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Birth trauma: Widening our knowledge of postnatal mental health

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Every year approximately 4.1 million women in the U.S.A. and 0.6 million women in the UK give birth. The birth of a baby is an emotional and challenging time that involves substantial life change and adaptation. Many women have a broadly positive experience and enjoy the birth of their new baby. However, a proportion of women have difficult or even traumatic experiences. Pregnancy and birth is therefore a time that can involve a wide range of emotions that encompass normal and abnormal stress responses. Unlike many other challenging or stressful experiences, the perinatal period is particularly important because it has such a wide-ranging impact. Research using ultrasound technology shows stress and anxiety in pregnancy affects fetal behaviour and is associated with poor infant development (Talge, Neal, & Glover, 2007). Postnatal depression in women is associated with depression in their partners and with poor cognitive development in children, particularly for boys (Grace, Evindar & Stewart, 2003). The perinatal period is therefore a critical time that affects women, their partners and infants.

Research shows that 10 to 15% of women develop postnatal depression (O'Hara & Swain, 1996) and approximately 2% develop post-traumatic stress disorder (PTSD) after birth (Ayers, Joseph, McKenzie-McHarg, Slade & Wijma, 2008). Recent studies suggest postnatal anxiety disorders may be more common than depression, with up to 16% of women suffering some type of anxiety disorder such as panic, phobia, acute adjustment disorder or PTSD (Wenzel, Haugen, Jackson, & Brendle, 2005). Anxiety disorders are also likely to be comorbid with depression. This means that each year up to 1.5 million women in the UK and USA may suffer some form of psychological problems after birth. In this article we focus on research into birth trauma and PTSD, outlining key debates and controversies in the area, and why it is an area where health psychology can make a valuable contribution.

Can birth be traumatic?

DSM-IV diagnostic criteria specify that PTSD can only be diagnosed if a person has experienced an event in which (A1) they think their own or someone else's life or physical integrity is threatened; and (A2) in which they respond with intense fear, helplessness or horror. Symptoms of PTSD form three clusters: (B) re-experiencing the event, such as nightmares and intrusive thoughts; (C) avoidance of reminders of the event and emotional numbing; and (D) increased arousal, such as hypervigilance and irritability. Symptoms have to last for more than one month and cause significant disability or impaired functioning.

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A fundamental question is whether childbirth can be a traumatic event. Pregnancy and birth are normative events in society and differ from other traumatic events in many ways. Pregnancy and birth are very positive experiences for some women. Pregnancy and birth are usually planned (i.e. voluntary), broadly predictable, yet involve huge physiological and neuro-hormonal changes, and breeches of bodily integrity that are not involved in other types of traumatic events such as war or natural disasters. Therefore one approach to studying trauma after birth would be to define what constitutes a traumatic birth and focus only on these. A useful

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analogy is that examining PTSD in all childbearing women is like including all people who drive when looking at PTSD after car accidents[1].

There is no simple answer to this issue. Research including all postnatal women shows 20 to 33% of them report birth as traumatic according to DSM-IV criteria above (Ayers, Harris, Sawyer, Parfitt, & Ford, in press). This is much higher than actual life threat to women or the baby, which occurs in just under 1% of cases in the UK. Other research has focused on severity of birth events as an indication of traumatic birth, such as emergency caesarean. However, although instrumental and caesarean deliveries are associated with symptoms of PTSD the evidence is not consistent; and many women with severe PTSD symptoms have normal vaginal deliveries. Thus intervention in birth is not necessary or sufficient for PTSD following childbirth.

This lack of a dose-response relationship between severity of an event and psychological outcomes is not new in psychological research. Research into psychological distress after severe illnesses rarely finds an absolutely linear relationship between severity of an illness and psychological symptoms. The diathesis-stress approach provides us with a well-established framework for understanding how the severity of an event interacts with individual factors to determine outcome. In accordance with this, various risk factors have been identified for PTSD symptoms after birth, including a history of psychological problems, previous sexual trauma, women having their first baby, anxiety or depression in pregnancy, dissociation during labour, negative emotions during labour, poor support and negative perceptions of care (see Olde, van der Hart, Kleber, & Van Son 2006 for a review).

In the UK we have been particularly interested in social and cognitive risk factors for traumatic birth, and the application of PTSD theories to childbirth. It is important to explore whether theories of PTSD are applicable to childbirth and similarly whether childbirth research can inform theories of PTSD. Unfortunately a lot of research into postnatal PTSD lacks a theoretical basis. The few studies that have been done support cognitive explanations of postnatal PTSD, with evidence that maladaptive beliefs and appraisals are associated with postnatal PTSD symptoms (e.g. Edworthy, Chasey, & Williams, 2008).

The importance of support in trauma was recently incorporated into an interpersonal theory of PTSD (Charuvastra & Cloitre, 2008), which proposed that support and attachment style interact with event characteristics to determine PTSD. This is particularly relevant to birth where the importance of support is well established. Studies have shown that providing continuous support during labour reduces use of analgesia, emergency caesareans, and increases maternal satisfaction (Hodnett, Gates, Hofmeyr, & Sakala, 2003). Conversely, lack of support is associated with increased anxiety. An experimental analogue study using birth stories showed that the level of support during birth affects women's mood, anxiety, and perceived control more than stressful interventions (Ford & Ayers, 2009). However, we know little about the types of support or interpersonal stress that are important, and whether this interacts with attachment or relationship style. We personally believe the social context of trauma is important and highly relevant to birth. Whether others subscribe to this view or not, the application of theories of PTSD to childbirth is an area that warrants further research and development. The benefits of this are two-fold. First, we will gain a more sophisticated understanding of the processes that determine whether women develop PTSD during pregnancy and childbirth or not. Second, by examining traumatic stress prospectively in pregnant women, this work has the potential to contribute significantly to our understanding of traumatic stress responses, in particular predictive and prognostic factors.

How do women respond to traumatic birth? Symptoms of PTSD and beyond

The birth of a new baby requires substantial adjustment and the postnatal period involves unique physical and psychological demands. A critical issue is therefore to distinguish PTSD symptoms from normal postnatal responses. For example, symptoms of arousal could be affected by normal physiological changes and fatigue after birth, rather than being an indication of PTSD. Motherhood and routine postnatal healthcare make it hard for women to avoid reminders of birth, such as midwives or the baby, so they might have fewer symptoms of avoidance. Evidence supports this with studies finding more women report symptoms of arousal (25 - 50%) than symptoms of avoidance (2 - 27%) (Ayers et al. in press).

Consequently, focusing only on symptoms may confuse normal and abnormal postnatal symptoms. To identify women who require treatment we should

[1] We are indebted to Johan Soderquist for this analogy.

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concentrate on women who fulfill all diagnostic criteria for PTSD. An alternative approach is to identify women who have significant disability or impaired functioning. The advantage of this is that it would highlight women whose lives are significantly affected by psychological symptoms, regardless of the type or level of symptoms. This allows for the possibility that women respond differently to traumatic birth: either with different symptoms or a wider range of symptoms. For example, up to 75% of women with PTSD also have depression (Parfitt & Ayers, in press). Qualitative studies have identified women with physical problems after a traumatic birth, such as vaginismus (spasm of the vagina so penetration is very painful). Further research into the range of symptoms after birth is therefore needed. In the meantime, using disability and impaired functioning as an indication of need for treatment is a promising way to account for the range of possible symptoms.

Impact of traumatic birth: Different symptoms, different effects?

Qualitative studies suggest traumatic birth has a profound effect on women, future pregnancies, and their relationship with their partner and infant. Of particular interest is the impact on the mother-infant relationship and effects on child development. Qualitative studies suggest traumatic birth can lead to avoidant/rejecting or anxious/overprotective behaviour (Nicholls & Ayers, 2007). Quantitative studies show PTSD symptoms are associated with more negative perceptions of the infant and a poorer mother-infant bond (Davies, Slade, Wright, & Stewart, 2008). However, this may be confounded by depression. Parfitt & Ayers (in press) found that PTSD symptoms were directly associated with the mother-infant bond; but the effect on the couple's relationship was fully mediated by depression.

We therefore need to recognise that different symptoms might affect different areas of functioning; and that some symptoms may be associated with worse outcomes. A recent analysis of over 1400 women found that symptoms of PTSD after birth fell into two clusters: (1) re-experiencing and avoidance symptoms; and (2) emotional numbing and arousal symptoms. Emotional numbing and arousal symptoms were more predictive of disability and impaired functioning than a widely used screening measure for postnatal depression (Ayers et al., in press). This suggests emotional numbing and arousal symptoms might be particularly pathogenic after birth. This is consistent with general PTSD literature, where emotional numbing is associated with poor outcomes. Numbing and arousal symptoms are also those which have a strong effect on interpersonal functioning; for example feeling distant or cut off from people around you (emotional numbing), and feeling irritable or having fits of anger (arousal). The impact of these symptoms is likely to be exaggerated after birth when new bonds are forged and existing relationships change.

How can health psychologists help?

Knowledge and treatment of postnatal mental health can benefit from input from health psychologists in many ways. First, research is needed that continues to apply and refine our theoretical understanding of the interaction between key vulnerability factors, birth events, the postnatal environment, and mental health. We also need more information on the impact of traumatic birth on women and their families. The range of research skills that health psychologists have is very useful in applied areas such as this, which often involve multidisciplinary teams. Second, screening tools are essential to identify women with impaired functioning or in need of treatment. Health psychologists can contribute to the development and evaluation of screening tools, ensuring tools are accessible and training available. Third, health psychologists can audit maternity services and develop more effective systems of care. This encompasses antenatal education and screening, care during labour and after birth, and treatment such as psychotherapy. Another interesting possibility is the use of technology for self-help and treatment. Computerised CBT has been shown to be effective for the treatment of moderate anxiety and depression in the normal population so may be a useful way to provide self-help education and intervention for postnatal psychological problems. Finally, the prospective study of postnatal mental health has the potential to inform our understanding of normal and abnormal stress responses. Unlike many other potentially traumatic events, the event of childbirth is a predictable event that is experienced by a large number of women. This means it provides a rare opportunity to prospectively examine the interaction between pre-existing vulnerability, event factors, and the recovery environment in determining psychological outcomes.

Conclusion

The study of traumatic birth is still in its infancy but is already contributing to a wider understanding of postnatal mental health. The importance of postnatal mental health and the potential impact on the woman, infant, and partner means it is a valuable area of study with many possible applications. Research in this area is rapidly increasing and an

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international research network was set up in 2006 to encourage international debate and collaboration (see http://www.sussex.ac.uk/affiliates/ukbrn/index.html). We would welcome contact from psychologists interested in working in this area.

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original article

Psychology in medical curricula: "need to know" or "nice to know"?

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Given the wealth of research evidence demonstrating the importance of psychological and behavioural factors in a range of illnesses, and the influence of doctor-patient interactions on patient satisfaction and adherence, one would hope that psychology would be an entrenched and valued part of medical curricula. To practice effective evidence-based medicine, doctors must know how psychological and behavioural factors influence health and illness: medicine should be taught from a biopsychosocial perspective. However, this does not appear to be the case. The hidden curriculum makes a separation between the "need to know" biomedical sciences, and the "nice to know" behavioural and social sciences.

The past

The struggle to entrench psychology within medical curricula has been long (Litva & Peters, 2008). For example, the Flexner report (1910) recommended that doctors develop a socially-oriented perspective of medical practice. However, it was acknowledged that it was unlikely that psychology would be accepted in medical education unless its relevance to clinical practice could be demonstrated. As evidence of the importance of psychological factors in health, illness, and medical consultations accrued, the arguments for the inclusion of psychology in medical curricula should have become stronger. However, psychology did not become a core component of all medical curricula.

The present

In recent decades there has been a desire to change the perception of psychology from something that is "nice to know" - an interesting, but not essential component of medical education - to "need to know" - an indispensable component of medical education (Peters & Litva, 2006).

In the United Kingdom, the General Medical Council signalled a shift in the status of psychology from "nice to know" to "need to know" with the recommendations in "Tomorrow's Doctors" (GMC, 1993), the revised edition of which (GMC, 2003) states that graduates must understand the influence of behaviour on health and illness, as well as normal processes of physical, intellectual and social development. They must also understand the psychosocial experiences of patients and how these affect medical consultations, treatment, and recovery.

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The last decade has seen the redesign of the curricula of many existing medical schools and the establishment of "modern" curricula in newly-created medical schools. The old curricula - in which students began their clinical training only after completing several years of study of basic biomedical sciences - are being replaced by new curricula - in which students have early exposure to real patients and are taught relevant behavioural and social sciences from the first year of their education. However, different medical schools decide which aspects of psychology they will teach, and incorporate psychology in different ways.

The push for a standardised psychology curriculum for medical education in the UK was recently boosted when the British Psychological Society (BPS) endorsed the "Psychology Core Curriculum for Undergraduate Medical Education" proposed by BeSST (Behavioural and Social Science Teaching in Medicine: www.heacademy.ac.uk/besst/PsyCoreCurric.asp). The BPS anticipates that its endorsement of the core curriculum will facilitate the establishment of evidence-based methods of teaching psychology to medical students. However, the existence of a core curriculum (let alone its endorsement and application) is unusual in Europe. ►

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Recent research in Europe has demonstrated low levels of acceptance of psychology within medical education. For example, a survey of medical students in Lithuania, Poland, and Russia found that while many agreed that psychology is important in medical education, close to half were unsure or disagreed (Jakušovaitė & Blaževičienė, 2007). As one lecturer told me:

> "They do like the hard core medical stuff, but not in their view the indirectly related topics. Mostly they find it boring"

There is also evidence that the low position of psychology in a hierarchy of medical education becomes more entrenched as students progress. Verhoeven et al. (2002) found that with each year, growth in students' psychological knowledge trailed behind growth in knowledge of clinical sciences, suggesting that the curricula and/or students gave diminishing attention to psychology as they moved closer to graduating.

However, it is not all bad news: many medical students do appreciate the importance of psychology, and many enjoy studying it. This is especially the case for students who choose psychology options within their courses. However, all students need to understand the importance of psychological knowledge, not just students with an interest in psychology.

The future

After reviewing their experiences of teaching behavioural sciences in Israeli medical schools, Benbassat et al. (2003) identified three pressing issues: (1) a need for a clearly defined hierarchy of learning objectives that prioritises the acquisition of clinically relevant skills; (2) a need for integrated curricula based on the biopsychosocial model to facilitate links between behavioural sciences and clinical practice; and (3) a need to identify and train lecturers with expertise in applying behavioural sciences to medicine. Each of these needs will be addressed in turn with reference to my recent communication with academics teaching psychology in medical schools in Europe.

Clinical relevance

There is a need to demonstrate clearly the relevance of psychology to students and those people responsible for developing curricula. One academic I spoke to expressed his frustration:

> "Psychology is not a structural part of the medical curriculum ... and that's a bloody shame."

The academics I spoke to agreed that medical students prefer psychology subjects which have obvious links to pathological processes (e.g. psychiatry and neuropsychology), but are less keen about "common sense" subjects such as health beliefs and illness perceptions. An important part of changing this situation is replacing the focus on theory and models characteristic of much academic psychology with a focus on applied knowledge and skills. Lecturers cannot simply hope that their lectures to psychology students will be suitable for medical students. One experienced lecturer remarked:

> "You will lose the battle immediately if you start with theoretical models or with concepts or with theories. They will be bored within a second [...] We do not get away with teaching them formal psychology. It's very applied."

This opinion reflects the findings of a British study which found general agreement among lecturers that clinical application is more important than "theory for theory's sake". (Russell et al., 2004, p.413). As one lecturer said:

> "After all, we're training doctors rather than psychologists - so it's actually demonstrating to the students how psychology is relevant to medicine and being a doctor, and how it can contribute to helping them to become better doctors."

However, specialised resources are needed to accomplish this. Several of the academics identified a need for more resources and teaching aids specific to the context of teaching psychology to medical students (see also Russell et al., 2004). In particular, there was a clear need for specialised textbooks applying psychology to medicine.

Integrated curricula

It was agreed that to make psychology more relevant, it is essential that psychology is an integral part of the curriculum, rather than something that is added onto a biomedical core. Favour was given to "vertically integrated" curricula whereby early psychology sessions are used to establish an underpinning conceptual framework which can be built upon in subsequent courses.

Many medical schools now have curricula in which clinical skills are addressed from the first year of study. In some schools, students are out in the ►

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"real world" of patients and practitioners within the first weeks of their course. Psychologists teaching in medical schools with traditional programs felt that early exposure to the "real world" would enhance the perceived relevance of psychology and help to enhance understanding of psychological concepts and skills:

> "Exposing them to real patients in the first week of their education ... will help medical students to understand more that real patients are much more difficult than they think."

In addition to changes to program structures, several academics identified assessment practices as a barrier to integration:

> "We have one or two questions [on psychology] that are part of the total assessment ... And the students are very good at calculating and they think 'Well, this is 2 marks from the 100 or 150', and they just don't read it."

I have had similar experiences where students skipped the entire block of questions assessing psychology content. These students presumably calculated that by not revising psychology they could spend more time revising the biomedical sciences, and still pass. One way to overcome this problem would be to insist that students pass psychology and anatomy and cell biology, etc. rather than simply achieving an overall passing grade.

In addition to the experiences described above, other lecturers identified difficulties integrating modes of assessment preferred in psychology and biomedical sciences:

> "The modes of assessment that we use are very limited ... psychology is often best assessed by some sort of discursive answer rather than a multiple choice question, which is a very blunt instrument."

Multiple choice questions (MCQs) are well-suited to assessing "surface learning" of facts, but are inappropriate for assessing "deep learning" of underlying concepts and their applications (Biggs, 2003). Discursive short answer questions are well suited to assessing medical students' understanding of theoretical concepts and their clinical applications. However, students find such questions more difficult than MCQs, and this may mark psychology as "different" from the biomedical sciences with which it should be integrated.

Expert lecturers

Because many aspects of psychology are perceived to be 'common sense', there is a tendency for medical educators to assume that they can be taught by people without specialized knowledge or training (Russell et al., 2004). However, one of the barriers to improving medical students' engagement with psychology is a lack of lecturers who specialise in applying psychology to medicine:

> "[We need] psychology staff who are really committed to the medical world ... not psychologists who are experts in conditioning, but psychologists who are experts in applying conditioning."

There is a need for more academic posts in medical schools for behavioural scientists with the knowledge and skills to identify and teach relevant behavioural sciences. Behavioural scientists also need to be better represented in curriculum design teams.

Much may be gained by developing networks similar to BeSST in the UK in other parts of Europe - or indeed, establishing a European network for academics teaching psychology as applied to medicine:

> "It would be good to have an international or European society that would exchange books and papers or whatever and ideas on assessment ... and jokes ... that would help our lives a lot."

A European network was seen to be a potential source of material and emotional support. The latter may be particularly useful given that many psychologists teaching in medical settings report feeling somewhat alienated from both the medical establishment and their core discipline of psychology (see Russell et al. 2004).

The British academics I contacted reported that BeSST had been an important source of information and support. They also highlighted the importance work of BeSST in developing the core curriculum endorsed by the BPS. Academics in other parts of Europe appreciated the role of an organisation like BeSST, and felt that it would be useful to develop a European core curriculum for psychology in medical education. ►

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> "It would help my group and the other groups in this country to have an agreed upon curriculum for various years. It's a very good idea."

Conclusion

Recent years have seen growing awareness of the value of psychology applied to medicine, and growing inclusion of psychology in undergraduate medical curricula. Although progress has been made in the three domains discussed in the latter part of this article, it is clear that more work is needed. The establishment of a European network of academics teaching psychology in medical schools may be an important part of ensuring that across Europe the full range of clinically relevant aspects of psychology are properly integrated into medical curricula and taught by expert lecturers. I would be pleased to hear from people interested in establishing such a network. ■

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original article

How much health is there in disease?

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Health as a concept has various meanings and objective references. It can refer to somatic, psychological or social functioning. In health psychology it is emphasized that health can also be viewed objectively when it is a result of medical examination or when health refers to psychological assessment of the level of realization of aims, fulfilling personal needs and social demands. Health can also be characterized by various overriding concepts such as state of health, process of health and health potential represented by generalized resistance resources. Health as a disposition emphasizes personal abilities to realize physical, psychological and social capabilities and to cope with external demands.

Thinking about health as a potential shaping personal development and resistance leads to searching for health resources in individuals, groups and the environment. It is represented in everyday language. For instance, one can say: 'I have good health', 'I am a resistant person' and 'This person is capable of overcoming that adversity'. Resistance resources refer to various personal attributes and levels of functioning. They are utilized in the health process or the dynamic counterbalancing of personal needs and external demands. Health processes depend on threats (risk factors) and personal resources. The process perspective on health is associated with a dimensional approach towards health.

The analysis of health within the health-ease – disease dimension gives a framework for discussing how health is related to disease. For instance, we can say that having a specific condition or disability does not exclude the possibility of maintaining health if assessed on some other dimension for instance a psychological condition manifesting itself in creative activity. Moreover, new health potentials can at times be identified within some diseases. In the now classic WHO definition of health, well-being was defined as an important concept in various spheres of human functioning such as physical, psychological and social. Recently, a spiritual sphere has been also increasingly included within the remit of well-being (Heszen, 2008a).

We can describe a health construct as composed of several interrelated components. A state of physical health characterized by limited daily activity or pain

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(e.g., after a surgical procedure, or due to rheumatoid arthritis or cancer) significantly deteriorates subjective health. Particularly, the social dimension of health may be affected, e.g. when a person can no longer fulfill social roles and loses a professional position. But at the same time adaptation to disease and coping strategies used to redefine aims and values can lead the individual to undergo psychological development and reach higher levels of mental health (Heszen & Sęk, 2007).

Those who have experienced traumatic events, including life- and health-threatening situations, tend to disclose in their testimonies and display in their coping with these situations that a positive change is possible. People discover new abilities and as a result of redefinition of meaning of different life domains they acquire new sense of purpose, learn how to appreciate beauty and understand importance of daily routines and relationships with others. This process has been described as posttraumatic growth (Tedeschi et al., 1998). Thus a somatic disease may positively affect psychological and spiritual spheres of well-being associated also with development towards creative aims.

We also know that an individual's mental strength and resources such as hardiness, sense of coherence and resiliency have a positive influence on coping with the stress of disease and as such impacts on recovery. Experimental research on the meaning of positive emotions for cognitive functioning, memory, thinking and creativity and also for undoing

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somatic dysfunctions have shown that positive emotions have a positive role in processes of health development and on maintaining and preventing disorders such as posttraumatic stress disorder or cardiovascular disease (Fredrickson & Levenson, 1998; Fredrickson, 2002; Tugade & Fredrickson 2004; Nadolska & Sęk, 2007). In the field of health psychology it is possible to take a positive inspirations perspective to analyse different levels of human emotional functioning such as physical, experiential, esthetic, cognitive, social and spiritual. Every such context of experiencing positive emotions contributes different elements for health and well-being (Sęk, 2008).

Positive psychology (Seligman & Csikszentmihalyi, 2000; Synder & Lopez, 2002; Czapiński, 2004) has played an important role in development, research and practices of such perspectives on the health-disease relation. In the psychology of stress, increasing attention is put to those strategies of coping with problems of disease which lead to redefinition of meaning, raising hope and many other positive phenomena (Folkman & Moskowitz, 2006; Heszen, 2008b; Kwissa-Gajewska & Wojtyna, 2008).

In these new frameworks it is important to distinguish the health process from disease from health resources (potentials) and health deficits. It may be worthwhile to think about health as a process of balancing demands and capacities. This process depends on the interaction of personal resources and deficits (physical, psychological and social) with health risk factors such as stressors in life, education and work or certain pathogens (Sęk, 2007)

Taking these new perspectives into account may lead to new areas of theoretical analyses and research. Particularly noteworthy seems to be the problem of recovery and maintenance of the sense of health despite chronic disease. One may search for those elements of the pillars of health (physical, psychological, social or spiritual) which have the potential to restore and strengthen oneself. It also can be assumed that new positive experiences of resilience, satisfaction, hope or gratitude can be preserved, leading to the development of new health resources. ■

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original article

What difference does a frame make? Potential moderators of framing effects and the role of self-efficacy

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Health-promoting communications usually stress the value of healthy behaviour, but they can do this in many ways. In particular, the message can be framed in terms of the benefits of performing the behaviour (gain frame – e.g., ´quitting smoking is healthy´) or in terms of the costs of failing to perform the behaviour (loss frame – e.g., ´continuing to smoke is unhealthy´). Unfortunately, studies show inconsistent results with regard to which type of framing is more persuasive. The results of several studies have suggested that gain-framed information is more persuasive than loss-framed information, the results of other studies have suggested that loss-framed information is more persuasive and some studies have reported no differential effects (for meta-analyses see O'Keefe & Jensen, 2006; 2007). To account for these inconsistent findings, many researchers have been concerned with identifying possible moderating variables of message framing effects.

Behaviour function: Prevention and detection behaviour

One potential moderator that has been proposed is the function of the recommended behaviour. Several scholars have made a distinction between behaviours that serve to prevent an illness (like exercising or quitting smoking) and behaviours that serve to detect an illness (like skin self-examination or obtaining a mammography). According to Rothman and Salovey (1997), people perceive disease-prevention behaviours as relatively safe, because they minimize the chance of falling ill. In contrast, people perceive disease-detection behaviours as inherently risky because they entail the possibility of finding out that one is ill. Because Prospect Theory holds that people are risk-aversive when considering gain-framed information and risk-seeking when considering loss-framed information (Kahneman & Tversky, 1984), Rothman and Salovey (1997) go on to suggest that gain-framed information is more persuasive when advocating disease-prevention behaviours, because gain-framed information makes people risk-aversive and thus more likely to engage in relatively safe disease-prevention behaviours. In contrast, they suggest that loss-framed information is more persuasive for disease-detection behaviours, because loss-framed information makes people willing to take risks and thus more likely to engage in relatively risky disease-prevention behaviours. A recent meta-analysis showed, however, that for behaviours serving to detect an illness, gain- and loss-framed messages were not differentially persuasive (O'Keefe & Jensen, 2006). For prevention behaviours, a small advantage of gain-framed messages was found, but additional analyses revealed that this effect was only found in a limited amount of studies on dental health (O´Keefe & Jensen, 2007). Thus, a distinction between prevention and detection behaviours does not seem to be sufficient to explain differences between the effects of gain- versus loss-framed information.

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Perceived risk as a potential moderator

Although message-framing effects do not seem to differ systematically between prevention- and detection behaviours, Latimer and colleagues (2007) have argued that Prospect Theory could still provide an adequate framework for studying message framing. They argue, however, that researchers should focus less on whether the recommended behaviour serves to prevent or detect illness, but more on the way the recipient perceives the behaviour. For instance, even though smoking cessation is clearly a prevention behaviour, some people might perceive quitting smoking as entailing many risks, such as the risk of nasty withdrawal symptoms. Similarly, exercising and eating a ►

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healthy diet obviously have great benefits in terms of health, but may be perceived as having many potential costs and drawbacks. When this is the case, people might be more responsive to a loss-framed message. Some studies have found support for the hypothesis that loss-framed information is more persuasive than gain-framed information for people who perceive the advocated behaviour as risky, whereas loss-framed information is more persuasive for people who perceive the advocated behaviour as risk-less. However, more research is needed to resolve this issue.

Cognitive elaboration as a potential moderator

A third moderator that has been proposed in the literature is mode of information processing. According to dual process accounts of persuasion, persuasive messages are processed in one of two modes: heuristically or systematically. With heuristic processing, attention is paid to surface features of the message (e.g., the expertise of the message source, the length of the message). These surface features can work as heuristic cues to facilitate persuasion. With systematic processing, attention is paid to particular details in message content. Several factors can influence people's mode of information processing, among which are personal involvement with the issue, a person's mood, and a person's need for cognition.

Some authors have argued that when people process persuasive messages heuristically, people use positive rather than negative information in the message as a heuristic, responding more favourable towards more positive messages. Thus, under conditions of heuristic processing, gain-framed information should be more persuasive than loss-framed information (Maheswaran & Meyers Levy, 1990). Indeed, some studies have found that for individuals with a low need for cognition (i.e., individuals who are likely to process information heuristically), gain-framed information was more persuasive than loss-framed information, while for individuals with a high need for cognition (i.e., individuals who are likely to process information systematically) gain- and loss-framed information had no differential effects.

It has also been proposed that, when processing information systematically, people tend to focus more on negative information than on positive information, because of a 'negativity bias' (Maheswaran & Meyers Levy, 1990). The negativity bias refers to the assumption that, because people perceive the world as predominantly positive, negative information will trigger more attention than factually equivalent positive information. Paying more attention to negative cues than to equivalent positive cues makes sense from an evolutionary point of view, as it increases chances of survival in a dangerous environment (Dijksterhuis & Aarts, 2003). The results of several studies have suggested that loss-framed information might indeed be more persuasive than gain-framed information under conditions of systematic processing (Maheswaran & Meyers-Levy, 1990). However, there is no clear theoretical reason why positive cues would be more powerful than negative cues under conditions of heuristic processing and why the negativity bias would only occur when people process information systematically (as opposed to heuristically). Thus, the influence of mode of processing on the effects of framed messages is currently less than clear.

The role of self-efficacy

Recently, we have proposed that, in addition to the above-mentioned factors, self-efficacy can moderate the impact of gain- and loss-framed messages on health intentions and health behaviour. We have tested this hypothesis in three experiments, using gain- and loss-framed information on smoking cessation, skin self-examination and reducing salt-intake.

Loss-framed messages have been found to evoke a greater sense of threat than gain-framed messages (Cox & Cox, 2001). Fear-appeal research suggests that this greater sense of threat might increase persuasiveness, but only if recipients feel capable of averting the threat by performing the recommended action (Ruiter, Abraham, & Kok, 2001). If recipients have low self-efficacy expectations, however, this greater sense of threat may result in less message acceptance due to defensive avoidance and message derogation processes. Thus when perceived self-efficacy is high, loss-framed messages might be more persuasive than gain-framed messages, whereas when perceived self-efficacy is low, gain- and loss-framed messages might not be differentially persuasive. The latter theoretical assumption can explain why, in some cases, loss-framed messages are more persuasive than gain-framed messages, whereas in other cases they are not.

Based on this reasoning, we hypothesized that loss-framed information would be more persuasive than gain-framed information for people with high self-efficacy, and that there would be no differential effects of gain- and loss-framed information for people with low self-efficacy. In the remainder of this article, we report on three experiments that investigated whether participants' self-efficacy could moderate the effects of gain- and loss-framed messages.

Smoking cessation. For the first study (Van 't Riet, Ruiter, Werrij, & De Vries, 2008), which ►

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investigated the effects of framed messages promoting smoking cessation, data was collected at various markets and fairs throughout the Netherlands. In total, 592 adult smokers agreed to participate in the experiment. First, we assessed participants' self-efficacy to quit smoking. Next, participants were randomized into a gain-framed message condition, a loss-framed message condition and a no-message control condition. During the immediate follow-up, their post-test intentions to quit smoking were assessed. The results showed that, for participants with low self-efficacy, there were no differential effects between the gain-framed, loss-framed and no-message control condition. For participants with high self-efficacy, however, reading a loss-framed message resulted in stronger intentions to quit smoking than reading a gain-framed message or reading no message, in line with our hypothesis.

Skin self-examination. One problem with our first study was the fact that we did not assess whether the loss-framed information was indeed perceived as more threatening than the gain-framed information. Therefore, we conducted a second study in which we assessed perceived threat as a result of the framed messages. In addition, because several authors propose that framing effects are different for prevention versus detection behaviours (e.g., Rothman & Salovey, 1997), and to increase the generalizability of our results, we used framed information advocating skin self-examination (SSE) in the second study (Van 't Riet, Ruiter, Werrij, & De Vries, 2009).

Before we conducted the main experiment, we pilot-tested our messages among 41 university students. We invited these students to our laboratory, where they were randomized into a gain- and a loss-framed condition and were asked to what extent they found the information promoting SSE threatening. Results showed that the loss-framed information was perceived as more threatening than the gain-framed information. We then used these framed messages in the main experiment, in which 124 students participated, once again in our laboratory. We assessed their self-efficacy to perform SSE and provided them with either gain- or loss-framed information. After this we assessed their intentions to perform SSE on a monthly basis.

The results showed that self-efficacy moderated the effects of gain- and loss-framed information on intention as hypothesized. For participants with low self-efficacy, the gain- and loss-framed messages were not differentially persuasive. For participants with high self-efficacy, loss-framed information resulted in a stronger intention to perform SSE than gain-framed information.

Reducing salt-intake. The two studies reviewed above suffered from two important limitations. First, in both studies self-efficacy was assessed observationally. Thus we cannot completely rule out that the effect of self-efficacy was due to some other factor. Evidence that an experimental self-efficacy manipulation could moderate the effects of framed communications would allow us to draw firmer conclusions about the causality of the effect. Second, neither of the two studies included a long-term follow-up, making it impossible to assess behavioural effects. In our third study (Van 't Riet, Ruiter, Smerecnik, & De Vries, submitted), we aimed to investigate whether our previous findings could be replicated, using a self-efficacy manipulation instead of a self-efficacy assessment and including a three-week follow-up assessment of behaviour (in this case: salt consumption). A total of 575 adults, recruited from an Internet-panel, took part in the study. Half of the participants received self-efficacy enhancing information, whereas the other half received no such information (participants in both self-efficacy conditions did not differ in baseline self-efficacy as measured with a five-item self-efficacy scale). After this self-efficacy manipulation, half of the participants received a gain-framed, and half of the participants received a loss-framed message promoting a low-salt diet. As in the study on SSE, a pretest showed that the loss-framed information was perceived as more threatening than the gain-framed information. We assessed intention and behaviour as the outcome measures.

In line with our hypothesis, the results of this study showed that the loss-framed message resulted in healthier behaviour after three weeks (i.e., less salt intake), but only for those participants who also received self-efficacy information. However, the effect of the interaction between self-efficacy and framing on salt consumption was not mediated by measures of intention to reduce salt-intake. In contrast to the previous studies, no interaction effect on intention was observed. This surprising effect shows that more research is needed to deepen our understanding of message-framing effects. However, we note that these findings are in line with previous studies that have also found effects on behaviour, but failed to find effects on determinants of behaviour (Banks et al., 1995; Detweiller, Bedell, Salovey, Pronin, & Rothman, 1999). For instance, in a study investigating the effects of framing and ethnic targeting on mammography use Schneider and colleagues (2001) found effects of framing on behaviour at a six-months follow-up, but failed to find effects on numerous psychosocial variables, such as risk perceptions, self-efficacy, outcome ►

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efficacy, attitudes, social norms, and intentions. Perhaps different findings can be expected for different health behaviours. Quitting smoking and performing regular skin self-examination may require planning, which makes it likely that intention plays an important role. Other health behaviours may be performed without conscious planning, making it more likely that framing exerts a direct influence on behaviour. More research is needed to test this assumption.

Recently we have conducted two experiments which yielded different findings. We found that participants with high self-efficacy were more likely to be persuaded by gain-framed information than by loss-framed information (Werrij, Ruiter, Van 't Riet, & De Vries, in preparation). It seems, then, that in some cases self-efficacy might have different effects than described above. Perhaps in the latter two studies, the loss-framed messages might not have been sufficiently threatening. The first study investigated the effects of gain- and loss-framed information advocating sunscreen use among student participants. Since many participants indicated that they already regularly applied sunscreen it seems plausible that the loss-framed information did not evoke high levels of threat. Similarly, in the second study, which investigated the effects of framed information advocating the consumption of organic meat, again among student participants, the disadvantages of non-organic meat (e.g., added antibiotics) might not have been perceived as particularly threatening. Loss-framed information may be more persuasive than gain-framed information for people with high self-efficacy, but only when the loss-framed information is perceived as sufficiently threatening. Unfortunately, perceived threat was not assessed in these studies. We are currently investigating whether perceived threat can determine whether highly self-efficacious people are more persuaded by gain- or loss-framed information. More particularly, we are investigating the possibility of moderated mediation. We have proposed that loss-framed information is perceived as more threatening than gain-framed information and that this greater threat can enhance persuasion, but only for people with high self-efficacy. This actually implies a model in which framing has an effect on perceived threat, and threat has an effect on persuasion which is moderated by self-efficacy. Because we have so far used pretests to assess whether message framing affects perceived threat, we have not yet been able to test this model of moderated mediation. In the future, we hope to be able to shed more light on this issue. We conclude that, although some questions remain, self-efficacy seems an important variable in message-framing effects.

Conclusion

Taken together, our results suggest that self-efficacy can operate as an important moderator of message-framing effects. It seems that loss-framed information has a greater potential to persuade people than gain-framed information, because of the greater threat it entails. However, this greater threat only results in health-conducive intentions and behaviours when recipients feel they are capable of averting the threat. The results also illustrate that research aimed at identifying the circumstances under which gain- or loss-framed information is more persuasive is indispensable to foster our understanding of message-framing effects and can be helpful to increase the effectiveness of persuasive messages. ■

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original article

A psychosocial model of behaviour change and a role for life events

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As an undergraduate I was taught about the importance of life events theory in the context of both depression and physical illness. The work of George Brown and colleagues was held up as a cornerstone of psychological research and paved the way for a multitude of interesting studies which integrated a number of varied psychological perspectives. The other day I looked in the back of a current textbook on abnormal psychology to find the name George Brown absent. Life events theory now seems to have been removed from our repertoire. This paper is not a eulogy to that work but reports some of our own recent research which indicates that life events may still have a role to play in our understanding of behaviour change and that such an approach may be a useful route to get the individual's social world back into our ways of thinking.

Current work on behaviour change

Predicting and explaining health related behaviour has long been the domain of health psychology. Over recent years, however, health psychologists have turned their attention to exploring the nature of behaviour change. To date this has mainly drawn upon two approaches. The first has involved the development of interventions based upon models such as stages of change theory, the theory of planned behaviour or the health belief model and has highlighted the role of skills training, cognitive shifts, implementation intentions or education as a means to promote healthier behaviour. This approach has been applied to a number of behaviours including diet, sexual health, exercise and safety helmet use (see Rutter and Quine, 2003 for a review). The second approach has involved an analysis of existing intervention-based data as a means to identify the strategies or components of strategies which are most effective at bringing about change. To this end, researchers have coded a multitude of different interventions to develop a taxonomy of the active ingredients of change (Abraham and Michie, 2008).

Although varying in their focus of analysis both these approaches have two fundamental perspectives in common. Firstly, they emphasise the central role of individual psychological factors such as cognitions, emotions and motivations as the mechanisms of change. Secondly, they conceptualise behaviour change as the result of a slow process of cognitive shifts and the development and implementation of behavioral intentions, motivation or plans. In particular, social cognition models emphasise behavioural intentions and planning, and the work evaluating interventions highlights the impact of repeated attempts at change. These analyses omit two additional possible sources of change. First, the role of social and structural factors remains neglected. It is often as if the individual exists in an environmental vacuum. Second, behaviour change may occur in a more dichotomous fashion following a specific event which has been explored using a number of different terms including teachable moments, life events, life crises, epiphanies and medical triggers. This approach reflects the work of Miller (2004) who argues that decisions to initiate and possibly maintain behaviour change are quantum rather than linear events and suggests that such quantum leaps result from a sudden rise of motivation or inspiration that is greater than the sum of its constituent cognitive parts. It is also in line with life events theory that was a central part of psychological theory and research towards the end of the twentieth century (eg. Brown and Harris, 1978). In a similar vein, West and Sohal (2006) and Larabie (2005) report that many smokers quit smoking "cold turkey" without planning and Matzger et al (2004) report that people who sustained long term remission from alcohol, were twice as likely to have done so after experiencing a transformational experience traumatic life event. Our recent research has explored the role of ►

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both psychological and social factors in promoting behaviour change with a particular emphasis on the impact of specific life events.

Life events and behaviour change

Our first study in this area (Ogden and Hills, 2008) involved a series of qualitative interviews with those who had shown sustained behaviour change in terms of either smoking cessation (n=10) or weight loss maintenance (n=24). The analysis highlighted the role for a number of different life events relating to their health, relationships or salient milestones. The results also illustrated that the impact of these life events was mediated through three key sustaining conditions; namely, reduced choice over the previous unhealthy behaviour, reduced function of their past behaviour, and a model of their health which emphasized behavioural causes and solutions. Using the example of weight loss maintenance, it was argued that the initial change in diet triggered by the life event is translated into sustained behaviour change if the event reduces the individual's choice about when and how much to eat, if it reduces the function and benefits attached to eating and if the individual believes that their weight problem is caused by their behaviour. Further, we concluded that sustained behaviour change is facilitated through a process of reinvention as individuals respond to the life event by reinventing themselves as a healthier and thinner person. This model is illustrated below in Figure 1.

Several components of this model have now been operationalised and tested in two subsequent quantitative studies. In the first study, members of a slimming club (n=538) completed measures concerning two events which had caused changes in diet and exercise resulting in either weight loss or weight gain (Ogden, Stavrinaki and Stubbs, 2009). They then described the event and rated a number of sustaining conditions. The majority of participants could describe a time when a life event had resulted in weight loss (73.9%) and weight gain (85.4%) including relationship problems, pregnancy, illness and death of someone close. In addition, differences were found between weight loss and weight gain in terms of the sustaining conditions; the weight loss event was perceived as reducing the choice over food and the function of eating and as increasing the choice over exercise and the function of this behaviour whereas the weight gain event showed the reverse effects. In the second study dieters who had lost 10% of their weight for more than 1 year (n=431) were compared to unsuccessful dieters (n=592) on the same components of the model (Epiphaniou and Ogden, submitted). The results showed that successful dieters reported a reduced choice over their old diet and exercise behaviours, more benefits from their new healthier behaviours and indicated greater endorsement for the behavioural and solutions to their weight problem. Both these studies therefore provide some empirical support for the role of life ►

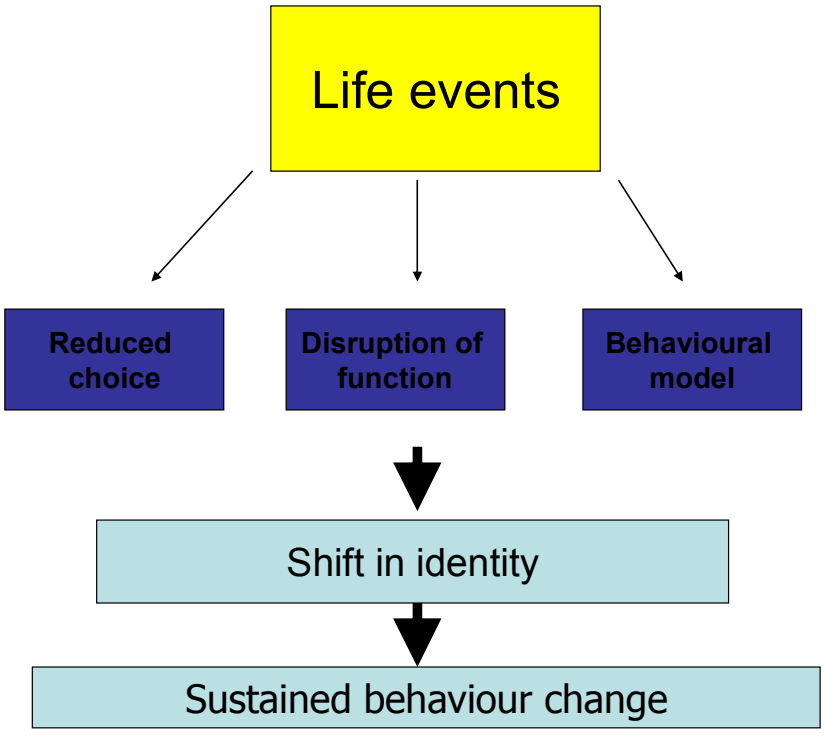

Figure 1: Life events and behaviour change (Ogden and Hills, 2008)

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events in behaviour change. Furthermore, they support the notion of sustaining conditions that enable initial changes to be translated into sustained behaviour change in the longer term. Further research is needed to explore how these variables culminate in a process of reinvention.

A psychosocial model of sustained behaviour change

Much research on behaviour change emphasizes planning and a process of slow cognitive shifts. Our research indicates that at times changes in behaviour may be more dichotomous than this and can follow sudden triggers or life events. Furthermore this research also indicates a central role for social and structural factors which can often be neglected in psychological research. Firstly, the life event happens to the individual from within their social world and may well be the result of a change in their relationships or job that is imposed upon them. It is true that this event needs to be appraised and interpreted by the individual involving the entire repertoire of psychological processes studied within psychological research. But the event itself remains an external structural factor which impacts upon the person. Second, central to the sustaining conditions outlined by the model are changes in the individual's environment. For example, a reduction in the benefits of the older unhealthy habits could result from the breakdown of an unhappy relationship making comfort eating no longer necessary, the onset of a new relationship in which smoking is no longer acceptable or a new job whereby colleagues no longer gather together to have a cigarette. Similarly, a reduction in choice could reflect a change of job to a work place where smoking was prohibited throughout the day, or a change of relationship whereby a new person was responsible for bringing food into the house. The extreme case of choice reduction occurs in those who have lost weight through obesity surgery and have had choice over food intake removed by the limited capacity of their new stomach size. Research indicates that rather than feeling prohibitive this can be experienced as liberating and result in a renewed sense of control (Ogden et al, 2006). Such changes in the individual's structural world may then provide them with the support and incentive to reinvent themselves as a healthier individual.

To conclude

Some changes in behaviour may occur as the result of plans and incremental changes in cognitions reflecting the role of internal psychological processes. But individuals exist within a social world and sometimes this world generates sudden life events which can also promote behaviour change. Furthermore, this initial change may be translated into new behaviour patterns which can be sustained if a number of conditions are met, many of which also involve the individual's environment. Put simply, behaviour change can be sustained if changes in the individual's social world make it easier to be healthier and offer the opportunity for the individual to reinvent themselves. As psychologists we can help individual's to process life events in ways which make them seize the opportunity to create a new sense of self. And as social people we can argue and support changes to the environment which make initial changes easier to sustain. ■

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Health Psychology in Italy: a decade of developments

Elvira Cicognani[1], National Delegate for Italy and EHPS National Delegate Officer

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In September 2009 the Italian Health Psychology Society (Società Italiana di Psicologia della Salute, SIPSa) will participate in the organisation of the 23rd Annual Conference of the European Health Psychology Society (EHPS) in Pisa, Italy. In this contribution we will briefly sketch the developments of Health Psychology in Italy, emphasising some aspects and the main issues that have been faced during the Society's ten years of existence, with particular reference to research, training and applications of the discipline to social- and health-related practice.

The Italian Health Psychology Society (SIPSa)

The Italian Health Psychology Society was founded in 1997, thanks to the initiative of a group of psychologists, including academics and professionals from different areas. As reported in its Statute, its aims are "to promote and develop empirical and theoretical research in Health Psychology in Italy" and "to facilitate the exchange of information amongst its members and members of other national and international societies". Instruments for the achievement of such aims include the organization of biennial congresses, the publication of a journal and the promotion of exchanges and training initiatives.

Over the ten years of its existence, and under the Presidency of Mario Bertini (Rome), Giovanna Petrillo (Naples) and currently Pio Enrico Ricci Bitti (Bologna), the Society grew very rapidly and important objectives have been reached. At the end of 2008, the Society included 170 members, and, many more researchers and professionals attend Congresses and initiatives within health psychology and publish their work on the official Journal. Moreover, about 150 psychologists are currently receiving their training in Health Psychology. Several members of the Society have also contributed to international health psychology research.

Training in health psychology

In Italy, access to the specific training in health psychology is possible upon obtaining a degree in Psychology. Following 13 years of compulsory schooling (five years of primary school, three years of junior high school, and five years of secondary high school), the degree in Psychology may be obtained after attending a three-year first degree course, followed by a two-year second degree in Psychology. By law, a State examination needs to be successfully passed (following a one-year period of supervised training) to become Chartered Psychologist (at present, they are about 70.000). At this point, in order to specialize in health psychology there is the possibility to attend one of the three existing Schools, run by the University of Rome, the University of Turin and the University of Bologna (all three have been established in late nineties). A recent law (D.M. 24.6.2006) aimed at reorganising the training within Schools of Specialisation in the Psychological domain, established that training in health psychology should last five years and that 70% of the training should be devoted to professionalising activities in order to acquire specific competences and abilities. All the three Schools, irrespective of their theoretical orientation, allow the possibility of registering as a Chartered Psychotherapist following positive evaluation of the training.

Other possibilities of obtaining some form of training in health psychology can be offered by post-degree courses lasting one or two years offered by some Universities. After the experience of a PhD programme in Health Psychology by the University of Florence in late nineties, at the moment health psychology is included as a curriculum within the PhD in Psychology offered by some Universities (e.g. Naples). Moreover, it is possible do research in health issues within other PhD programmes (e.g. PhD in Social psychology, Clinical Psychology, etc.).

Congresses

Since 1998, every two years the Italian Health Psychology Society organizes its Congress, which attracts hundreds of participants, both members and non members, presenting their most significant research studies and intervention experiences. Congresses have had a central role in the development and growth of the discipline by fostering exchanges among researchers from neighbouring disciplines. Past Congresses have been hosted in Milan, Orvieto, Florence, Naples, Cesena, and have featured a steady increase of participants. The most recent (titled "Health as a shared social ►

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Health Psychology in Italy: a decade of developments

responsibility") took place in 2008 in Rovigo from October 1st to 4th. Over five hundred participants attended the Congress; several issues were discussed, including substance abuse, immigration and health, health of children and elderly, work and health, health psychology and sport, family health, disability, emergency psychology, the architecture of health services, evaluation of health promotion interventions, etc.

More specific initiatives are also organised, focused on specific themes or issues; among the most recent of these, the University of Rome hosted (in June 2008) the International Conference on "Psychology and Economics of Happiness. Toward a change in political action" organised in honour of Daniel Kahneman, during which he was awarded an honorary degree in Psychology.

The Journal

"Health Psychology" (Psicologia della Salute), the official Journal of the Society, was first published in 1998, and edited by Mario Bertini (Rome), Saulo Sirigatti (Florence), Dario Romano (Milan) and Pio Enrico Ricci Bitti (Bologna) (since 2002 a fifth Director was added, Giovanna Petrillo, Naples). The Journal publishes different typologies of contributions (research, intervention experiences, discussions, etc.). To celebrate its tenth anniversary, the fourth issue of 2008 was devoted to a reflection on the status of Italian health psychology.

Current developments and significant achievements

In the Editorial of the special issue of the Journal, three important developments of Italian health psychology have been identified. Firstly, even though it has only recently been officially established and can be considered still a "young" discipline compared to European and North American health psychology (HP), a specific "Italian" perspective on health psychology can be identified, and its roots can be traced back both to scientific/academic developments that occurred in previous decades and to the organisation of health services (Ricci Bitti & Gremigni, 2008). The last decades of the twentieth century saw interests and practices in Italy converging to provide a contribution of psychology to health research and practice. From an academic point of view, Italian health psychology had two important precursors both with a solid tradition in theory and practice: medical psychology and psychosomatic medicine. During the seventies and eighties, Faculties of Medicine began to pay attention to the contribution of psychology toward health practice and associated problems by introducing courses in medical psychology. These courses fostered and articulated interest toward several psychological aspects of health practice, such as training of professionals working within health services, understanding of organisational aspects of health intervention, attention toward the ill, understanding of interpersonal processes characterising doctor-patient relationship, etc. Thanks to the development of such areas of interest, a further specific disciplinary area developed: psychosomatic medicine. The approach of "behavioural medicine", which flourished in other European and North American contexts and gave such and enormous impulse toward the establishment of the discipline on the international arena, attracted somewhat less interest.

A further important impulse to Italian health psychology was given by the introduction of the National Health Service (1978), which emphasised a preventative approach (besides treatment) and the integration and collaboration between different professionals (including psychologists) within decentralized local health services. This promoted a widespread and articulated presence of psychologists in different local health services and within hospitals. Psychologists could contribute to mental health services, in schools, in drug addiction services, in disability services, in preventative and public health services, in occupational medicine services, in hospitals, and in rehabilitation institutes. Over the years important contributions have been made by health psychology approaches to research and practice in contexts such as the school, the community, the workplace, the hospital.

Considering theoretical developments, clinical health psychology is still the more traditional and productive area, even though clinical psychologists are not always aware of their potential association to health psychology. Most significant contributions of Italian clinical health psychology focus on basic psychological and psycho-physiological mechanisms affecting health and well being, doctor-patient relationship, and quality of health care. Public health psychology is another area which has attracted contributions in Italy since the beginning, with issues such as communication in health, negotiation of health behaviors, participation and empowerment of citizens with respect to decisions concerning ►

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Health Psychology in Italy: a decade of developments

health, development and evaluation of health promotion interventions.

New perspectives are also growing in the Italian context; among these, community health psychology and occupational health psychology. During the last fifteen years, several social and community psychologists have developed a body of research (e.g., on psychosocial and contextual influences on health and illness) and approaches to prevention and health promotion that are consistent with community health psychology theories and methods (e.g., participatory action research). Among the most interesting areas of research is health promotion in educational and school contexts, where a strong emphasis has been put not only on the promotion of individual competences and skills (e.g., associated with adequate health behaviors) but also on the development of school policies in order to enhance the construction of health-promoting school environments. Moreover, an original area of intervention concerns the relationship with urban and community contexts, and strategies to promote urban planning approaches capable to enhance collective well-being in cities.

Finally, a "critical" tradition of health psychology can also be found in Italy, associated with the use of qualitative methods; many epistemological arguments and theoretical models typical of critical approaches have been widely discussed and adopted, even though less awareness seems to be present about the international developments of this area.

If we compare the Italian context with other European and North American contexts, we can conclude that Italian health psychologists show a reflexive attitude, and a great openness toward different methods and theories of reference. Over the years, attempts to translate theoretical models into interventions aimed at promoting health and well-being in different contexts have increased, including interventions in schools, in sport contexts, in the workplace, in health services, in the wider community. ■

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Conference Announcement

The South-east European Regional Conference of Psychology
30 October to 1 November 2009, Sofia, Bulgaria

The Regional Conference of Psychology – 2009 (SEERCP2009) "Southeastern Europe Looking Ahead: Paradigms, Schools, Needs and Achievements of Psychology in the Region" will allow us to demonstrate the achievements and enhance the capacity-building collaboration of the psychologists in the region and the world.

SEERCP2009 will help psychologists representing the countries in the region to share and increase their professional knowledge of what is going on in their countries, to learn about the paradigms, schools, needs and achievements of psychologists across the region and other parts of the world.

Conference Program includes:

- 2 Plenary sessions with Keynote addresses and brief country reports
- 8 Symposia with Paper and Poster Presentation sessions in the following areas:
  - ✓ Clinical and Counseling Psychology
  - ✓ Adolescents' Health Psychology
  - ✓ School and Educational Psychology
  - ✓ Organizational Psychology
  - ✓ Applied Social Psychology
  - ✓ Psychological Assessment
  - ✓ Disasters Management
  - ✓ Applied Psychology as a Profession

For submissions and contacts:
office@psychology-bg.org

For more information:
http://RCP2009.wordpress.com

ehps report

23rd EHPS Conference 2009 Pisa, Italy – updates

By Carmen Berrocal, Organizing Committee

The 23rd Conference of the EHPS is just around the corner. The organization has been busy and the preparations are going smoothly. Here are some recent updates on the conference preparation:

Scientific program and conference venue

This year about 1200 abstracts were submitted for the EHPS conference, one fourth of which were accepted as oral presentations, while many high quality abstracts had to be accepted as posters to comply with space and time constraints. The selection was made by the Scientific Committee (SC) on the basis of quality and relevance of the abstracts, and by admitting at most one presentation for the same first author.

Delegates can access the provisional Scientific Program (SP) at the the Conference website (please, see below). The SP is organised into four major categories of presentations:

- Keynote Addresses. Four talks have been scheduled, one per day:
  - Linda Cameron (University of Auckland, New Zealand): "Imagery and Affect as Motivators of Health Behaviours: Implications for Interventions"
  - Gian Vittorio Caprara (University of Rome "La Sapienza", Italy): "Positive orientation: Turning potentials into well functioning"
  - 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): "Is obesity an eating disorder?"

- Poster Sessions. Around 800 posters have been accepted. Posters have been organised into five sessions which have been scheduled from Wednesday 23 to Friday 25. Posters assigned to each session will be in turn clustered into thematic sessions of 10 to 12 presentations each. The final Poster program will be available in July.

- Parallel Sessions. A total of 28 symposia, 3 round tables and 31 oral sessions (each composed of five short talks) have been organised in 8 slots of parallel sessions.

Pre- and post-Conference activities include:

- "Meet the Expert" sessions. The EHPS Executive Committee has decided to continue with the initiative of providing young researchers with the opportunity to consult with leading scientists in their field of interest through "Meet the Expert" sessions, which will be held on Wednesday 23 morning.

- Workshops. Three Workshops have been scheduled on Wednesday 23 morning and three other workshops will be held on Saturday afternoon.

You can visit the Conference website -sections Scientific Program and Registration- for details on how to apply to attend pre- and post- Conference activities.

A provisional version of the Proceedings as well as the guidelines for oral/poster presentations will be available on the Conference website by June 15th. The final version of the Scientific Program will be available in July.

All the scientific sessions will be held at the Congress Palace of Pisa. Information on how to get the Congress Palace is available in the Conference webpage - Section "Conference Venue".

Poster awards

The Local Organising Committee (LOC) will offer young researcher awards to the best poster presentations. The awards will be assigned by senior members of the Society present at the Conference on the basis of the quality and of the visual display. ►

ehps report

23rd EHPS Conference 2009 Pisa, Italy – updates

Registration

Authors should register for the Conference before **June 7th** in order for their proposal to be included in the final version of the Scientific Program and in the Conference Proceedings. All those attending the Conference must register, whether or not they will present a contribution.

Early registration is encouraged, to benefit from the reduced fees. Reductions are also available for students, delegates from in-development countries, EHPS or SIPSA (Società Italiana di Psicologia della Salute) members.

Social program

- The Welcome Reception has been scheduled on Wednesday 23rd at 7 p.m., and the Conference dinner will be on Friday 25th. A packet including "Welcome Reception plus Conference Dinner" for accompanying persons is available in the registration webpage.
- Participants registered for the Conference can obtain low cost cards to visit various monuments and museums in Pisa (around 1 euro per monument/museum). Information on how to apply for obtaining the low cost card will be available on the Conference website in July.
- The LOC is trying to negotiate an agreement with the Trade Association of Pisa to offer special prices in different bars and restaurants in the city to participants.
- This year the city of Pisa offers a varied and multi-faceted program of cultural and social activities to celebrate the 400-year anniversary of the first astronomical observations by Galileo Galilei. The Galilean Year (Anno Galileiano) Program can be accessed from the Conference Website.

The LOC is also working to organise additional social events. Considering the high number of proposals submitted to this edition of the Conference and in order to guarantee adequate organisation, additional details about the social program will be provided when the precise number of registered delegates is available.

Accomodation

Participants can book accommodation in Pisa while registering for the conference. Since a limited number of budget rooms is available on campus, early booking is strongly suggested for those rooms. A list of budget rooms is accessible from the Conference website.

Further information and contacts

Registered participants will receive delegate information via email in July. Participants can also visit the Conference website (http://www.ehpspisa09.unipi.it) for details about the scientific programme, social activities, registration, accommodation and travel information. Please, note that the Conference website is continually updated.

- For further information about registration, accommodation or tourist information, please contact the Organising Secretariat -AIM ECM S.r.l.-: Phone +39 0500986136; Fax: +39 0503869188, email: ehps09@aimecm.net.

- For further information concerning scientific activities, please contact the local organisers: ehps.pisa2009@med.unipi.it

We look forward to seeing you in Pisa!
Carmen Berrocal, Organizing Committee ■

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 2009 – meet the expert

"Meet the Expert" 2009 at 23rd Annual Conference of the European Health Psychology Society in Pisa

"Meet the Expert" pre-conference sessions provide a unique opportunity for early career scientists to talk and get advice about their research ideas and career plans from experts in their field in a relaxed and friendly environment.

The group of experts are established research leaders with numerous scientific publications and an outstanding record as academic teachers in health psychology. Five experts, Profs. **Lucy Yardley** (UK), **Linda Cameron** (New Zealand), **Robbert Sanderman** (Netherland), **Denise de Ridder** (Netherland) and **Paschal Sheeran** (UK) agreed to facilitate the initiative this year. The above group of experts proposed a very broad range of health psychology domains for consultation; developing and evaluating interventions, self-regulation, cancer screening, health communication and implementation intentions are only a few of the domains.

The consultations are 30-minute one-on-one or small-group consultation sessions that will take place on the morning before the opening of the annual conference in Pisa. Participants are asked to send in some information about themselves and their study and prepare some questions in advance. This way the experts will have the opportunity to study this information carefully and thus made optimal use of the meeting time. The consultation aims to respond to the needs of each participant and includes the provision of advice on:

- Research perspectives and ideas (in order to encourage research originality).
- Issues relevant to study design (e.g. research tools selection and outcome measures).
- How to combine clinical practice with research and specifically, how to develop interventions and combine this with research.
- Important papers or books (where this was relevant, experts can provide references and other materials).
- How to apply for and obtain funding.
- Career development and networking opportunities.
- Strategies for designing research programmes that address both the development and refinement of theory and the development and assessment of interventions.

Feedback collected systematically last year showed that these sessions fulfilled participants' expectations and they found the sessions to be very useful and supportive, of high quality and optimal length. Many participants added their impressions from this experience:

- 'The atmosphere was very friendly'
- 'Excellent experience, the expert I met with was very helpful and gave me some clear and practical advice that I needed for my PhD'
- 'Although it was a group session, I had the time to answer all the questions I had, and it was nice to meet others with common interests.'
- 'My expert was very generous and helped me plan my research'
- "Excellent initiative, keep it up"

►

ehps 2009 – meet the expert

"Meet the Expert" 2009 at 23rd Annual Conference of the European Health Psychology Society in Pisa

Angeliki Bogosian (UK), who participated in "Meet the Expert" last year, has joined the organizing team and we hope that this will be a success again.

We invite you to take part in this effort!

Registration deadline:

31st July 2009

For more information or to apply click here

Evie Kirana and Angeliki Bogosian

On behalf of the EHPS Executive Committee ■

Meet the Expert 2009

Lucy Yardlev

Robbert Sanderman

Linda Cameron

Denise de Ridder

HEALTH PSYCHOLOGY from knowledge to interventions

Paschal Sheeran

ehps 2009 – synergy workshop

PRAGMATICS OF RUNNING CLINICAL TRIALS: DESIGN, MANAGEMENT AND THE PROCESSES OF CHANGE.

SYNERGY 2009 Workshop
20th-22nd September 2009, Pisa, Italy

Recently, there has been a strong call for health psychologists to engage in more translational research. Two recent editorials in Psychology and Health by leading health psychologists focused on this theme. Taylor (2008) proposed that intervention research should ask two interrelated questions "how can we make a difference in prevention or patient care, and if we do, what mechanisms might underlie these effects?' (p 133). Leventhal et al. (2007) argued that we not only need to translate concepts from theory into practice to create interventions but we also need to make sure our work meets the standards of current evidence-based practice. Intervention trials are often the most challenging forms of research but if set up correctly they can also be the most rewarding. This year's SYNERGY workshop will provide an opportunity to bring together experienced and more novice researchers to critically examine some of the more pragmatic aspects of clinical trials and address the following key topics:

- Designing trials to maximise outputs throughout the trial focusing on process and outcome (e.g. choosing control conditions, addressing ethical issues, assessing therapist effects and fidelity of treatment)
- Setting up intervention trials and the day-to-day running of clinical trials
- Testing mediator and moderator designs both in relation to improving theory and enhancing intervention effectiveness

The workshop will last three days and the scheduled timetable is: Sunday 20th September 1400-1730, Monday 21st September 0930-1730 and Tuesday 22nd 0930-1730.

The workshop will be facilitated by: **Prof Rona Moss-Morris**, University of Southampton, UK; **Prof Trudie Chalder**, Institute of Psychiatry and King's College London, UK; **Dr Alison Wearden**, University of Manchester, UK; **Prof Gijs Bleijenberg**, University Nijmegen, Netherlands.
The facilitators will guide the work, support and moderate the discussion.

The workshop fee is EUR 255 (this includes the workshop materials, lunch for Monday 21st and Tuesday 22nd Sept, coffee breaks and the workshop dinner). Please note that accommodation is not included. Rooms have been reserved at the Hotel Granduca (approx. 85EUR pn; see http://www.hotelgranduca.it). Also a few rooms are available at the Campus (approx. 35 EUR pn) for students and/or low economy citizens (see contact info below). Alternatively, you can check for further options via http://www.comune.pisa.it/turismo/index-gb.htm.

Note that the EHPS is offering 2 grants to those who want to attend the SYNERGY workshop but do not have sufficient financial resources. Each grant will be EUR 1100. For further information about the grants, please check the EHPS webite (http://www.ehps.net/) and under EHPS Grants and Stipends 2009

The workshop will be held at Congress Palace of Pisa.

The workshop will be held in English language.

Participants need to become a member of the EHPS and therefore will also receive the benefits of EHPS membership (www.ehps.net). ►

ehps 2009 – synergy workshop

Application Procedure

1. In order to facilitate the discussion within the workshop, each participant is required to submit the following information:
    1. a brief CV (including **ONLY** name, contact details, current position and relevant publications).
    2. a brief **abstract** summarizing your research on the topic (not more than 500 words).
    3. a paragraph on: a) your expectations regarding the workshop, i.e. which topics would like to concentrate on and what would you like to get out of it and b) your possible contributions.

    Please submit this information to **ab2406@soton.ac.uk**
    Submission deadline – June 30th, 2009

2. You will be notified by email or regular mail whether you have a place at the workshop by **July 15th, 2009**.
3. Please note that participation must be confirmed by registering and paying the workshop fee (**deadline is July 25th, 2009**).
4. The other participants' abstracts and a programme outlining discussion topics will be sent to all participants by **August 8th, 2009**.

Registration (only for accepted workshop participants)

Participants need to become a member of the EHPS and therefore will also receive the benefits of EHPS membership (www.ehps.net).

For registration and payment please use the **online form**

Please note that the registration **deadline** is **July 25th 2009**.

For questions or further information please contact the workshop organisers:

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Synergy 2009 Facilitators


Gijs Bleijenberg


Rona Moss-Morris


Alison Wearden


Trudie Chalder

conference announcements

conference title	date	location
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 **Keynote Speakers** ▪ **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
South-east European regional conference of psychology 2009	30 Oct – 1 Nov 2009	Sofia, Bulgaria