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in this issue

an interview with

Health promotion in developing countries: an interview with Bart van den Borne

with Rik Crutzen

Bart van den Borne, professor emeritus in patient education, was originally trained as a social psychologist. Although his professional career initiated in the agricultural sector, most of his work as a researcher was related to problems regarding health and health care in general. In 1995 he was appointed as professor in patient education at Maastricht University. Since then, he also focused more and more on health promotion in developing countries.

ehp: *Where did your interest for working in developing countries come from?*

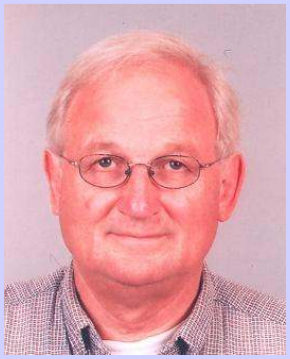
BvdB: It started soon after I graduated. In my opinion, huge steps can be taken in developing countries, because health problems are large while the budgets for health care are small. In the Netherlands, for example, about 10% of the GNP is devoted to health care, while in most developing countries this is 2% at the most. Because of the scale of the problems, it also provides more opportunities to gain insights into health problems.

ehp: *Which kind of insights?*

BvdB: In Western societies, we frequently study health problems at the individual level. The main thing I have learned is that we also have to look at the context to understand health problems properly. To give an example, health problems such as HIV/AIDS, tuberculoses and malaria are largely related to the socio-economic opportunities which people have. There is a constant struggle for life in those countries. For example, prevention of diseases related to the consequences of smoking, unhealthy nutrition or lack of physical activity is perceived as less important compared to the care for daily bread. If we want to change something in developing countries, we have to take the socio-economic context into account. We also need to look at structural measures to solve those health problems.

ehp: *What is the role of more traditional health education regarding health problems in developing countries?*

BvdB: It remains important to understand how people behave in a specific context. We need to take this context into account, however, while developing health education materials and interventions. People still need to be informed about health problems and where they come from, they still need to have a positive attitude towards protective behaviours and they still need the skills and motivation to prevent health risks and to have a healthy lifestyle. Theories from health psychology can also be applied in developing countries. Nevertheless, we should also investigate how the socio-economic context interacts with individual characteristics and motivation. Traditional theories from health psychology are still relevant, but need to be studied in a different context.



Professor Bart van den Borne
Department of Health Promotion
Maastricht University
The Netherlands

ehp: *What is the status of health promotion in developing countries?*

BvdB: With respect to health promotion there are a lot of initiatives and activities, for example from local NGO's, but a very important problem is the lack of expertise, and many initiatives and programmes are not well grounded in empirical research. A substantial part of my job is to develop capacity for scientific research focused on the development of evidence-based health promotion in developing countries. The health problems in these countries serve as a pretext to develop this capacity. The primary goal is to give people opportunities to solve these problems themselves. We can only help to build the expertise needed, especially regarding underserved aspects such as health psychology and health promotion.

ehp: *How did you start your work in developing countries?*

BvdB: In the beginning it was adventurous with a lot of uncertainty, because you cannot predict how things end up. In hindsight, we may conclude that our approach of developing capacity has proven to be effective. We saw the opportunity of our work from the very beginning. A few students from developing countries participated in our summer courses ►

an interview with

Prof Bart van den Borne

related to health promotion and intervention mapping. Through these courses, students became interested in acquiring further qualifications (i.e. a PhD). In that way they built the expertise needed and they opened up new perspectives for themselves (e.g. a job). Therefore, these students became very motivated. The formula we use is that they conduct their research in their own country. They visit our university once or twice a year and we visit them once or twice a year in their own country, mostly for short time periods. The advantage this brings is that people do not become alienated from the context in which they conduct their research. Furthermore, it prevents brain drain from developing countries. We also work with local co-supervisors if possible. This has the advantage of development of their expertise and helps to create a better supportive environment for the student. When looking back, we also see that none of our graduate students moved away from their home country after obtaining their PhD. This probably results from our selection process. An important criterion is that students are embedded in an organisation which stimulates research and offers them time and opportunities to conduct research. They develop structures for working within their home country. A nice example of this is the department of health promotion research and development which is founded within the Medical Research Council in South Africa. This department now employs about ten people and based on their research they advise the national and provincial governments, NGO's and other organizations regarding health promotion issues.

ehp: *What are the challenges you encountered during your work in developing countries?*

BvdB: While conducting research, you always run into problems which are specific to that country. For instance: the transition period after the apartheid in South Africa. This also influences researchers and how they look at and conduct their work. Sometimes graduate students conduct their research in countries in which the political situation is very precarious, like for example in Sudan. We never visited institutions in Sudan to explore the situation and develop linkages. Although it is our regular procedure to visit the organisations we cooperate with, this can be very difficult in such situations. Visiting is possible, but you should take care that you are not used for political purposes. I refused certain offers, for example, because I did not want to advise a government whose policies I do not agree with. This does not mean that you cannot supervise individual students, but that you should be careful in certain countries. Another challenge is to conduct research in another culture. Sometimes not even half your population is literate. In that case, you have to spend a lot of time in developing measurement instruments to collect valid data among a population. Furthermore, the way you measure certain concepts, e.g. depression, also depends on the culture. People in other cultures name feelings differently, express them differently and have different associations. For example, compared to people in Western countries they link different symptoms and emotions to depression. Instruments which are validated in Western settings cannot directly be transferred and applied in different cultural settings, since they are based on Western definitions and concepts. These instruments have to go through a new phase of development. This is not easy, but it is possible. The same applies to theory. The theories which are used in Western countries can also be used in developing countries, however, this should not be done thoughtlessly. Fortunately, editorial boards of international journals are more and more sensitive to the health problems in developing countries and the need to publish research methods and theories which have been developed in the context of developing countries.

ehp: *To conclude, do you have a general message for researchers who would like to work in developing countries?*

BvdB: First of all, it should appeal to you. It can be very interesting, since you run into interesting health problems and opportunities. It is interesting to investigate what you can achieve with theories which are developed in Western countries, by applying and adapting them to the specific situation in a developing country. It provides you the opportunity to see whether these theories are generalisable or whether they are specific for a certain cultural setting. Furthermore, it is interesting to study certain problems in situations where they are serious. To draw a parallel, I conducted a lot of research on cancer, which has a big impact on people's lives. If you study problems which are very serious and have a big impact on the lives of people, such problems are much more apparent. In that case, the causes of those problems are easier to identify. The same goes for developing countries, where health problems are big. Insights one gains by studying health problems in developing countries can also help to gain insight into health problems which we encounter in Western countries. ■

original article

Issues arising in the evaluation of digital behaviour change interventions

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It may not be immediately obvious why digital behaviour change interventions (BCIs) should not be evaluated in exactly the same way as any other behaviour change interventions. The aim of this paper is therefore to consider the parallels and differences between BCIs delivered in person and BCIs delivered by means of the internet (and other digital media), and the implications these differences have for the evaluation of digital BCIs. Five aspects of BCIs and their evaluation will be considered: the aims, and therefore intended outcomes, of the BCIs; the mode and process of delivery; the method of recruitment and resulting sample characteristics; methods of assessment; and approaches to analysis of intervention effects.

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Aims and intended outcomes

It can be assumed that since the aim of any BCI must be to change behaviour, digital BCIs, like other BCIs, should evaluate change in behaviour itself (Glasgow, 2007). There is now consensus (Michie, Rothman, & Sheeran, 2007; Yardley & Moss-Morris, 2007) that evaluation of BCIs should also include assessment of the effects of the intervention on the antecedents of behaviour that are likely to have mediated intervention effects, such as changes in attitudes or self-efficacy. If long-term behaviour change is intended, it is also desirable to evaluate maintenance as well as initiation of the target behaviour (Glasgow, Klesges, Dzewaltowski, Bull, & Estabrooks, 2004), although long-term follow-up by internet can pose particular problems (see below).

These outcome measures are common to all BCIs. However, from the outset, the internet has been valued for its potential to empower lay users. This ethos is reflected in Eysenbach's manifesto (2001) setting out the '10 Es' as defining characteristics that e-Health programmes should aspire to: efficiency; enhancing quality; evidence-based empowerment; encouragement; education; enablement; extending access; ethics and equity. Not all of these aims would be typical of traditional health-care BCIs, which are often less user-led and more focused specifically on either health or behavioural outcomes.

A systematic review of 37 digital health-related BCIs (Griffiths, Lindenmeyer, Powell, Lowe, & Thorogood, 2006) confirmed that the rationale for digital BCIs frequently did include aims of this kind, such as providing more timely and convenient access for users, reaching isolated or stigmatised groups, and reducing provider costs. However, the authors of the review note that few digital BCIs actually evaluate the extent to which these wider aims are achieved. If the intended outcomes of digital BCIs include these broader objectives then it is clearly important that they should be included in the assessment of outcomes.

Process of delivery

There is consensus that the first step in the development of all BCIs should be to ensure – and report - that the intervention incorporates behaviour change techniques which theory and previous research indicate should be relevant to behaviour change (Craig et al., 2008; National Institute of Health and Clinical Excellence (NICE), 2007). Consequently, in common with other BCIs, evaluation of digital BCIs should include some description and assessment of the theoretical and empirical basis for intervention components. There is some evidence that this important step may currently be omitted from the development of many digital BCIs (Evers, Cummins, Prochaska, & Prochaska, 2005).

In face-to-face BCIs, an equally important aspect of the process of delivering an intervention is the extent to which the intervention is effectively implemented as intended. This may include ensuring that those delivering the intervention have appropriate qualifications and credentials, have ►

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original article

Issues arising in the evaluation of digital behaviour change interventions

the necessary skills (e.g. therapeutic and communication skills) and closely follow instructions for intervention delivery (Davidson et al., 2003; Glasgow et al., 2004). In digital BCIs, the issue of effective intervention implementation is equally important, and an advantage is that the entire content and format of the intervention is explicit and standardised. However, the factors affecting the effectiveness of delivery are rather different. For example, to replace the authority and trust inspired by delivery of an intervention by health professionals in a clinic setting, a health intervention website may need to present the credentials of the authors and sources, or seek endorsement from a trusted independent body such as the Health on the Net Foundation. Instead of good interpersonal communication skills to deliver an intervention effectively, a digital BCI needs to be accessible to all (including those with disabilities and lower health and computer literacy levels) and be clear and easy to navigate, drawing on human factors principles to optimise usability (Lin, Choong, & Salvendy, 1997). The intervention must anticipate the needs of a variety of users, containing all the required elements to persuade and support users, including when necessary links with peers or professionals, and choice of alternative options or additional information.

A further consideration when evaluating how an intervention is implemented in practice is the extent to which users understand and adhere to the intervention, which may be affected by their abilities and motivations, and whether they attend to and follow the advice given. Digital BCIs offer opportunities for examining adherence in great detail, as it is possible to objective record not only how often a website is visited (the most widely used measure of adherence), but also what features of the website were used, what data was entered, which pathways were followed, and how long was spent on each section. Analysis of this information can provide useful insights into what elements of a digital BCI are most effective in changing behaviour, and whether it is preferable to constrain users to view essential pages or to allow them to choose from a rich set of resources (Severson, Gordon, Danaher, & Akers, 2008).

Sample characteristics and assessment methods

The gold standard for evaluating BCIs delivered in person is to recruit a random sample of the target population, and use objective independent measurement of the outcome of the intervention in almost all participants. In digital BCIs it is seldom possible to achieve this. Unless an existing sampling frame has been used (such as workplace employees), participants are typically self-selected volunteers who happen to have come across the website on the internet or through advertising. Participants may be very widely dispersed geographically - often from around the world - making follow-up using objective measurement rather than self-report impossible. There is the potential for identity fraud, and for users to register more than once in the hope of being randomised to their preferred intervention arm, and it may be very difficult to detect this if different computers are used (Bowen, Daniel, Williams, & Baird, 2008). Moreover, dropout before follow-up is usually high despite the best efforts of researchers, typically exceeding the 10-20% which face-to-face interventions can realistically aim for (Vandelanotte, Spathonis, Eakin & Owen, 2007).

While remote, automated assessment has potential disadvantages with regard to objective measurement, identity fraud and dropout rates, it does also have some potential advantages. In-person assessment carries the risk of unintentional researcher influence on responses, with the consequence that often part or all of the follow-up is administered remotely, by postal questionnaire. Internet follow-up avoids the problem of researcher influences on responses, and rates of missing data are typically much lower than with postal administration of questionnaires, since the programme can require users to complete questions they have omitted. However, it is therefore important to be aware that the way people respond to a questionnaire over the internet can differ systematically from their response to the same questionnaire administered in a different setting (Vallejo, Jordán, Díaz, Comeche, & Ortega, 2007) and caution must be taken if response patterns are compared. For example, people responding remotely may be less anxious, or more willing to admit socially undesirable behaviours such as non-adherence or risky behaviour.

Approaches to analysis

The differences between digital BCIs and BCIs delivered in person described above have implications for how analysis of outcomes can and should be approached. Currently, meta-analyses of internet-delivered interventions tend to show significant effects but large heterogeneity. This may partly reflect our current ignorance regarding what are the most important variables to use for tailoring or the most effective formats and media for communication – and of course these are likely to differ for different behaviours and populations. Traditional randomised controlled trials must undoubtedly play a part in contributing to our understanding of what works, for whom. ►

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Issues arising in the evaluation of digital behaviour change interventions

However, there are often considerable obstacles (described above) to carrying out traditional gold standard RCTs, whereas digital BCIs offer new and exciting opportunities for different approaches to analysing intervention effects.

The best digital interventions offer users some choices, and 'tailor' the information and advice provided to the beliefs, preferences or circumstances of the individual (Kreuter, Farrell, Olevitch, & Brennan, 2000). Many researchers have suggested that therefore evaluation of interventions must take into consideration the fact that users will have experienced rather different interventions, depending on the responses they gave and the choices they made. One way to examine the effects of subcomponents of the intervention is to use a fractional factorial experimental design (Collins, Murphy, & Strecher, 2007). Another is to use an observational design to identify how usage of particular intervention components may influence outcome. Large samples are ideally required for analysis of mediators and moderators of outcome – and automated interventions delivered by internet to a potentially huge population provide an opportunity to collect the sample sizes required. Recently developed software (www.lifeguideonline.org) can support this process of digital intervention evaluation. The software allows researchers to easily create and test different versions of internet-delivered interventions, provides opportunities for creating large pooled datasets from interventions using the same or similar components, and permits detailed analysis of the usage of each part of the intervention by every individual.

Conclusions

Digital BCIs share many features with BCIs delivered in person, but it is important to recognise that they also raise new considerations for evaluation. They may have different aims, and the mode of delivery necessitates developing expertise in new ways of communicating. They can be difficult to evaluate using traditional RCT designs, but they offer new opportunities for examining more precisely the effects of intervention components, at the level of the individual or using large samples. ■

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ask the expert

by Emely de Vet and Justin Presseau

As a new feature of the EHP, and starting in the March 2009 issue, we are introducing a new section called "Ask the Expert". In each issue a particular topical question will be answered by experts in health psychology or related fields. The EHP invites all readers to send their burning questions and suggested experts to the editors for the next issues of the EHP. For this first "Ask the Expert" we have posed the following question:

Are implementation intentions a panacea for health behaviour change?

Background: Implementation intentions (Imps) are if-then plans specifying when, where and how one will act in order to achieve a goal ("If I encounter situation X, then I will perform behavior Y"; e.g. "If I arrive at work in the morning, then I will take the stairs instead of the elevator to my office") (Gollwitzer, 1993; 1999). By forming imps individuals commit themselves to acting as soon as the specified situation is encountered. Forming implementation intentions has been proposed as a potentially effective and inexpensive intervention, particularly suited to help people to act upon their positive intentions. Meta-analyses showed that imps interventions may be a powerful tool in changing a range of health behaviors (e.g., Gollwitzer & Sheeran, 2006). But are implementation intentions a panacea for health behaviour change?

"It is important to remember that implementation intentions apply to positive intenders. From a public health perspective, this limits its potential effect. For instance, individuals who have a negative intention will not plan "when", "where", and "how" to adopt a given health behaviour. For these individuals, other approaches than implementation intentions will be required to favour behavioural change. Moreover, even if a substantial proportion of individuals are holding positive intentions but fail to act, it remains possible that true barriers are responsible for this situation. This would limit its use for less volitional behaviours. In conclusion, there are several issues that need to be addressed before claiming that implementation intentions represent a "panacea" for behavioural change, particularly from a public health perspective."

Prof Gaston Godin
Université Laval, Canada

"There is substantial variation in the techniques that are reported as prompts to form implementation intentions: there is no single implementation intention intervention. In addition, several studies have reported moderating effects of motivational, personality and plan related factors. Whilst intention appears to be a clear limiting factor, others such as conscientiousness show apparently conflicting findings. Moreover, there has been insufficient research on the effect of qualities of the cue and of the relationship between the chosen cue and the chosen response to know whether these might moderate the efficacy of the technique. Given these considerations, one would expect that future research will demonstrate further limitations of the technique as well as enhancements."

Dr Ian Kellar & Prof Stephen Sutton
Cambridge University, England

"Since Gollwitzer (1993) first introduced the concept (a) implementation intention formation has been found to promote the accomplishment of a variety of self-regulatory tasks (e.g., getting started, shielding goal striving from unwanted influences) that facilitate the translation of goal intentions into action, (b) research has clarified the mechanisms of implementation intention effects (enhanced cue accessibility, strong cue-response links, automaticity of action initiation), and (c) studies have identified several key moderator variables. For instance, forming an implementation intention can only be expected to benefit goal attainment when goal intentions are strong, activated, and self-concordant, and there is a 'gap' between intention and action. Implementation intention formation is a powerful self-regulatory tool but there is no panacea for health behaviour change."

Prof Paschal Sheeran
University of Sheffield, England

►

ask the expert

"Action planning (=implementation intention) constitutes one out of several factors that have been found very beneficial in motivated participants of health promotion programs. However, in less motivated persons (so-called non-intenders) there is not much evidence that planning helps. Thus, planning is one important volitional (=post-intentional) construct, among others, that should be considered for interventions addressing motivated individuals. Other constructs are, for example, action control and perceived self-efficacy. If clients are not self-efficacious they cannot translate their plans into action. "

Prof Ralf Schwarzer
Freie Universität Berlin, Germany

"The evidence supporting the influence of implementation intentions (II) could be summarized in a statement that compared to a lack of any intervention II seems to be a good tool if we need to induce a short-term change in self-reported behaviours. Certain discrepancies in research protocols (e.g., individualized approach including training in forming precise plans; filling in an implementation intentions form once or on multiple occasions) make it difficult, however, to generalize this prediction for any strategy used to form plans. Further, it may be expected that research will soon provide more evidence for the role of moderators and mediators restricting (or enhancing) the effectiveness of making plans. Clearly defined moderators (e.g., cognitive abilities, personality variables, baseline cognitions and habits) would allow for the identification of the populations in which II would be the most beneficial. Finally, in my opinion, to label II a panacea for health behaviour change we may need some more convincing evidence indicating that II is indeed better than "standard care" (as suggested in the Consort guidelines), instead of just proving that II may be better than a lack of any psychological intervention."

Prof Aleks Luszczynska
University of Colorado, USA

"The implementation intention (imps) research programme has made major contributions to our understanding of behaviour change by providing a theoretically sound approach, proposing simple, applicable intervention techniques that target behaviour directly rather than through distal predictors. However, most studies of action planning interventions for health behaviour change differ substantially from the rigorous laboratory-based paradigms developed by Gollwitzer, Sheeran and Webb (2006) to test the effects, mediators and moderators of imps. Obvious differences include a) in health psychology, participants are usually asked to form personally meaningful action plans, rather than being provided with researcher-specified imps, b) most health behaviour studies test the effects of action planning on general (unconditional) levels of behaviour performance (e.g., physical activity) rather than on conditional behaviour (e.g., levels of physical given that the 'if' condition of the implementation intention occurs) and c) initial experiences of enacting a personally meaningful action plan will affect learning and future performance in a way that is likely to differ from pressing keys in the lab. As a result, planning health behaviour change will differ from imps in terms of effects, mediators and moderators which I discuss in more detail in the paper "Towards a theory of intentional behaviour change: Plans, planning, and self-regulation" which will appear in the May 2009 issue of the British Journal of Health Psychology (Sniehotta, in press). Publication bias and variable methodological quality of planning studies indicates that more research is needed to understand when and how planning affects real-life behaviour."

Dr Falko Sniehotta
University of Aberdeen, Scotland

The editors would like to thank the respective authors for their contribution to *Ask the Expert*. If you have any questions or suggested experts to answer your questions, or you'd like to reply to any of the comments made in this section, please contact Emely deVet. ■

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ehps report

EHPS application for NGO status with the United Nations

By Irina Todorova*, EHPS President

The European Health Psychology Society has a broad international network of health psychologists, a strong commitment to improving health and well-being on a global scale and to developing adequate health policy. We can further these objectives of our society by expanding our partnerships with the United Nations, the dozen psychological societies and the 3000 other non-profit organizations affiliated with the UN. The EHPS can actively contribute to global health and health policy by becoming affiliated with the United Nations and becoming involved in the work of the NGO committees within this international organization. Psychologists are members of many of the NGO committees, such as the Committee on Ageing, on Children's and Women's Rights, on HIV/AIDS, and on Mental Health, many of which have direct or indirect relevance to health psychology. As a Society with UN NGO status, the EHPS would be able to express its voice at the UN through appointing EHPS representatives, participating in the discussions of different NGO committees at the United Nations in Geneva, Vienna and New York, and informing and implementing UN decisions.

The contributions of psychology to UN activities are broad and are being highlighted through a new initiative – the *Annual Psychology Day at the United Nations*. The first such Day took place on October 10th, 2007, and is discussed in the December 2007 issue of the EHP. Recently, a second Day was held on November 19th, 2008, and was entitled *Psychology and Social Justice Related to the UN Global Agenda*. Participants were individuals or representatives of the UN affiliated psychological societies such as The International Association of Applied Psychology (IAAP), Society for the Psychological Study of Social Issues (SPSSI), The International Council of Psychologists (ICP), the International Union of Psychological Sciences (IUPsyS), International Society for Traumatic Stress Studies (ISTSS), The American Psychological Association (APA) and others.

To give you a sense of the topics addressed by psychologists at the UN, the following describes the three panels convened at the Second Psychology Day. The first panel was entitled: *Human behavior and climate change: A social justice issue*, chaired by Peter Walker, representative for SPSSI at the UN. Speakers were David Uzzell and Inka Weissbecker, representative of the IUPsyS at the UN. They covered topics related to participatory approaches to environmentally supportive behaviour and the mental health aspects of climate change, particularly in low income settings. The second panel was on the topic of *Poverty reduction and social justice: The role of psychology*, chaired by Mary O'Neil Berry and Walter Reichman, UN representatives from the IAAP. The speakers were Anthony Lemieux and Anthony Marcella. They addressed the social justice aspects of the existence of immense poverty in the context of immense wealth. The third panel was on *Psychological perspectives on the abuse of power*, chaired by Deanna Chitayat, UN representative for the APA. The speakers were Susan Opotow, Stacey Sinclair, and Rita Chi-Ying Chung and covered the topics of exclusion, implicit prejudice and human trafficking.

We are aware that many members of the EHPS have worked with UN organizations through the years, some of which were described in the December 2007 issue of the European Health Psychologist. At this point in time, the EHPS Executive Committee is asking all EHPS members to share their views as well as their experiences of working with UN programs and projects. To acquire NGO status with the United Nations we will be following the application process at the NGO section of the Department of Public Information at the UN www.un.org/dpi/ngosection/index.asp. We have formed a working group for the UN application currently made up of Irina Todorova, Susan Michie and Suzanne Skevington, which will advance the application process. If our application is successful, we will make a call to members for nominations for EHPS UN representatives.

Dear EHPS members, we look forward to your opinions, suggestions and recommendations regarding EHPS affiliation with the UN. Please let us know if you would like to join the working group; also, for the application process, it would be very helpful if you could send us examples of past and current projects and activities that you have undertaken in collaboration with the United Nations and its programs, such as the WHO, UNESCO, UNICEF, UNFPA and others. Please send such information to Irina Todorova, and let us know if we can include it in the EHPS application to the UN. ■

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ehps report

Updates from the Strategic Meeting of the Executive Committee, January 2009

By Elvira Cicognani, Paul Norman, Britta Renner, Holger Schmid, Irina Todorova, and Manja Vollmann

On a clear and very cold day, six EC members arrived in Sofia to attend the winter Strategic Meeting of the Executive Committee, this time hosted by our President, Irina Todorova, in her home city. Our eighth member, Vera Araujo-Soares, was unable to join us this time – she is the proud new mother of baby Daniel and is on maternity leave. Bulgaria was in the midst of the Russia-Ukraine gas crisis but nothing could stand in the way of completing our task: Two full days discussing and formulating plans regarding the Society's many areas and activities– budget, conferences, education and training, national delegates, CREATE, Synergy, publications, website, grants, new initiatives and others. We began by reviewing EHPS financial and membership situation, which we can report are in good shape.

We reviewed the events that took place after the Bath conference in relation to the venue for the conference in 2010. We expressed our appreciation of the willingness of both Israeli and Romanian members to host a conference in their countries. The new EC led the process of deciding between these venues according to the Society's Articles and Bylaws and aimed to involve all members in the decision process. The virtual discussion board enabled us to simulate a real members' meeting, which led to an expression of diverse views and opinions regarding the proposed conference venues, including political arguments. In our EC meeting, we reiterated the objectives of the Society as a professional, non-political organization. We believe that it is important to continue to strengthen the international nature of the EHPS so that all members feel equally welcome, can contribute equally, and feel they benefit from belonging to the society.

The annual EHPS conferences are the Society's main activity and therefore also the main issue with which the EC is concerned. Our experience in the last few years has led us to realise that we need to ensure that we maximize our learning from year to year. Therefore, we have taken steps to consolidate our knowledge and experience in this area and to make sure it is passed on to each new Executive Committee. As part of this move, we have decided to create the position of Conference Officer and appointed Paul Norman, our President-Elect. We will also be updating our conference procedures to reflect what we have learned from recent conferences. For example, we will offer hosts the possibility of working with an international conference company if they want to, and offer recommendations of particular companies that will be available regardless of the venue.

We also discussed the procedural aspects of reaching decisions about conference venues. In the future, a formal call for conference venues with an appropriate deadline will be issued each year, requesting specific information about the proposed venue. If there are several suitable proposals, we will study them, discuss with the applicants and decide based on various criteria such as their availability, geographical balance, previous conferences in that country, and any strategic issues. We will continue to strive to present one venue per year for members' approval, while also providing members with details of the proposals we have received and the reasons for our recommendation. At the moment, we are lucky to have quite a few countries that have expressed their interest in hosting an EHPS conference and we hope to visit all of them over the next few years.

Another major issue that was addressed was our budget: Don't worry; even though the world is threatened by a financial crisis, the EHPS is currently in a good financial situation! This is due to the success of all our recent conferences, including the last 2008 joint EHPS/DHP Conference in Bath. Therefore, we will soon be announcing several new initiatives, which will be confirmed each year based on the Society's financial situation. All these initiatives are intended to promote networking and/or cross-national research that has an added value to EHPS members. For example, the conference grants will be increased to cover recipients' costs up to a ►

ehps report

Updates from the Strategic Meeting of the Executive Committee, January 2009

set maximum. We will be making a call for proposals for cross-national research initiatives, which we will be funding. We have also approved two promising initiatives proposed by CREATE and intended for CREATE members: The tandem stipend, which will allow two young researchers from different countries to visit one another to work on a joint project, and the visiting scholar award, which will allow a young researcher to visit a senior researcher in another country.

In the area of Education and Training, we will be working in three main directions: clarifying the professional situation of health psychologists in Europe, sharing information about the content, structure and requirements for Master's degrees in health psychology from different countries, and creating a resource for available training programs in Europe. Many of these activities will be conducted with the help of the National Delegates. We will maintain our contacts with the NDs and open a discussion about the professional identity of health psychologists in specific countries, including organizing a roundtable in Pisa.

We are also happy to let you know that we have a new office assistant Franziska Unholzer, who will be assisting with membership processing and financial calculations. We will also be having some website support from Aljoscha Triendl. Thanks to both of them and we wish them an enjoyable term with the EHPS.

The preparations for the Pisa 2009 EHPS Conference, Synergy 2009 and CREATE 2009 are proceeding smoothly and we look forward to seeing everyone there! Please take advantage of the extended deadline to send in more paper and poster submissions and to register for the interesting pre-conference workshops and Meet the Expert initiative. The first steps in preparing the 2010 EHPS Conference n Cluj, Romania have also been taken.

These are only some of our plans for the next year. We will continue to keep you informed about our plans and activities. More importantly, we would like to encourage each and every one of you to become involved in the EHPS, to initiate and take part in its activities. Please contact us if you would like to propose ideas or join some of the sub-committees working in specific area. ■

Call for contributions

The European Health Psychologist (EHP), the official bulletin of the European Health Psychology Society, would like to issue a general call for contributions to members of the EHPS. The quarterly online publication of the bulletin reaches all members of the EHPS and as such is a vehicle for transmitting timely and thought-provoking ideas and research. Past issues have featured wide ranging scientific topics written by contributors based both within and outside of Europe and the EHP aims to continue this trend into the future. Contributions may include, but are not restricted to:

- ✓ **Position papers (think pieces)**
- ✓ **Overview papers**
- ✓ **Research letters**
- ✓ **Interviews**
- ✓ **Controversy**
- ✓ **Reports about conferences and workshops**
- ✓ **Country/research group profiles of EHPS conference host countries**
- ✓ **Other important information relevant to EHPS members**

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

ehps grants

The Executive Committee of the EHPS is pleased to announce several new initiatives this year. The EHPS and its interest groups CREATE and Synergy will be able to offer grants to support conference and/or workshop attendance at our Pisa 2009 Annual Conference as well as stipends to support collaboration and networking.
To apply for the grant or the stipends, please submit the following application materials. The application materials and checklist will be available on www.ehps.net.

Grant and stipends application - Deadline is May 10th 2009

EHPS Conference Grants 2009

The purpose of these grants is to encourage talented researchers and graduate students who do not have access to funding to attend the EHPS conference and CREATE or Synergy workshops. For the upcoming 2009 conference the following grants will be offered:

1) Synergy Workshop participants: 2 grants for **researchers** who plan to attend the Synergy workshop and who are EHPS members. Each grant is for a maximum of 1100 Euros toward workshop registration, conference fee, accommodation and travel.

2) CREATE Workshop participants: 2 grants for **graduate students** who plan to attend the CREATE Workshop. Each grant is for a maximum of 800 Euros toward workshop registration, conference fee, accommodation and travel.

3) EHPS Conference only: 3 grants for **graduate students and researchers**. Each grant is for a maximum of 750 Euros toward conference registration, accommodation and travel. Grant is contingent upon acceptance of your paper or poster for the conference.

How to apply for EHPS Conference Grants: checklist

- ✓ A one-page narrative, describing your reasons for applying for the grant, your planned participation in the specific workshop and/or EHPS Conference and your estimated financial need. Please indicate which of the three grants you are applying for.
- ✓ Curriculum Vitae
- ✓ Abstract of your paper or poster that has been accepted for the EHPS Conference
- ✓ For the graduate students, proof of student status, such as copy of student ID
- ✓ An official statement from your employer or supervisor that no funding is being provided from your University or Institution and confirming your financial need.
- ✓ Synergy applicants please also fill out the Synergy Workshop application form (Forms are available at http://www.ehps.net/synergy/ws2009/workshop2009.html)
- ✓ CREATE applicants please also fill out the CREATE Workshop application form. (Forms are available at http://www.ehps.net/create)

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ehps grants

CREATE Stipends 2009

The EHPS will fund two new initiatives with the **purpose** of promoting collaboration and networking across countries.

1) The **tandem stipend** is intended to allow two **young researchers** from different countries to visit one another to work on a joint project. Two tandem stipends are available for a maximum of 2000 Euros for each tandem.
2) The **visiting scholar award** is intended to allow a **young researcher to visit a senior researcher** in another country. Two visiting scholar awards are available for a maximum of 1000 Euros each. Details about these programs are available on the CREATE web site: http://www.ehps.net/create.

How to apply for CREATE Stipends: checklist

Please indicate which one of the two stipends you are applying for (tandem stipend or visiting scholar).

- ✓ For the Tandem Stipend: A one-page narrative, describing your reason for application, the joint project, the anticipated scientific contribution and dissemination plan.
- ✓ For the Visiting Scholar stipend: A one-page narrative, describing the reasons for application, the relevance to current PhD project and the anticipated scientific contribution and a Letter of support from your host for the Visiting Scholar stipend

For both CREATE stipends:

- ✓ Curriculum Vitae (i.e. of both partners for the tandem grant)
- ✓ Recommendation letter from supervisor
- ✓ For the graduate students, a proof of student status, such as copy of student ID
- ✓ An official statement from your employer or supervisor that no funding is being provided from your University or Institution and confirming your financial need
- ✓ Further information is available at: http://www.ehps.net/create)

Grants and Stipend Selection Process

The selection of EHPS grant recipients will be conducted by a committee consisting of a CREATE member, a Synergy member and the EHPS Education and Training officer. The selection of CREATE stipend recipients will be conducted by a committee consisting of a CREATE member, the EHPS Education and Training Officer and another EHPS Executive Committee member.

The selection criteria will be:
(a) Relevance of the applicant's work to the topic of the workshop (for Synergy and CREATE grants), relevance of the submitted abstract to the conference (for the EHPS conference grant), or relevance of your collaboration project (for CREATE stipends) to the promotion of networking)
(b) Demonstration of financial need
(c) Potential of the fund to promote the career of the recipient
(d) Complete application package (see checklist on www.ehps.net and http://www.ehps.net/create for CREATE stipends)

You will be informed of the results by May 20th, 2009.

Please send all application materials electronically (include scanned copies of the official letters and student ID cards) to Holger Schmid, Education and Training Officer: holger.schmid@fhnw.ch

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conference announcements

conference title	date	location
Society of Behavioral Medicine Annual Meeting & Scientific Sessions	22 – 25 April 2009	Montreal, Canada
11th European Congress of Psychology	7 – 10 July 2009	Oslo, Norway
116th Annual APA Convention	6 – 9 August 2009	Toronto, Canada
British Psychological Society Division of Health Psychology	9 – 11 September 2009	Aston, England
23rd Conference of the EHPS <u>Keynote Speakers</u> ▪ **Linda Cameron** (University of Auckland, New Zealand): *"Self-regulation and health, an intervention perspective"* ▪ **Gian Vittorio Caprara** (University of Rome "La Sapienza", Italy): *"Optimal functioning: turning potentials into well-being"* ▪ **James C. Coyne** (University of Pennsylvania, USA): *"The role and responsibilities of the critic in moving health psychology forward"* ▪ **Jane Wardle** (University College London, UK): *"Health behaviour change and cancer prevention"*	23 – 26 September 2009	Pisa, Italy