiana di Psicologia della Salute, SIPSa), established in 1998. The Society (www.psicologiadellasalute.org) organizes a biennial Congress, and publishes a Journal ("Psicologia della Salute", http://www.francoangeli.it/riviste/sommario.asp?IDRivista=72), currently indexed on Scopus.

The current President of the Italian Society of Health Psychology is Pio Enrico Ricci Bitti (2015-2017) (past president Elvira Cicognani).

The Italian Health Psychology Society (SIPSa) organized its XI Congress in Catania (28-30 May, 2015). The Keynote speaker was Irina Todorova. Key themes of the Congress were the following: training in health psychology, health promotion in virtual environments, health psychology in primary care, health promotion in educational settings, organizational models of health services, community health promotion, evaluation of health promotion, health promotion in organizational settings, inequalities in health, quality of life in the elderly.

A key issue in current scientific and professional debate in Italy is the role of Health Psychology in primary care and the emergent profile of "Psicologo di Base" (Primary Care Psychologist), a professional category still formally missing within the Italian National Health Service, even though several significant experiences of collaboration between psychologists and the medical profession have been documented at local levels. A similar profile ("Psicologo del territorio", e.g. territorial/community psychologist) has been introduced at regional level (e.g. Region Campania). Several initiatives have been organized at local level, by Local Health Services in collaboration with the Order of Psychologists (e.g. Treviso, Parma); a national workshop was organized by the Department of Psychology of the University of Bologna in early June.

The discussion will continue in spring 2016, when the Italian Health Psychology Society will organize a national seminar in Rome.

Future important events planned in 2017 Italy are the XII National Congress of Health Psychology (Florence) and the EHPS Conference, which will be organized in Padua.

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report

Annual Report - Norway

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About Health Psychology in the country

There is no national society for health psychology in Norway, but a few researchers are very active.

Norway hosted the EHPS conference: The Social Dimension in Health, August 28, 1995 to August 30, 1995 in Bergen, Norway

Education, training & professionalization

Health psychology can be studied both at a master and PhD-level. This needs to be done in a regular masters in psychology with an emphasis on health psychology.

Research

There are no national journals on health psychology. Norwegian researchers are very internationalized and publish their work in international journals.

Annual Report 2012/2013/2014/2015

There has not been any documented the last years, but Norwegians take part in EHPS international conferences.

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report

Annual Report - Poland

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Conferences and meetings

During the past year two meetings of the Health Psychology Section of Polish Psychological Association took place: one in November 2014 and the second one in October 2015. The latter held an election as a 3-year term of the board came to the end. The new board is as follows:

-President: Helena Wrona-Polańska, Jagiellonian University, Cracow

-Vice-President: Michał Ziarko, Adam Mickiewicz University, Poznan

-Secretary: Agnieszka Pasztak-Opiłka, Silesian University, Katowice

-Members: K. Bargiel-Matusiewicz, E. Gruszczyńska, T. Ostrowski, D. Włodarczyk

The Section comprises of 66 members now.

A national health psychology conference entitled "With Psychology for Health: Prevention and Promotion – Myth or Reality?" was held in Gdansk in May 2015. Organizers: Institute of Psychology of the University of Gdansk, Health Psychology Section of the Polish Psychological Association, Health Psychology Unit of Gdansk University of Physical Education and Sport. It was the tenth, thus jubilee conference, with 20 years of tradition behind it (it is a biennale event). It informs about the stability and maturity of health psychology as a scientific discipline in Poland.

Legislation

The Ministry of Labour and Social Policy has been continuing work on a new regulation act. The process has been slow, but progressive. However, it is difficult to envisage when it will be completed. Thus, once again, it can be stated that the legal recognition of psychology as a profession is still far from the satisfactory in spite of the fact that the attempts to regulate this issue started nearly 15 years ago.

Education

There have been no significant changes regarding educational scheme for studying psychology. Psychology can be studied in a 5-year cycle or in two cycles (a 3-year bachelor's and a 2-year master's degree, separately), although this second option is significantly less popular. All major universities provide health psychology modules but they have different status in curricula, not always making up a coherent health psychology master's programme, which if exists, is usually called 'specialization'. Due to the mentioned reasons in the paragraph above there is no formal certification in health psychology.

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report

Annual Report - Portugal

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Applied developments

In the Health Psychology field, the Portuguese Psychological Association has organized a special training course on "Psychological Interventions in Disaster Situations". This course aims to train psychologists on how to act in disaster situations and thus create a register of 1,000 psychologist volunteers, at a national level, properly trained to act in these situations, who will work in coordination with the relevant authority in this matter, namely with the National Civil Protection Association.

EHPS-related activities

Throughout 2015, we have tried to make the information disseminated by the EHPS available more effectively through the Portuguese Society of Health Psychology (SPPS) platform, with an attempt to inform all SPPS members about EHPS initiatives (i.e., annual conference, CREATE and Synergy initiatives, as well as international employment opportunities). However, there is still need to improve the flow of communication.

Conferences

The SPPS organizes its congress every two years The 11th National Congress of Health Psychology will be held in Lisbon, Portugal, between the 26th and 29th January 2016.

The conference theme is: "Health Psychology Challenges in a Changing World".

Important dates:

Submitting communication proposals - until 30 September, 2015

Communication of acceptance – 30 October, 2015

Registration at reduced prices - until 15th November, 2015

Sending text to the proceedings - until 30 November, 2015

This is a conference that has mobilized colleagues from various countries, with a great expression of interest from Brazil, but which also intends to encourage colleagues from other countries to actively participate!

More information will be available at: http://sp-ps.pt/site

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report

Annual Report - Romania

Catrinel Craciun
Babes Bolyai University

In 2014 we were very happy to celebrate Prof. Adriana Baban receiving the EHPS award for her activity during the health psychology conference in Innsbruck. Also in 2014, Dr. Diana Taut was elected and started her activity as secretary within the EHPS Executive committee.

Research and Publications

In 2014 we finished the FP7 (EU) project "Improving quality and safety in the hospital: The link between organizational culture, burnout, and quality of care" conducted in cooperation with universities from Greece, Ireland, UK, Croatia, Turkey, Portugal, Bulgaria and Macedonia. The project coordinator for Romania was Prof. Adriana Baban. Dr. Diana Taut is conducting a project on breastfeeding among Romanian mothers. Several publications resulted from the completed project on resources for positive aging, conducted by Dr. Catrinel Craciun that appeared in the Journal of Health Psychology and Journal of Aging Studies.

Conferences and Visibility in the Community

Several members of the Romanian Health Psychology Association were present in 2014 at the Psychosomatic Medicine Conference held in 2014 in Sibiu, Romania. Prof. Baban was invited to give a talk at the Psychosomatic Medicine Conference this year in Nuremberg, Germany.

Dr. Catrinel Craciun was invited to give a talk at the German Center of Gerontology in February 2015. She was also invited to take part in the EU meeting on the topic of Active and Healthy Aging in Brussels in March, and at the Gender and Aging Conference organized at the Humboldt University in Berlin, 25-26 June.

Since 2015 the activities of the health psychology association in Romania, have become more visible in the community through a Facebook page coordinated by Dr. Diana Taut. Another channel for engaging with the community has been via television. For instance, Dr. Catrinel Craciun participated in a TV show on psychology topics and talked about how to reach an active and healthy old age.

Education

Another generation of students has graduated from the Master of Clinical Health Psychology and Public Health in 2015. Several MA and PhD thesis were completed this year addressing several topics in health psychology. For example, our colleague Dr. Alina Cosma defended her thesis on bullying in school aged children and is now working as a researcher within the Health Behavior School Children Team.

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report

Annual Report - Switzerland

Jan Willem Nieuwenboom
University of Applied Sciences and Arts Northwestern Switzerland

National Associations

The Swiss Society for Health Psychology (Schweizerische Gesellschaft für Gesundheitspsychologie SGGPsy / Société Suisse de Psychologie de la Santé SSPsyS) is member of the Federation of Swiss Psychologists (FSP). Its main goal is the promotion of Health Psychology as an independent discipline of psychology in Switzerland. It was founded on April 19th, 1997 in Fribourg. Membership requires a university degree in Psychology and practical experience of at least two years in the field of Health Psychology.

As part of the strategy to establish Health Psychology as a separate discipline, the Swiss Society cooperates with other organizations and disciplines in similar fields e.g., Public Health Switzerlandhttp://www.public-health.ch/logicio/pmws/publichealth__home__de.html and Mental Health Network Switzerland http://www.npg-rsp.ch/de/metanav/english.html.

The Swiss Society for Health Psychology is currently headquartered at:

University of Applied Sciences and Arts
Northwestern Switzerland
School of Social Work, Institute of Social Work and Health
Riggenbachstrasse 16
CH-4600 Olten
Tel.: 062 957 21 36
E-mail: holger.schmid@fhnw.ch
Link to webpage:
http://www.healthpsychology.ch/

Education, training and professionalization

There are at least four universities in Switzerland where health psychology is being taught, namely at the universities of Zurich, Lausanne, Geneva and Fribourg. A Master Degree in health psychology (MSc) can be obtained in these universities. A postgraduate curriculum exists in order to attain the professional degree as Health Psychologist recognized by the FSP. With the new federal law on psychology (PsyG) that came into effect by April, 2013, Health Psychology is mentioned in the law as a practical specialization of Psychology in the health system comparable with Psychotherapy and quality standards for a continued formation that should lead to a federally recognized title of "Health Psychologist" were stipulated. Three universities in the French-speaking part of Switzerland have jointly developed a continued formation programme (Master of Advanced Studies MAS) that meets the quality standards. These standards were defined in a cooperative process in which the federal government, the universities, the professional organizations FSP and SGGPsy and the accreditation commission were involved.

Journals

There is no Swiss journal of health psychology yet, but Swiss health psychologists publish in a variety of scientific journals. The Swiss Society for Health Psychology distributes a newsletter at least twice a year.

Other

In Switzerland, Health Psychologists are active in various settings; hospitals (e.g. tobacco prevention), research (at universities and universities of applied sciences) and in the field of networking. One important network, for instance, is the Mental Health Network Switzerland (Netzwerk Psychische Gesundheit/ Réseau Santé Psychique Suisse) which was initiated by the Swiss Federal Government and encompasses three Ministries as well as a health promotion foundation and the GDK/CDS (i.e. the committee of health ministers of the cantons). This network is coordinated by the health psychologist Alfred Künzler: http://www.npg-rsp.ch/ . The Swiss Society for Health Psychology is also consulted in decision making processes with regard to governmental strategies and law-making on relevant fields.

Year 2014-2015

Associations

By autumn 2015, the Swiss Society for Health Psychology counted 74 full members, 19 of whom have the professional degree as Health Psychologist FSP. Note: this title has not to be mixed up with the new federally recognized title mentioned above.

Academic development

A Master of Advanced Studies (MAS) in Health Psychology (90 ECTS credits) has been created as a postgraduate education for psychologists by the "Triangle Azur", a network allowing cooperation between three universities in the French-speaking part of Switzerland (Geneva, Lausanne and Fribourg). Its curriculum consists of three Courses of Advanced Studies (CAS) each with a total of 30 ECTS credits, a specific education in practice, theories and methods (10 credits), a master thesis consisting of a research paper or an intervention report (16 credits), supervision (4 credits) and an internship (or proof of thorough practice in intervention or research) (30 credits). It fulfills the federal quality standards. A recognition as a specialization comparable to psychotherapy is foreseen by the Swiss confederation according to the law on the protection of the profession of psychology. See for more information http://mas-psychosante.ch . The first course is due to start by January 2016.

Current research

In 2015, there was a wide range of research in Switzerland in which health psychologists were involved or which cover fields of Health Psychology.

Conferences

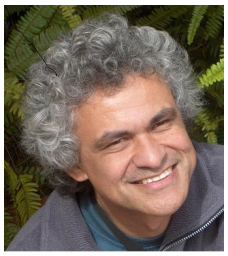
In August 2014, the Swiss Public Health Conference was held in Olten on the topic of Mental Health. It was a cooperation between the School of Social Work of the University of Applied Sciences and Arts in Olten, Public Health Switzerland and the Mental Health Network Switzerland (see also below). Although this was not a Health Psychology conference per se , Health Psychologists played an important role as they organized the conference and took part in the presentations and workshops: http://sph14.organizers-congress.ch/index_de.php.

Wim Nieuwenboom was elected unanimously as new National Delegate of the EHPS. He represented us at the last EHPS-Conference in Limmasol.

The fourth network conference of the Mental Health Network Switzerland took place on August 2015 and health psychologists were involved in it.

Other activities

The Swiss Society for Health Psychology has been asked to give its opinion with respect to a variety of governmental strategy papers and hearings. For instance, we were consulted in a hearing with respect to a draft paper on mental health (20.11.2014) and took a position with respect to conceptual ambiguities and the derivation of options for action. Second, we were involved in the National Addiction Strategy (May 2015). Here, we criticized an approach that is too medical and proposed one that focuses more on the psychological and social determinants of health. Third, members of the board of the SGGPsy were also involved in a consultation about the National Strategy on Non-communicable Diseases in September 2015. Alongside conceptual improvements, an approach that does not exclusively focus on the individual but appropriately takes into account the contextual (social and economic) framework in which health behaviors occur was proposed.



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report

Annual Report - Turkey

Zuhal Baltaş
Istanbul University

Developments / Challenges

• The field of health psychology started to be represented as a separate division in the Turkish Psychological Association. Since 4.11.2014, relevant regulations are officially shared on the association's web site.

• Early in 2015, the Turkish Ministry of Health officially started a new project called "Collaboration Protocol; Moral Support Offering in Hospitals". According to this project, those who graduate from the psychology of religion at the faculty of theology, will be formally responsible for giving "moral support" to hospitalized patients. This project has been heavily criticized by psychologists and psychiatrists across the country.

• Universities and psychology departments are struggling with the problem that there are not enough health psychology courses. Therefore, academic studies and subsequently medical – psychological interventions in the field are not as effective as they could be.

Academic Developments

• Fatih University Psychology department officially opened the first Master's Degree programme in Health Psychology, in Turkey at 2013. Currently, nine students are registered with the programme. Seven of them are at the dissertation stage and the remaining two are preparing their defenses. Curriculum and electives are announced on the university web site (http://sbe.fatih.edu.tr/?yukseklisans,428).

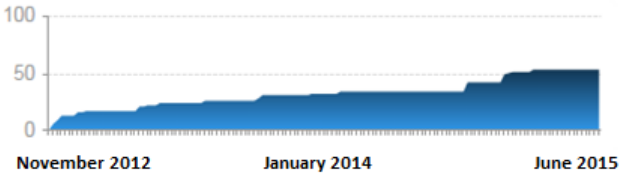
• Few other universities were announced combined Master's Degree programmes with clinical psychology on the term of 2014-2016.

EHPS-Related Activities

• Activities on the Linkedin Platform

We resumed sharing posts from the EHPS mail bulletins on our Linkedin platform, "Turkish Health Psychology Group", which has academics, practitioners and students among its members. We translated and re-posted four conference announcements, three job advertisements, two research projects, and two content notifications for the new issues of Psychology & Health journal, and European Journal of Health Psychology.

As seen in the graph below, our number of members increased to 59 since November 2012.



• *Announcement of the 29th EHPS Conference in Limassol, Cyprus*

We informed the directors of psychology departments at the universities, developed and delivered the posters of the 29th EHPS Conference in Limassol, Cyprus.

• *Announcement of the CREATE Workshop "Writing science for journals, funders and other audience" for the 29th EHPS Conference in Limassol, Cyprus*

We delivered the workshop announcement to 35 universities in Turkey, which have psychology departments and/or health psychology instructors, and encouraged them to inform their students.

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report

Annual Report - United Kingdom

Angel Chater
UCL School of Pharmacy

Health Psychology in the UK (2014-2015)

The British Psychologi-cal Society's (BPS) Division of Health Psychology (DHP) aims to support and promote the discipline of Health Psychology, both nationally and internationally. The DHP had 1,993 members in total as of July 2015, constituting 686 full members, 1,115 general members and 192 members in-training. Membership has reduced over 2014-2015, rather than the usual increase year on year (1,601 in 2010, 1,676 in 2011, 1,947 in 2012, 2,036 in 2013 and 2,115 in 2014) and this appears to be mainly a reduction in general membership (1,224 in 2014).

The DHP committee, chaired by Sasha Cain during 2014-2015, alongside past Chair Professor Paul Bennett and Chair elect Professor Karen Rodham, has key sub-committees to help support and promote the discipline in the areas of Research, Practice, CPD (continuing professional development), Training, Publicity and Liaison, Postgraduate Affairs and Conference organization. DHP Northern Ireland (Dr Noleen McCorry), DHP Scotland (Hannah Dale), and DHP Wales (Dr Michele Gray) are also represented in their own right. Furthermore, Anna Sallis has joined the committee as the Policy officer to facilitate links between the Division and public health policy.

The Health Psychology in Public Health Network (HPPHN) has now been launched, Chaired by the Director of Public Health, Hertfordshire, Jim McManus, with myself (Dr Angel Chater) as Chair Elect, and had its first annual general meeting (AGM) in February 2016. For further details please contact the HPPHN secretary admin@hpphn.org.uk. This network aims to bring together academics, practitioners and policy makers with an interest in applying health psychology to public health.

More information on the DHP, along with activities, events and targeted leaflets that give details about Health Psychology to the general public, employers, employees, GPs, Directors of Public Health and commissioners can be found on the website through the following link: http://www.bps.org.uk/dhp

Training and Professional Development in Health Psychology in the UK

Requirements for training in Health Psychology in the UK remains as a 1 year full-time (or 2 year part-time equivalent) MSc in Health Psychology, which when accredited by the BPS leads to a Stage 1 qualification in Health Psychology. This must then be followed by a period of 2 years (or part-time equivalent) supervised practice in Health Psychology which must show competency in the key areas of generic professional practice, research, teaching, consultancy and behaviour change for a trainee to be eligible to apply for Full membership of the DHP and Chartered Status with the BPS. This training provides the trainee with the Standards of Proficiency (SoPs) needed to register with the Health and Care Professions Council (HCPC), a legal requirement to be able to practice as a Health Psychologist in the UK. There are currently 33 accredited MSc Health Psychology (Stage 1) programmes within the UK registered on the BPS accredited programme site.

Stage 2 can studied through either a university route, of which there are 6 accredited courses in the UK, or via an independent route, whereby the student would be independently supervised by a suitably qualified Health Psychologist to gain the competencies through a BPS agreed training plan. For this, supervisors should be registered on the RAPPS (Register of Applied Practice Psychology Supervisors), which can be found on the BPS website.

Supporting continuing professional development (CPD) portfolios in health psychology, the CPD sub-committee of the DHP, chaired by Francis Quinn is continuing to host events in the area. These are advertised through the BPS learning centre and have this year included topics such as Behaviour Change Intervention Design, Mindfulness and Health, and Acceptance and Commitment Therapy (ACT). This represents the increasing interest in skills relevant for the practitioner aspects of the discipline.

Many of our members including myself continue to deliver career talks around the country, with a focused session for Health Psychologists in Training at our last annual meeting. Our Twitter account is growing year on year and in July 2015 we had 3,359 followers (up from 2,824 last year). This, along with other social media, allows us to keep those interested in Health Psychology informed in DHP activity, new research, appointments and issues relevant to health psychology. Anyone can follow the DHP @divhealthpsych or join the Division of Health Psychology Community Group on Facebook where they can also post topics of interest to the group.

Health Psychology Research and Dissemination in the UK

The impact factor of the British Journal of Health Psychology has risen to 2.776, led by the current editors Professor Alison Wearden and Professor David French. The Division of Health Psychology also publishes the Health Psychology Update, which goes out to all members of the DHP and is managed by the Publicity and Liaison Sub-committee.

The Research Sub-committee of the DHP, led by Dr Koula Asimakopoulou, has turned its focus to the collation and future promotion of REF (Research Excellence Framework) case studies that may be of interest to those aiming to submit their research to the next research assessment in 2020. The most outstanding Health Psychology MSc thesis award continues, with two well deserving winners this year. Students who have achieved the highest grade in their institution can be nominated by their course director for this award. Winners are invited to attend and present at the annual conference. The sub-committee also continues to highlight opportunities for health psychologists to represent the discipline on research funding panels to support Health Psychology research.

Health Psychology research in the UK is mainly disseminated through the DHP annual conference held from the 16th-18th September 2015 in the capital of London. Key note speakers included Professor Peter Gollwitzer & Professor Gabriele Oettingen (New York University); Professor Rob Horne (UCL School of Pharmacy; Centre for Behavioural Medicine) and Professor Lance McCracken (Kings College London). However, another noteworthy conference that covers health psychology research is the UKSBM (UK Society for Behavioural Medicine) annual conference held in Newcastle on the 8th-9th December 2015. In 2016, there will be a meeting jointly hosted by the DHP and EHPS in Aberdeen from the 23rd-27th August 2016.

Linking the EHPS with UK Health Psychology

Going forward, it would be good to create more formal links with the EHPS and the Divisions, Networks and Societies that have an interest in Health Psychology in the UK and any ideas on how to

do this are welcomed. During my time as EHPS National Delegate, I have been fortunate enough to sit on the DHP committee and now the HPPHN committee so I am able to comment on Health Psychology developments within the UK, however, this is not a formal, nor funded link. So please do contact me and let me hear your thoughts on how I can facilitate more formal relationships with those working in Health Psychology as the UK National Delegate for the EHPS.

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