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Editorial

Rik Crutzen &

Emely de Vet
Editors

Dear Readers,

Welcome to the final issue of the European Health Psychologist in 2010. As announced in the September issue, a new editorial team has been assembled in the past months. First, we would like to take this opportunity to express our thanks and best wishes for the future to the outgoing editor of the European Health Psychologist, Gerry Molloy. His role as editor is taken over by Rik Crutzen, who was already active as a co-editor. We are pleased to announce that the following co-editors are now part of our Editorial Board: Richard Cooke (Aston University, UK), Anthony Montgomery (University of Macedonia, Greece), and Jana Richert (Freie Universität Berlin, Germany). Natalie Schüz (Freie Universität Berlin, Germany) continues to serve as the EHP's editorial manager. We are very happy with the new editorial team and look forward to produce EHP issues that are of great interest to the EHPS members.

In this issue, workshop reports of the past EHPS conference (in Cluj-Napoca, Romania) are included. Both CREATE and Synergy could look back at excellent workshops regarding, respectively, computer-tailored interventions and stretching and enriching qualitative research practice. Furthermore, the experiences from CREATE's first grant generation are reported in this issue. Besides these reports, two original articles are included in this issue. First, Professor Anita Jansen argues on why obesity needs experimental psychology; effective treatments for many behavioural disorders exist because there is a longstanding tradition of rigorous and outstanding experimental research into the maintaining psychological mechanisms of these disorders. Second, Professor Collins Airhihenbuwa argues on why and how to make culturally sensitive interventions.

The EHP will continue to publish relevant information from the EHPS and provide an unorthodox vehicle for the rapid exchange of your scientific findings, reflections and ideas. Hereto, the EHP invites a number of different types of contributions. Authors are invited to submit scientific contributions including position papers (think pieces), overview papers, research letters, interviews, controversial debate, and country or research group profiles. The EHP provides guidance for potential authors on its website: http://www.ehps.net/ehp/

Please do not hesitate to contact us or any of the editorial team if you have any queries or proposals for the EHP. We thank all those that have contributed over the last year and we look forward to receiving and publishing new thought-provoking pieces in 2011.

Rik Crutzen and Emely de Vet, Editors

EHPS president's message

Paul Norman
President - European Health Psychology Society

Dear colleagues,

It is a great pleasure to write my first President's message for the European Health Psychologist. I am deeply honoured to take on the position of President of the EHPS for the next two years. I have a long association with the society, through regular attendance at the annual conference, as Secretary (1996-2000) and as Editor of Psychology & Health (2001-2006). Over this time the society has grown considerably, not only in terms of its membership but also in the range of activities it now supports. During my time as President I hope to build on the success of the society and introduce a number of initiatives which will hopefully further improve the functioning and scope of the society.

Over the next two years I will be supported by a new Executive Committee (EC) that was elected at the Cluj conference in September. The new EC has both continuity and new members. Irina Todorova remains on the EC as Past-President. I am very fortunate to be able to draw upon her expertise and knowledge. During her time as President she introduced a number of important initiatives, including the Networking Grant for EHPS members, which I hope to consolidate. Manja Vollman steps down as Treasurer/Membership Secretary, but remains on the EC as an Ordinary Member. Manja oversaw a marked increase in the membership of EHPS during her tenure which, in no small part, was due to her excellent work developing procedures for facilitating membership recruitment and retention. Given her expertise, she will take on special responsibility for overseeing the website and electronic communications as well as providing support to the incoming Treasurer/Membership Secretary. Holger Schmid remains on the EC with special responsibility for Education and Training. Holger has been instrumental in overseeing the development of our portfolio of conference/workshop grants, the CREATE tandem and visiting scholar grants as well as the EHPS Networking Grant that we introduced this year. I also welcome new members to the EC. Amelie Wiedemann is the Treasurer/Membership Secretary. She has served successful terms as Treasurer of both CREATE and Synergy as well as Chair of CREATE. Likewise, the new Secretary, Karen Morgan, has served as Chair of CREATE and was instrumental in convening the new Synergy board. Gerry Molloy joins the EC and will have special responsibility for communications and publications. He has relevant experience from his successful spell as Co-Editor of the European Health Psychologist (EHP) which he will bring to this position. Finally, I welcome Falko Sniehotta as President-Elect. Falko has been heavily involved in many EHPS activities over the past 10 years, for example as a member of both the CREATE and Synergy boards, as an Associate Editor of Health Psychology Review, and as a Co-Editor of EHP. Falko brings with him a wealth of experience as well as many new ideas for the development of EHPS. Since the Cluj conference, the new EC has also asked Efrat Neter to act as National Delegate Convenor. Efrat has a particular interest in developing the National Delegates section of the society in order to encourage membership, support networking activities (e.g., joint applications for research funding), and develop the range of the society's training activities. I am looking forward to working with such a strong and enthusiastic group of colleagues and, in particular, welcoming them to Sheffield for our winter EC strategy meeting in February.

I would like to take this opportunity to also acknowledge the work of members of the outgoing EC who stepped down at the last election. Britta Renner, who was Past-President, has had a major influence on the development of the society both as President and in her previous roles on the EC. Her input and support will be missed. Yael Benyamini served two terms as Secretary. It is difficult to describe how important she has been in ensuring the smooth workings of the society over the past four years. I am pleased that she will continue to be in close contact with the EC as liaison officer for the Crete conference. Vera Araujo-Soares served as the Communications Officer and brought a range of new ideas for the development of this post. Finally, Elvira Cicognani was the National Delegates Officer in the last EC and, in addition to encouraging closer links between National Delegates, was instrumental in developing and administering the EHPS Networking Grant.

The end of the year marks the end of Rona Moss-Morris and Lucy Yardley's tenure as Editors-in-Chief of Psychology & Health. On behalf of the EC, I would like to thank them, and their editorial team, for

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all their excellent work on the journal over the past four years. In particular, I would like to highlight four major achievements. First, they oversaw the introduction of the web-based submissions procedure which has helped to reduce the time for decisions to be made on submissions. Second, the number of submissions has grown year on year, and the journal has increased in size to accommodate this increased interest in the journal. Third, Rona and Lucy successfully applied for Psychology & Health to be indexed in Medline. This should serve to increase the visibility of the journal. Fourth, the journal's impact factor reached 2.00 for the first time during their time as Editors-in-Chief. We are fortunate to have appointed Mark Conner and Daryl O'Connor from the University of Leeds (UK) who will be the new Editors-in-Chief of the journal from 2011. They bring with them considerable editorial experience and expertise in a wide range of topics in health psychology. Over the past month I have met with the new Editors-in-Chief along with Martin Hagger (Editor of Health Psychology Review) to discuss ways in which both journals can grow and support each other.

The new EC will be meeting in Sheffield early in the New Year for its winter strategy meeting. This will allow us an opportunity to consider the recent achievements of the society and to develop our aims for the next two years. We will be discussing a wide range of issues, but I would like to highlight two initiatives that we plan to prioritise. First, with the development of digital technologies over the past two decades, the voting procedures for EC elections have become somewhat antiquated. With the support of the Cluj Members Meeting, the new EC will revise the articles/bylaws of the society so that members are able to vote electronically. This will not only streamline the administration of EC elections but will also hopefully encourage more members to vote in EC elections. Second, health psychology in Europe has grown considerably as an academic discipline over the past two decades. There are now a plethora of Masters levels courses in health psychology available across Europe, some of which are detailed in the National Delegates' pages on our website. In addition, many of our colleagues are seeking to develop new courses. A recurrent theme in the National Delegates Meetings at recent conferences has been the wish for EHPS to develop a 'core minimum curriculum' that we would expect Masters levels courses in health psychology to cover. This would need to be flexible enough to encapsulate current practice across Europe, but detailed enough to provide a framework for the development of new courses. To this end, we propose to bring together experts from different countries to work on a proposal that can then be sent to EHPS members to comment on and the National Delegates Meeting to discuss. This endeavour will hopefully aid harmonisation across Europe and may ultimately feed into a specialized a EuroPsy qualification to enable health psychologists to practice in different countries.

The society's annual conference continues to be a "flagship event" that highlights some of the very best research in European health psychology. We were fortunate to hold our 2010 conference in the Romanian city of Cluj-Napoca. The conference was very popular, attracting over 1000 abstracts, and was expertly organized. The success of the conference was due to work of a large number of people including the Organising Committee, the Scientific Committee, the Track Chairs, the keynotes, the workshop organisers and facilitators, the student helpers, as well as all of the delegates who attended and presented their work in symposia, oral sessions, poster sessions, roundtables and workshops. Special thanks are owed to the Chair of the Organising Committee, Adriana Baban, who did a phenomenal amount of work both in planning the conference and dealing with the myriad of problems that can occur during the conference itself. Without her dedication, calmness and organisational expertise the conference wouldn't have been so successful and enjoyable. Our next conference that takes places in Crete (20-24 September, 2011) will be the 25th Conference of the EHPS. This marks a special point in the development of the society and I know that the Conference President, Evangelos Karademas, and the Chair of the Scientific Committee, Efharis Panagopoulou, have a number of activities planned to celebrate this important event. We look forward to working them over the next few months and visiting Crete in September.

As we approach the 25th conference of the EHPS in Crete next year, the society is in a strong position. With over 500 members and a vibrant annual conference, the society is well placed to fulfil its aims "to promote empirical and theoretical research in and applications of health psychology within Europe". Given the maturity of health psychology as an academic discipline, coupled with the recent development of the professional status health psychology, it is perhaps appropriate that the theme of next year's conference focuses on "Engaging with other health professions: Challenges and perspectives".

Season's greetings to everyone from a very snowy Sheffield! I wish you every success and good health in 2011.

Paul Norman, EHPS President

Original article

Obesity Needs Experimental Psychology

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'*Genes load the gun; the environment pulls the trigger*' is a popular metaphor that intends to illustrate the cause of the current obesity epidemic. People who are genetically determined to be obese do badly in the present environment that facilitates overeating. Highly palatable energy-dense foods are abundant, cheap, aggressively marketed, and easy to get. If one's genetic software is programmed to overeat, it is almost impossible to resist these environmental temptations. This argument, obesity following from an interaction between genetic predisposition and environmental triggers, is very common amongst obesity experts. The interaction between genes and environment is considered a sufficient explanation of obesity. The argument, however, sidelines psychology while psychological processes do play a big role in overeating, becoming obese and staying obese.

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The ultimate cause of obesity, or excess body fat, is calorie intake exceeding calorie output. This energy imbalance between calories consumed and used is mainly due to increased intake of palatable foods high in energy and it is one's eating behaviour that is a very strong predictor of one's weight gain (Hays, Bathalon, McCrory, Roubenoff, Lipman, & Roberts, 2002). People who get obese overconsume calories and they are unable to refrain from eating despite, in many cases, the desire and intention to do so. Why are some people not able to restrict their food intake to a level that maintains a healthy weight or to a level that reduces overweight? Psychological processes are responsible. Let us review some of them.

Learning processes

Learning processes are underestimated in the explanation of obesity while they play a big role. High-calorie foods are extremely reinforcing because they signal energy to survive. They are strongly wanted reinforcers (Epstein & Leddy, 2006) that easily lead to reward-driven or 'hedonic' eating. Because food is such a strong positive reinforcer, it has high potential for conditioning. Any time food is ingested, there is an opportunity to associate consumption with cues and contexts that are present at the time (Bouton, Woods, Moody, Sunsay, & Garcia-Gutierrez, 2006). The physical location where is eaten, the people with whom is eaten, specific actions that are done during eating, food preparing rituals, the smell and taste of foods, and also moods and mental states; they may all become associated with the eating and when this happens, classical conditioning occurs. Frequent exposures to large portions of highly palatable high-calorie foods make a large number of daily learning opportunities. The context and/or cues become signals for eating and every time one is exposed to a context or cue, strong eating desires are triggered – also called cue reactivity – thereby increasing the chance of overeating: cued overeating. To give you an example of learned cue reactivity and cued overeating: Imagine that you have been dining in an excellent restaurant. You ate a starter and a main dish and you drank some glasses of good wine. You decide to skip the dessert because you have had enough. The dessert card passes and you read 'chocolate mousse'. You think of the very delicious chocolate mousse you ate a month ago and you decide to order the mousse. Thinking of the delightful mousse made your mouth water, despite being satiated. You showed cue reactivity; the cue is the word chocolate mousse and your thinking of how delicious the mousse would be. Your response is the desire that you experience, possibly combined with bodily reactions like the release of insulin and a salivation response (the mouth watering). At that moment, eating is the most appropriate response. ▶

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Jansen (cont'd)

Many animal studies show that cued overeating is easily learned. Conditioned cues are able to elicit feeding in sated rats. It was even found that a context in which rats had learned to eat highly palatable foods, induced the overeating of unpalatable foods after conditioning (Boggiano, Dorsey, Thomas, & Murdaugh, 2009). Few human studies were done, but these few do consistently show that conditioned food cues and food contexts strongly determine intake (e.g., Van Gucht, Vansteenwegen, Van den Bergh, & Beckers, 2008). They also show that the extent of cue reactivity determines the amount eaten. Cue reactivity promotes overeating, and is positively correlated with Body Mass Index (BMI) in adults and children.

Food cue reactivity is yet an underestimated risk factor for relapse. The reinforcing value of food starts the conditioning process and learned cue reactivity is the maintaining mechanism of overeating. Cue reactivity makes it difficult to not eat: it is difficult to resist food in a cue reactive state. One is not always aware of the cue/context – eating associations and one's own reactivity: cues or contexts can automatically trigger a desire to eat, approach behaviour and excessive eating. Most of the time, overeating in response to increased cue reactivity is done more or less automatically. This 'automatic overeating', of which one is not aware, might easily end up in habitual overeating or habitual snacking (Rothman, Sheeran, & Wood, 2009). Habitual overeating in response to everyday cues strongly correlates with long-term weight gain and obesity. The automaticity of this context-induced or cued overeating makes it very difficult to control the overeating (Jansen, Stegerman, Roefs, Nederkoorn, & Havermans, 2010; Jansen, Havermans, & Nederkoorn, in press). An exciting prediction is that cue exposure with response prevention should be able to extinguish the learned eating desires and automatic overeating (Jansen et al., in press).

Negative Affect

Another psychological process that strongly influences overeating is related to mood. It has been documented frequently that the obese are vulnerable for depression. Many studies show strong and significant associations between depressive symptoms and obesity. While strong emotions usually lead to decreased intake, emotions do increase intake in many obese. The obese are more frequently self-reported emotional eaters compared to lean people. Associations between brain reward responses to food cues and self-reports of negative affect were demonstrated in emotional eaters (Bohon, Stice, & Spoor, 2009), indicating an association between low mood and food reward in emotional eaters. Emotional overeating is a main source of excessive calorie intake in many obese people and it might sabotage efforts to lose weight.

Impulsivity

Although the prevalence of obesity is growing, not everybody is obese, pointing to individual differences in vulnerability. Clearly, some people are better able than others to regulate their eating in spite of overwhelming environmental temptations. Robust findings show that personality characteristics are involved in these individual differences: the obese are more impulsive than lean people (Nederkoorn, Havermans, Roefs, Smulders, & Jansen, 2006). Individual differences in self-regulatory abilities are visible early in life. Some children are better in the 'delay of gratification' than others; they show good ability to wait for a bigger treat instead of an immediate smaller one now. Effective delay of reward is related to protective and positive outcomes later in life, like less negative affect, increased self-esteem, less mental health disorders, higher income and higher education level. Impulsivity can be divided in two components: a component reflecting high sensitivity to immediate reward and a component reflecting poor response inhibition. Many studies showed that obese people are extremely sensitive to reward and bad response inhibitors, also when these rewards and responses are not related to eating. It has further been documented that general reward sensitivity and poor response inhibition are also related to overeating, weight gain, and less weight loss during weight reduction treatment (Nederkoorn, Jansen, Mulkens, & Jansen, 2007). The finding that the induction of impulsivity in lean people led to overeating and weight gain, demonstrated that impulsivity is causally connected to overeating (Guerrieri, Nederkoorn, Stankiewicz, et al., 2007). Clearly, it is more difficult to regulate oneself and one's food intake when characterized by the personality trait impulsivity. Experimental studies show that inhibition training is a promising intervention to better resist temptations (Houben & Jansen, 2010).

Control resources

Being able to resist temptations of the current environment depends largely on someone's capacity to control oneself and the availability of cognitive control resources. Individuals differ in their capacity to control themselves, and recent studies into the role of this so-called executive system show that limited executive control capacity predicts overconsumption. The amount of control resources is also state-dependent. When control resources are depleted, for example because ▶

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somebody has been doing a hard job that required lots of self-control, this depletion might lead people to automatically give in to their impulses – at that very depleted moment there is no control system available to override impulses. Depletion of control resources and/or a weak executive system increase the risk of automatic or mindless overeating. Working memory training might be an interesting way to strengthen the executive system.

To conclude

Psychological processes contribute largely to obesity. They are able to explain, at least partly, why people overeat while they do not want to, and why they cannot lose weight. I reviewed some psychological processes that are obviously related to overeating and the maintenance of obesity: learned cue reactivity, negative affect, increased reward sensitivity, weak response inhibition, and depletion of control resources. Without doubt, there are more mechanisms that can explain excessive appetitive motivation. For example, there is some strong evidence for shared brain reward pathways for food and drug rewards in animals and that is another argument to consider obesity a 'food addiction' or mental disorder (Volkow & O'Brien, 2007).

It is amazing to observe that the influence of genetics and environment is reason to not consider obesity a cognitive behavioural problem. Many mental health problems, like depression, anxiety disorders, addictive behaviours, eating disorders and so on, have genetic roots and are triggered by cultures or environments. For these mental health problems, genetic contribution and context-specific triggers are not at all a reason to doubt the strong influence of cognitive and behavioural processes. On the contrary: it is often a reason to arm the individual against his or her own weaknesses in specific situations, for example by challenging and changing specific core beliefs and by exposures to situations that trigger the undesirable behaviour. It is clear that obesity suffers from a biomedical research bias. But obesity mainly is a behavioural problem: the obese overeats and is not able to reduce intake. Psychological studies into mechanisms that maintain the overeating and sabotage weight loss are highly needed.

At least half of the obese people are not happy. They are concerned about their body shape and weight and show depressive symptoms. Many of them report emotional overeating. These obese sufferers might benefit from treatment in mental health care. Many obese people report they want to lose weight but they are not able to, they fail time after time. These obese people might also benefit from treatment in mental health care. Cognitive behaviour therapists are trained to change behaviour. I know that behaviour therapy is not an effective treatment for adult obesity. Yet. Effective interventions need knowledge about maintaining mechanisms. We do not know anything yet about the weight maintaining mechanisms in obesity. We need to know more about the mechanisms that keep people eating and that sabotage intake reduction. Therefore, experimental studies into the mechanisms that maintain the behaviour are needed. What happens when the mechanism is manipulated? Induction of the putative maintaining mechanism should increase overeating and weight gain whereas a reduction or removal of the mechanism should induce decreased eating and weight loss. Experimental studies into the psychological mechanisms that maintain overeating and obesity are scarce. Very scarce. For many behavioural disorders effective treatments exist because there is a longstanding tradition of rigorous and outstanding experimental research into the maintaining psychological mechanisms of these disorders. That is what obesity needs too. After all, it is the obesogenic environment that loads the gun, but the mind pulls the trigger. ■

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Original article

Culture Matters in Global Health

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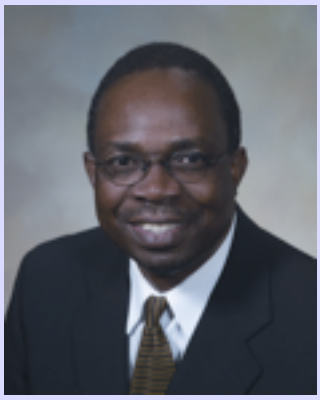
Foreground

Every global perspective begins with somebody's local perspective. This reality does not invalidate the reach and relevance of the 'local' and its place on the global landscape. However, it does allow one to examine the location of the local and its global vantage point. The privileging of individual power to change behavior regardless of the context of such a behavior is an example of somebody's 'local' becoming global. Individual preeminence over its environment is a cultural experience that may find relevance in many settings but should be located in its cultural vantage point of departure. In health and psychology, individual focused health behavior change has been recognized by many scholars as limiting and/or unsustainable even when a change does occur. It is the context of behavior known to influence health that should be the focus of health psychology and public health. Thus, what is absent, however, is a strategy to address the contexts of health behavior rather than focusing on individuals. One contextual factor that most scholars agree is central to understanding health behavior is culture. In culture, we learn to appreciate community assets and liabilities rather than focus only on the liabilities and hence the following declarations that have resulted from my research.

I contend that when you arrive in a community to address a health issue, you should begin with something positive that the community does correctly - their assets. If you cannot identify something positive, then you should not remain in the community, otherwise you are likely to focus only on their problems and may in fact become a part of their problems. This value in beginning any community project with identifying their assets and what is positive about the community has become a core of my health and culture mission over the past years. It illustrates what has become my mantra, signaling my point of departure on locating culture, especially positive aspects of culture, at the core of effective community health intervention programs.

The Journey

Research on the role of culture on health behavior has gained unprecedented attention. Earlier studies on culture typically focused on behavior of Africans and ethnic minorities in the West that have been 'Otherized' by representing them as problems for which their identity has become coupled. Over the years certain sub-groups in these populations have been targeted for global health efforts. For example, children are represented as those needing to survive and hence child survival, mothers needing to be saved and hence safe motherhood. It is as though children and adults in these cultures are of interest for the problems with which they have been identified and from which some international agencies must 'rescue them'. The primary lens through which these problems are defined and solutions advanced are based on individual psychology. This is premised on the notion that individuals have preeminence over their environment and they alone can change problems regardless of their contexts, hence we must teach them to gain power (read: empowerment) to change their behavior. In my earlier research in public health, I drew lessons from a variety of disciplines and from contributions offered by scholars whose identity is tied to those of men and women framed as having problems. What became evident was that the contexts that frame and nurture the humanity of Africans have been totally ignored in public health and psychological literature. Moreover, even though research reports and papers may focus on health, the scholarly convention in pro-



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Airhihenbuwa (cont'd)

moting a diseased 'Others' assumed a disciplinary normalcy in fields like psychology. It is from this earlier epistemic foundation that health psychology emerged as a field of specialization. The challenge of a culturally anchored health psychology project, therefore, is to erase these impoverished representations by unpacking the biases in their professional logic. Health psychology offers possibilities for promoting culture-centered ways of knowing to advance a strategy that allows one to engage 'Others' in understanding themselves from the perspective of their culture. Thus locating identity at the intersection of health and culture was the birth of the PEN-3 cultural model, which was first published over 20 years ago (Airhihenbuwa, 1989). PEN-3 is used increasingly in different cultures of the world to address a range of health problems, particularly in subpopulations that are 'Otherized' by being consigned to the margins of society.

To understand and appreciate the value of culture, one could recall the value of a Native American Indian expression that says 'the longest journey you will ever take is the journey between your head and your heart.' To engage in this journey is to begin the process of walking towards yourself, which is the beginning of knowing who you are without what you do. By 1988, at the beginning of the HIV and AIDS epidemic, Africa was again thrust into the doomsday lime light in attempts to frame either the origin of or who is to blame in what would come to be known as the pandemic of modern time. First was the blaming of the continent for the beginning and spread of HIV. What follows was and continues to be attempts by many to monotonize the continent as a single entity even though HIV incidence in some African countries is less than that in some Western countries. Moreover, some areas with the highest cases, like Botswana and South Africa, also represent areas with a stable economy and model governance. Yet response to HIV goes along the line of blaming cultural practices or ineffective governance.

The Point of Departure

The PEN-3 cultural model has been described in detail as a model used to understand the intersection of health and culture (Airhihenbuwa, 1995, 2007a, 2007b). PEN-3 prepares researchers to respond to the question which asks: do you know who you are without what you do? The single most unspoken tension between those developing interventions and the population for whom the intervention is developed is the inability to connect with the population at the human level. Academics and professionals are quick to cite their professional identity (read: professors, directors, supervisors, etc.) without ever engaging in self -reflections of who they are without their professional title. After all, it is at this level of who they are that they ought to engage the community.

In PEN-3, we approach a community to conduct studies on a given issue. In South Africa, for example, we examined the meaning of HIV and AIDS related stigma (Airhihenbuwa, et al., 2009). There are four basic steps to PEN-3. First, begin with a qualitative study (e.g., focus group) to generate community response to an issue, making sure that probes include perspectives on the issue that are positive, unique, and negative. Second, results (which may include findings from subsequent surveys) are then grouped into 9 cells of PEN-3 by crossing the domains of relationships and expectations with cultural empowerment. Third, return to the community to share with them the comments generated and ask the community to group them into the same groups as the researchers. Once the community has completed grouping this into categories, the fourth and final step is for the research team to share with the community how they grouped theirs. Points of convergence and divergence become the focus of discussion to better understand the logic employed to reach the groupings of both community and research team. Collectively, the researchers and community can decide and prioritize what intervention is needed and where to begin.

Since PEN-3 was first published (Airhihenbuwa, 1989), revisions have been made and the model has been used to address several health problems including cancer (Erwin, et al., 2007), hypertension (Walker, 2000), diabetes (Goodman, Yoo, & Jack, 2006) smoking (Scarinci, Silveira, Figueiredo dos Santos, & Bettina, 2007), food choices (Underwood et al., 1997), and obesity (Kumanyika & Obarzanek, 2003). The development and revision/strengthening of PEN-3 over the years has drawn from the wisdom of many scholars of diverse background. Generations of African writers have taken up the challenge of raising issues with the notion of a monolithic African. The writer Chimamanda Adichie cautioned about 'the danger of a single story' by challenging her audience to move beyond the simple construction of one dimension of an African to one where Africans are understood to have several stories, some good, some uniquely African and others not so good. The PEN-3 model, therefore, was developed to offer a cultural lens for those who are committed to addressing health issues and problems amongst Africans and 'Others' by beginning with the positive aspects of the culture. This is a bottom-up approach. A bottom-▶

Original article

Airhihenbuwa (cont'd)

up approach argues that the limitations observed in intervention outcomes are often the result of using models and theories that focus on individual problems, rather than locating the problem within its context.

PEN-3 also helps us to filter noise about culture that is not based on empirical evidence. Certain practices might go against the social goal of closing the gender inequity gap, for example, but the practice cannot be erroneously linked to the spread of HIV when available data suggest otherwise. An example is data that shows that polygyny is a risk factor for HIV when the reverse is supported by research (even though polygyny is not what we necessary want to promote). The notion of the hyper-sexed Africans has led to various interventions focused on how to desexualize Africans. Yet a study published in the Lancet (Wellings, et al., 2006) on sexual behaviors globally shows that Europeans have more sex than Africans yet Africans are portrayed as hyper-sexed. At a recent meeting convened by UNESCO to examine ways to anchor HIV prevention on culture, a participant wondered why donor agencies have not addressed how messages coming from their 'Western' cultures promoted some of the cultural practices that are being questioned today. Some of these practices believed to prevent HIV today where once proscribed by missionaries. For example, male circumcision was once denounced by missionaries in some cultures as 'immoral'. Home based care was once considered retrogressive but now it is promoted. Communities want to historicize the contradictions being advanced for Africans, and thus, question the question.

Questioning the question: From tobacco to obesity

Smoking prevention represents an example of the importance of changing the context of smoking before any reduction can be observed. Indeed, the gains made in smoking reduction are in large part due to program and policy interventions that addressed the contexts of smoking. It started by first restricting smoking in confined spaces beginning with airplanes, then restaurants and finally public buildings and spaces. Conversely, the growth observed in many countries with increases in smoking is in large part due to absence of related policy and context-based interventions. The next frontier for global health that now demands public health attention is obesity. It is quite evident that like smoking, the success of obesity will be measured by the degree to which cultural and contextual factors are taken into account. This is perhaps even truer in obesity than it was in smoking because individual weight management programs have failed to achieve sustained reduction in weight through diet and other individual based interventions. Indeed, the contexts that have established and nurtured obesity are systemic and structural, hence the need to turn to culture. Take the issue of food portion size in the United States, for example. Today's convention of larger portion size may have been introduced by fast food industries, but sustaining large portion size owes as much credit to family and mainstream restaurants as it does to fast food ones. Not only do the average family restaurants pride themselves at serving with individual meals more portion than they can finish at a seating, plate sizes have also significantly increased from what they were two decades ago. In fact the size of the plate for serving the main dish two decades ago is now the size of salad or desert plates. The size of the main meal dish has increased significantly and families have adapted to offer their family with enough meal to fill the plates. This system increase in not only the meal, but dishes, utensils, cups and other parts of serving the meal requires a systemic change that cannot happen at the level of the individual.

There are suggestions that the success of changing the context of smoking holds strong promise for strategies to reduce the global pandemic of obesity. The only problem is that unlike smoking, we all need to eat to survive. Smoking is not needed for human survival, and therefore, has no benefit for health. Eating on the other hand does. We all need to eat for our daily nourishment. Eating, or better yet, what is eaten is the primary cause of obesity. At the core of what we eat, how we eat and with whom we eat is culture. Eating becomes a form of expressing cultural identity whether or not it is intentional. Thus, while the context of a behavior like smoking played a major difference in smoking reduction by using policy to enforce certain changes in behavior, eating and the resulting obesity is better understood within the context of food production and distribution, and the culture of food. Obesity may very well be the first example of a chronic condition that offers insight into why certain water borne diseases remain endemic in countries of the Southern hemisphere. Obesity and the link to identity may offer insight into why certain water borne diseases persist in poor resource areas for decades. Food and water represent basic human needs. Left with a policy to regulate their content, value, quality and quantity, the outcome is obesity from food and diarrhea from water. Thus to understand the nature of obesity, like water borne diseases, one needs to begin at the level of the community to understand the role of culture in food and water consumption rather than focusing solely on the individual behavior. ■

Original article

Airhihenbuwa (cont'd)

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CREATE workshop report

CREATE 2010: "Computer-Tailored Interventions"

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How to develop a computer-tailored intervention? From 21 different countries, 30 participants attended the 2010 CREATE workshop to find out the answer. This year's host city was Cluj-Napoca, located in the central part of Romanian Transylvania, one of the most important academic, cultural, industrial and business centers in Romania. It hosts the country's largest university, Babeş-Bolyai University, the location of this year's EHPS Conference that took place from September 1st to 4th.

Being a well-established professor in Health Communication and one of the pioneers on computer-tailoring and e-health in the Netherlands, Hein de Vries was the facilitator of this year's workshop. His aim was to teach the basic principles of setting up computer-tailored interventions and developing tailoring algorithms, and to let us develop, pilot and evaluate a small computer-tailored intervention. Assisted by two co-facilitators Daniela Schulz and Matthijs Eggers, also from Maastricht University in the Netherlands and both experienced in the development of computer-tailored interventions, the early career workshop took off on September 29th.

Currently, computer-tailoring is one of the most promising and innovative approaches in health education. Better exposure, more intensive cognitive processing as a result of individualization and the self-evaluation properties of computer-tailoring have been proposed as important success factors (Krebs, Prochaska, & Rossi, 2010). Computer-tailoring can be defined as personalization of health education materials through a largely computerized process (de Vries, & Brug, 1999). In short, people are surveyed or interviewed, and the results are used to develop individualized feedback and advice (Brug, Oenema, & Campbell, 2003). De Vries sketched a clear stepwise approach of developing a computer-tailored intervention. An essential first step is formulating clear goals: what is our goal population and what do we want them to do? What behaviour and actions do we aim for? Both proximal and distal factors should be defined and recognized in a theoretical model: the foundation of the intervention. Consequently, the factors in the model should be assessed by a questionnaire. Our first challenge: create

CREATE 2010 workshop participants

this theoretical foundation and develop a questionnaire applicable to the health topic of interest. Once a buddy was found, we explored this first phase and soon discovered that setting up a computer-tailored intervention means making thoughtful decisions. The length of the questionnaire, type of constructs used, personalization of the question (i.e. "When I smoke, this will increase my chances of getting lung cancer" versus "Smoking causes lung cancer") and the type of answering scales (one- versus two-sided) used are directly linked to the drop-off rate, length of the tailored feedback messages and construct validity.

The next step was to design the tailoring program and provide tailored feedback messages. With the help of a bulky manual and two experienced co-facilitators we were introduced to Tailorbuilder, a web-based application that can be used to create and conduct web-based questionnaires and design and implement computer-tailored interventions. Tailoring and skip formulas, debuggers and advice blocks soon all became familiar expressions during the second day of the workshop. Here again, crucial decisions must be made and strategies must be planned. Obviously, building messages and communicating them needs clear objectives on tailoring and feedback strategies. For instance, incorporating recognizable aspects of a person in the ▶

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CREATE workshop report

CREATE 2010: "Computer-Tailored Interventions"

content information, personalization, is an important feedback strategy. Attention and motivation to process messages can be increased by identification (identifying a person by name or using pictures of that person), customization ("From the response that you gave, it appears that…") and contextualization (framing messages based on demographic information) of feedback messages (Hawkins, Kreuter, Resnicow, Fishbein, & Dijkstra, 2008). In addition, the content focus of the feedback messages can be switched from either descriptive ("You mentioned that smoking will help to make friends"), to normative ("There are more people that hold the same idea") and evaluative ("Actually, you are not quite right about that") or a combination of those.

We can conclude that this year's CREATE workshop was a well-tailored one. Being able to directly apply theory to the development of your own mini-intervention on your own health topic was a strong motivator for the participants. Although developing a computer-tailored intervention is a complex and comprehensive process, this workshop introduced us to the main principles of computer-tailoring and taught us a stepwise approach for its development and implementation. Finally, it was a great experience to get to know fellow researchers from different nationalities and backgrounds, but somehow all for various reasons interested in the topic of computer-tailoring. The CREATE team excelled in the organisation of the workshop and matching social programme. They offered us a glimpse of the city of Cluj-Napoca from multiple perspectives: historic, gastronomic, "choreographic" and sportive. I would definitely recommend fellow early career researchers to attend next year's workshop on "Systematic Review, Meta-Analysis and Qualitative Meta-Synthesis" on Crete and if I were you, I would already start practicing your dodgeball skills. ■

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Synergy workshop report

SYNERGY 2010: "Beyond Talk and Text": Stretching and Enriching Qualitative Research Practice

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The town of Cluj-Napoca, Romania provided the perfect backdrop for SYNERGY 2010, which was my first major workshop; made even more exciting because my MSc research paper was accepted for oral presentation at the subsequent EHP conference. SYNERGY had a varied programme and was extremely well organised thanks the outstanding work of the organising committee (Panayiota Andreou, Maria Karekla, Karen Morgan, Felix Naughton, Gjalt-Yorn Peters, Ann-Marie Plass, and Benjamin Schüz), and the local organisation of Eva Kallay.

Hard work at the workshop...

The eminent Professor Kerry Chamberlain, an expert in the field of qualitative research facilitated this SYNERGY workshop, which aimed to encourage participants to push the boundaries and explore innovative developments in qualitative methods; to develop critical thinking about qualitative research in general; and promote understanding of the value and the implications of a creative and reflexive approach to research practice.

The fifteen participants had diverse research interests and represented seven countries, with experience ranging from more naïve researchers about to embark on doctorate research (such as myself) to more established researchers. SYNERGY had all the ingredients to make a perfect workshop, comprising a handful of informal talks, a drop of discussion, a dash of group work, a sprinkling of delegate research presentations and a pinch of feedback, all stirred together with a generous splash of reflexivity.

Professor Chamberlain's talks were thought provoking and inspiring, and challenged us to think of qualitative research as fluid and flexible. We considered alternative approaches to qualitative design, data collection and analysis, and reporting of research findings. We learned that research is interpretive by nature, and should have a sound epistemological, theoretical and methodological basis but should be data driven. As researchers we should also be engaging in 'doing' theory rather than 'having' theory; theorising throughout the analytical process. We should be more adventurous in our data collection using multiple approaches where appropriate (e.g. art, theatre, elicitation, biography); move away from the restrictive "methodology" mind set towards a more critical approach; be more reflexive throughout the research process; focus on the issues, topic and research question (rather than the methodology); and finally be more interpretative in our analysis.

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The individual group-work afforded me the opportunity to stretch my skills and develop my PhD research, which was facilitated by other delegates through a process of knowledge sharing and constructive feedback. Each delegate presented their worked-up project to the whole group on the final day. The ideas and skills I developed within the workshop have without a doubt enhanced my PhD research project, and will enable me to 'do' more theorising, and to adopt a more reflexive approach. Ultimately, I was fortified with a greater insight into the essence and creative scope of qualitative research.

As SYNERGY drew to a close, a 'friendly' game of dodge ball with the parallel CREATE workshop delegates resulted in SYNERGY's first victory over CREATE for some years. A triumphant roar is in order for not only for the positive social outcomes of the SYNERGY experience, but also for the achievement of the original aims of the workshop. Aims to provide a support network for both early-career and established researchers, to facilitate collaborative working within Health Psychology throughout Europe and beyond, and to disseminate innovative ideas that will propel qualitative research within Health Psychology into exciting unchartered waters. ■

...and fun at the dodgeball game

CREATE grants

CREAT(E)ing New Research Network Opportunities for Early Career Scientists: From Riding a Tandem and Other Ventures

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Collaborative Research and Training in the EHPS (CREATE) is a subdivision of the European Health Psychology Society (EHPS) which promotes education and collaboration among early career researchers in the field of Health Psychology. CREATE is a platform for early career health psychologists aiming at sharing experiences, building international research networks and collaboratively learning from experts. This platform is organized mainly along three activities: Annual workshops prior to the EHPS conferences, the organization and maintenance of a networking research database for junior researchers on the internet as well as CREATE's new Facebook group. During the CREATE workshops, early career health psychologists from all over Europe and the world are given the opportunity to gain a common knowledge base facilitated by leading experts in the field. However, the added and lasting value of CREATE workshops lies in getting to know other early career researchers, developing international research collaborations and friendships (and of course in having a lot of fun during CREATE's renowned social programs). Besides the workshops, members of CREATE are invited to join the Facebook group called CREATErs and/or post their research profile on the member's database (www.ehps.net/create/join.html), which allows to identify common research interests and problem areas as well as discussing and sharing ideas. Becoming a CREATE member is easy – it is open to all doctoral or post-doctoral researchers working in the field of Health Psychology who are already members of the EHPS. Since 2009, CREATE members cannot only share ideas with senior experts and other postgraduate researchers during workshops, but also extend and strengthen their research network by applying for two new grant opportunities: the Visiting Scholar grant and the Tandem grant. These newly established funding initiatives offer early career scientists the opportunity to initiate and implement joint research either with one another or with a senior expert in Health Psychology. Whereas the Visiting Scholar grant is intended to allow an early career researcher to visit a senior researcher in another country, the Tandem grant is aimed to facilitate joint research among two early career scientists. Every year, CREATE awards two scholarships per grant type.

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From Riding a Tandem and Other Ventures: Experiences from CREATE's first grant generation

In 2009, the first two Visiting Scholar grants were awarded to Maartje Van Stralen (VU Medical Centre Amsterdam, Netherlands) who had the opportunity to collaborate with Professor Susan Michie (University College London, UK) and Lisa Mellon (Royal College of Surgeons in Ireland) who joined the work group of Professor Clemens Tesch Römer, Dr. Benjamin Schüz and Dr. Susanne Wurm at the German Centre of Gerontology (Berlin, Germany).

"*My visit to Prof. Susan Michie at the University College London was a great opportunity and an amazing experience. I learned a lot which I will definitely be able to use for my future research.*"
(Maartje Van Stralen, The Netherlands)

During her stay in Berlin, Lisa consulted with the research group of the German Centre of Gerontology on conceptual and discipline based challenges in collecting individual health psychology data in population based data sets, and furthered her knowledge on methodological problems in analyzing large scale data sets. Emphasis was placed on familiarization with statistical techniques and software employed by the German Centre of Gerontology in longitudinal analyses (e.g. using Mplus to apply latent growth curve modeling). Another goal of her stay was to identify points of mutual interest with potential for collaboration between the Irish Longitudinal Study on Ageing (TILDA) and longitudinal studies conducted by the German Centre of Gerontology, such as the German Ageing Survey and the project "Personal Ressources of Elderly People with Multimorbidity: Fortification of Effective Health Behaviour (PREFER)". Preliminary comparative analyses were conducted on similar items which allowed for prospective development of ideas for the enrichment ▶

CREATE grants (cont'd)

of cross sectional analyses from Wave 1 of TILDA.

CREATE's first generation of tandem grant teams – Theda Radtke (University of Zurich, Switzerland) and Daphne Kaklamanou (University of Sheffield, UK) as well as Lisa Warner (Freie Universität Berlin, Germany) and Keegan Knittle (Universiteit Leiden, the Netherlands) worked on creative joint research projects. Theda and Daphne initiated an innovative project on Compensatory Health Beliefs (Knäuper et al., 2004). Compensatory health beliefs (CHBs) are thoughts, convictions and opinions that an unhealthy behaviour (e.g. binge drinking) can be compensated for (or neutralised) through the performance of a healthy behaviour (e.g., eating fruit; Rabiau, Knäuper, & Miquelon, 2006). In their cross-cultural experimental study among 40 English and 40 Swiss women, they intended to investigate how CHBs are utilised within dietary behaviour in a nonclinical sample. CREATE's other research tandem, Lisa Warner (Freie Universität Berlin) and Keegan Knittle (Universiteit Leiden), worked on a joint manuscript investigating different sources of self-efficacy with regard to physical activity in people with multiple morbidities (Knittle, Warner, Ziegelman, Schüz, Wurm, 2010).

For next year's grant season (2011/2012) CREATE welcomes applications from early career researchers worldwide who are members of the EHPS and the CREATE network. ■

"The visit was enlightening to me in terms of developing a deeper understanding of longitudinal research, and learning from experienced researchers in the area of ageing perceptions. Their expertise facilitated the development of my PhD research questions and they provided clarity in terms of appropriate methodology and analysis for my PhD. I am also extremely grateful to have developed a good working relationship with the research team at the German Centre of Gerontology. Furthermore, I was able to facilitate the exchange of information between the Irish Longitudinal Study on Ageing (TILDA) and the German Ageing Study."
(Lisa Mellon, Ireland)

"Most PhD students only get to experience what it is like to work in their own, and maybe one other, department. Working on the tandem grant provided not only the opportunity to collaborate with others on an interesting project, but also the chance to see how health psychology groups at other universities and research institutions operate."
(Keegan Knittle, Texas)

"The tandem grant is a great opportunity for young researchers to get an insight into another research tradition, learn how to team work even over distances, and establish international networks. Apart from the scientific benefits, our Tandem was a lot of fun as well!" (Lisa Warner, Germany)

CREATE Research grants at a glance

- Launched in 2008
- 4 grants awarded each year: 2 Tandem grants (among two early career scientists) and 2 Visiting scholar grants (among early career scientist and senior expert)
- For application details & deadlines see: http://www.ehps.net/create/grants.html

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