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in this issue

Page

EHPS president's message

Dear colleagues,

Since our winter meeting in Sheffield earlier this year, the EC has been busy working on various ongoing activities and new initiatives, as detailed in my last President's Message. I will report on these in more detail in the next EHP, but in this issue I would like to highlight two important developments.

UN Association

I am pleased to report that the EHPS is now associated with the Division of Public Information/NGO Section of the United Nations. This has been a very long process which has involved many members who have completed countless documents over the past few years. In particular, I would like to acknowledge the work of our Past-President, Irina Todorova, who has been instrumental in ensuring that our application was successful. In addition, thanks should also be extended to Susan Michie and Suzanne Skevington, who worked with Irina Todorova on the UN application preparation subcommittee, as well as to Ad Kaptein, Margreet Scharloo and Manja Vollmann for assisting the application.

Our initial association is for a trial period of two years. During this time will we seek to solidify our relationship with the UN, by contributing to its activities, attending meetings and establishing connections with other professional psychological societies who are associates. Over the next few months members will receive more details about our association with the UN and requests to participate further in this exciting development for the society.

25th EHPS Conference in Crete

As you will be well aware, preparations for our 25th conference in Crete later this year are at an advanced stage. The conference organisers received over 1000 abstracts, which means that the conference is likely to be one of our largest to date. We are fortunate that the Creta Maris Convention Centre is large enough to comfortably accommodate all of us! Our conference liaison officer, Yael Benyamini, recently visited the conference venue and produced a glowing report for the EC on both the location and the facilities that we will have at our disposal. One of the challenges faced by the Scientific Committee and the Organising Committee has been how to fit so many abstracts into the conference programme. In particular, two changes have been made to the initial conference programme to accommodate more oral presentations. First, it was decided to extend the duration of the conference to utilise the first (Wednesday) morning of the conference. Thus, it was possible to fit in two additional time slots for oral presentations. As a consequence of this change, the pre-conference workshops and the Meet the Expert sessions have been moved to the Tuesday. Second, given the number of available lecture halls in the conference venue, it was decided to include an extra parallel session throughout the conference programme. As a result of these changes, there are now seven parallel sessions over ten time slots. In addition, there will be three poster sessions that will be held in a large open area within the convention centre.

Paul Norman
President - European Health Psychology Society

In addition to the main conference programme, Create and Synergy are both holding three-day pre-conference workshops. The Create workshop, facilitated by Richard Cooke, Rachel Shaw and Wendy Hardeman, is on systematic reviews and will be attended by 40 early career researchers. The Synergy workshop, facilitated by Marie Johnston, Derek Johnston and Diane Dixon, is focusing on testing "Theory and Intervention with Individuals". A few spaces are still available on this workshop. There are also a range of short workshops before, during and after the conference that delegates can sign up for.

We are indebted to the hard work of many people in ensuring that preparations for this year's conference have gone so smoothly. However, special thanks are due to the Chair of the Scientific Committee, Efi Panagopoulou, and the Chair of the Organising Committee, Vangelis Karademas.

When making your travel arrangements, please remember that the opening ceremony will be taking place on the Tuesday evening (in an outdoor amphitheatre) and will be followed by a reception to celebrate 25 years of EHPS conferences. The full conference programme starts early on the Wednesday morning this year.

I look forward to seeing you in Crete!

Best wishes,
Paul Norman, EHPS President

Original article

Explaining American Health Psychology to Europeans: A Personal Perspective

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Europeans are alternately fascinated, attracted, envious, or simply put off by American health psychology. Attending their first conference in America, they can be puzzled by differences from European conferences, even if they cannot say exactly what the differences are. If it is their first time at an American conference, they may be left feeling aliens and alienated, particularly as they witness some peculiar culturally specific American rituals in which they cannot bring themselves to participate. They may chastise themselves when they cannot follow the example of Americans and on the spot muster up a display of enthusiasm about their own work and succinctly explain why their results will be exciting to the larger field and improve patient outcomes. Yet, they may also come away feeling superior because they can see the obvious flaws in the research that is being presented that the American audiences seem to miss in heaping lavish praise on it.

Afterwards, they may feel in need of a beer with a sympathetic cultural interpreter who can understand their reactions and put them in context. Maybe this article could become the basis for a small pocket reference book that Europeans can consult like an interpretative guide to exotic fauna or exotic tourist destinations, but for now I can only provide some basics and some highly personal reactions.

It is helpful first to know that health psychology in the United States is thoroughly integrated with clinical psychology, starting with PhD programs that provide clinical training and preparation for licensure. There are still a few American health psychology programs in which students do not get prepared clinically, but concentrate exclusively on learning social and personality theory and developing research skills. There are some excellent older American health psychologists still around who are not clinicians or affiliated with clinical programs or working in clinical settings. But overall, American health psychologists come from PhD programs in which they do practica (or using the proper American incorrect word, practicums) before completing a full year, full time internship. They also tend to seek postdoctoral training that allows them to accumulate post-PhD clinical hours for licensure. Many Americans who call themselves health psychologists

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come out PhD clinical programs that offered a few health psychology courses, but no formal specialization. Personally, I identify myself as a clinical health psychologist, even though I had no idea during my PhD training that I would later call myself anything but a research-oriented clinical psychologist and never had a course in health psychology.

Even if they are not equipped with this background information, Europeans may quickly notice some of its profound implications. American health psychology research is dominated by work conducted by clinical psychologists, and health psychology intervention studies often evaluate interventions that would require licensure in the US to administer. Much of the "depression" research concerns depression diagnosed with a semi-structured interview, not just a self-report depression scale. There is also a growing body of research coming from clinical psychologists working in primary care settings where they deliver health psychology and mental health interventions or otherwise work to address health issues, such as improvement in physical health outcomes through improved adherence. Overall, there is much more of a clinical psychology emphasis to American health psychology, and a European clinical psychologist would probably find more of

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Original article

Coyne (cont'd)

interest in the presentations at an American health psychology conference than a European one.

In terms of sheer numbers, American psychology is dominated by clinical psychologists, and many have for their doctorate a PsyD, a more practice oriented degree with less research training than a PhD. Europeans who naively wander into the huge American Psychological Association Convention will find themselves awash in a sea of over 10,000 participants, most of whom are not research-oriented. The bulk of presentations are oriented to practice issues, like managing difficult clinical issues, prescription privileges or gripes about managed care and low reimbursement rates. Many presentations will lack a single slide with numbers. If European health psychologists go to an APA convention, it is best for them not to expect to find many research presentations of interest and they should realize that they must dash across town in buses to get from one to the next of the few research-oriented health psychology presentations that there are. It has been years since I last attended an APA convention, both because so many researchers have fled, leaving the convention to the clinicians, and because the APA health psychology division has been so tainted by its intimate connections to psychologists participating in 'enhanced interrogation' of detainees at Gitmo and Abu Ghraib.

American health psychology was formally established decades earlier than European health psychology, with the three major American health psychology organizations developing earlier and with boosts from larger, well established organizations. Thus, the American Psychosomatic Society started as the American Society for Research in Psychosomatic Problems in 1943, and initial meetings were held in conjunction with the American Psychiatric Association or the American Medical Association until a separate meeting in 1946. A name change to the American Psychosomatic Society occurred in 1948. The APS almost met its demise in the mid-1960s, because of its association with discredited psychoanalytic theories about the etiology of specific physical illness that now seem laughable. Thus, migraine headaches could be understood in terms of penis envy; they afflict women more than men and the headache is a symbolic representation of a blood engorged penis. There is an effort in the works to distance the organization even further from this past with yet another name change.

APA Health Division 38 slowly emerged over some decades until there was sufficient interest for a task force meeting at the 1974 APA convention (See http://www.health-psych.org/PDF/DivHistory.pdf). Health psychology was initially a section of Division 18, Psychologists in Public Service, which also had a section for Criminal Justice. In 1978, Division 38, Health Psychology was formally established, but all charter members were already members of other APA divisions.

Development of the Society of Behavioral Medicine was rooted in the efforts of behaviorally oriented clinicians to distinguish themselves from what they viewed as the failure of psychosomatic medicine to produce valid and clinically useful interventions (See http://tinyurl.com/behavmedhist). A conference to define behavioral medicine was held at Yale University in 1977. The Society of Behavioral Medicine was founded in 1978 and at first arranged its meetings contiguous with meetings of the American Association for Behavior Therapy, but now its meetings are held separately.

Differences among these three organizations remain, but they can easily be overestimated. The three tend to have overlapping membership and leadership, but APS tends to have more MDs and SBM is more interdisciplinary than APA Division 38, which is limited to psychologists. The contemporary APS is more oriented to behavioral cardiology and it is debatable whether the distinction between psychosomatic and behavioral medicine still holds. There was once an effort by some health psychologists to preserve a conceptual distinction with behavioral medicine, with health psychology intended to be less narrowly behavior therapy and intervention focus. The collapsing of the distinction is seen in the rather routine transitions from editorship of Annals of Behavioral Medicine to editorship of Health Psychology, although there have been some exceptions.

Health psychology research requires access to medical settings and medically ill patients, but in the United States, this is best achieved differently than in Europe. Many American health psychologists are on medical school faculties rather than in psychology departments. Even if they are senior investigators and are tenured for life (no mandatory retirement in America) they still must earn much—often as high as 100%—of their salary from federal grants or clinical work. Furthermore, American medical schools are addicted to overhead from grants to survive in their currently bloated sizes. In addition to the direct costs of doing the research including faculty salaries, funding agencies pay indirect or administrative costs, typically provided at the rate of an additional 50-75% of the direct costs. ▶

Original article

Coyne (cont'd)

Thus, researchers experience pressures not only to generate their salaries and research costs, but to contribute to keeping their universities lit and heated. This means larger, more ambitious and more expensive projects.

American health psychology research is therefore often better resourced than in Europe, but because research projects are more ambitious, they are slower in producing new findings. So at each conference, presenters must find a way to recycle things they said at the last one. And even before completing their project, senior investigators need to be applying for refunding and for funds for new projects. They need to be marketing themselves and their research output: highlighting the strength and importance of their findings to impress funding agencies and any potential reviewers who may be present. There often seems to be a conspiracy of silence among senior American investigators, a distinct stifling by which they loathe to comment on the obvious flaws in each other's work for fear that something negative will be said about theirs. European health psychologists may falsely get the impression that they are the smartest people in the room because they can see flaws in the research that is presented that apparently no one else can.

Americans can sit through sometimes outrageously bad presentations, replete with false and exaggerated claims, and then clap vigorously, even standing to deliver effusive, saccharine praise and then rush to the podium afterwards, as if the presentation was the best they have ever heard. Professor X, receives such praise at her symposium from Professor Y, and she can expect to reciprocate by giving a similar performance at Professor X's symposium hours later. New to American conferences, Europeans might infer that Professor Y's first performance was extraordinary, but spontaneous, and that Professor X's subsequent performance was an amazing coincidence. Ah, the spontaneous expressiveness and positivity of American culture bursting out everywhere!

Senior investigators also need to preserve their relationships with the funding agencies by stressing the alignment not only of their research topics, but the research findings with the priorities of funding agencies. Symposium sessions supported by funding agencies are notorious for their hype and hokum and recycling of past presentations. Seemingly impressive findings are presented, but then presented again and again, cleverly repackaged and with an increasing confirmatory spin. The choice of participants in such symposia is rigidly controlled to exclude anyone who would dissent from the dominant positive message. Frustration with these overblown, repetitive presentations stirred me to become more challenging of what I read and hear in health psychology, as in "Ain't necessarily so…." (Coyne, Thombs, & Hagedorn, 2008) or "…Bad Science, Exaggerated Claims, and Unproven Medicine" (Coyne & Tennen, 2010). Fortunately, resources and venues have sometimes been found for what has become billed as "great debates" where conventional ideas and interpretation of data can be challenged with evidence (Coyne, Lepore, & Palmer, 2006; Manne & Andrykowski, 2006), but the very rarity of such occurrences draws a large crowd. A few of my presentations rumored to be critical have been canceled ahead of time, and most often I have not found a way to enlist the investigators who make the wildest claims in debating their interpretation of their findings. More than once, I have senior investigators write to the president of my university to get me to tone down my critiques, or even to try to silence me altogether. I certainly could not expect to publish some of the brief contributions I have made in the European Health Psychologist (Coyne & Palmer 2007; Coyne, 2009) in America without anticipating howls of protest and maybe another letter or two to the president of my university.

If I can give one takeaway tidbit of advice to European PhD students planning on coming to American health psychology conferences: Repeatedly practice an elevator talk, a three to five sentence summary of what you are researching, why you find it interesting, and what you expect to find. Such talks are so named because they are designed to be delivered on a few minute elevator ride down from a hotel room to the lobby and are to be enthusiastically delivered to elicit a response from Americans in the elevator; "Oh, really this is so fascinating, I must hear more, but unfortunately, I have to get to next session and so can you send me a PDF? It was so wonderful talking to you."

I grew up in America, immersed in American values, but I have come to reject its pervasive marketing orientation: the hype, crassness and commercialism of American culture at its worst. I am acutely aware of the contradictions between espoused American values and lived American culture. I spend a lot of time in Europe, have a great deal of respect for its varied lifestyles, cultures and values, but I do not yet imagine myself becoming an expatriate. Yet because I value democracy, free exchange and free expression, and because I have an American distaste for hierarchy and oligarchy, I am much more comfortable at European health psychology conferences where I can be myself, express myself, ▶

Original article

Coyne (cont'd)

not worry about offending funding agencies or the powers that be, and I can remain comfortably oblivious to whatever power structure is in place, even if I am sure it is there.

So, I look forward to seeing you at the next EHPS gathering, where you are probably more likely to find me than at the next American health psychology conference. However, if you introduce yourself to me at EHPS, please have your elevator talk rehearsed. I am still an American, you know. ■

References:

Coyne, J.C. (2009). Are most positive findings in health psychology false.... or at least somewhat exaggerated? *The European Health Psychologist. 11*(3), 49-51.

Coyne, J.C., Lepore, S.J., & Palmer, S.C. (2006). Efficacy of psychosocial interventions in cancer care: evidence is weaker than it first looks. *Annals of Behavioral Medicine, 32*, 104-10. doi:10.1207/s15324796abm3202_5

Coyne, J.C., & Palmer, S.C. (2007). Does anyone read the classic studies they cite? *The European Health Psychologist. 9*(3), 46-9.

Coyne, J.C., & Tennen, H. (2010). Positive psychology in cancer care: bad science, exaggerated claims, and unproven medicine. *Annals of Behavioral Medicine, 39*(1), 16-26. doi:10.1007/s12160-009-9154-z

Coyne, J.C., Thombs, B.D., & Hagedoorn, M. (2010). Ain't necessarily so: review and critique of recent meta-analyses of behavioral medicine interventions in health psychology. *Health Psychology, 29*, 107-16. doi:10.1037/a0017633

Manne, S., & Andrykowski, MA. (2006). Are psychological interventions effective and accepted by cancer patients? Using empirically supported therapy guidelines to decide. *Annals of Behavioral Medicine*, 32, 98-103. doi:10.1207/s15324796abm3202_4

Original article

Applied Positive Psychology: Progress and Challenges

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Positive psychology is the study of human flourishing. It is an applied science, and a number of behavioral interventions in the field have been shown to increase subjective well-being. Despite this progress a number of challenges remain for positive psychology in the future. These include a shift in focus from individual happiness to group level well-being as an intervention outcome, a greater focus on contextual factors related to interventions, and the need to better synthesize research information. These topics are discussed in this article and specific recommendations for the field are made.

Applied positive psychology: Progress & challenges

Positive psychology is the study of human flourishing and, over the last decade, it has been a topic of increasing interest. Since its formation in the late 1990s, positive psychology has been the focus of international conferences, an academic journal, a growing number of graduate education programs and a number of popular books. The enthusiasm for this subject can also be seen in the proliferation of undergraduate university courses on positive psychology. By some counts, there are dozens of such courses taught in North America, Australia and Europe (Seligman, Steen, Park & Peterson, 2005). Although positive psychology is the scientific study of positive human phenomena such as optimism and happiness it has, from its inception, been an applied science (Seligman & Csikzentmihalyi, 2000). This means that there has been a heavy emphasis placed on interventions, assessments and the basic "usability" of the scientific results of positive psychological study. Positive psychology has been used in psychotherapy (Seligman, Rashid & Parks, 2006), coaching (Biswas-Diener, 2009), public policy (Diener & Diener, 2011), and organizational consultancy (Garcea & Linley, 2011).

As an applied science positive psychology continues to improve in sophistication. Early progress in the field was marked by two primary factors—the primacy of happiness as a desirable outcome measure and the testing of discrete "interventions." Among the early contributions of scientists to the field of positive psychology was a targeted investigation of the benefits of frequent positive affect (Lyubomirsky, King & Diener, 2005), the optimal level of life satisfaction (Oishi & Diener, 2007), and the health benefits of happiness (Pressman & Cohen, 2005; Diener & Chan, 2011). On this last point, researchers have found a number of health benefits associated with the experience of positive affect; findings which justify the need for the happiness-enhancing interventions of positive psychology. Researchers employing controlled experimental designs have found, for example, that cheerfulness predicts more robust immune function (Pressman & Cohen, 2005), that positive emotions accelerate cardiovascular recovery from emotional distress, and that positive mood among certain clinical populations is associated with lower rates of same-day pain and health care visits (Gil et al, 2004). Diener and Chan (2011) find the results of studies on health and happiness compelling enough that they conclude by saying: "It is perhaps time to add interventions to improve subjective well-being to the list of public health measures, and alert policy makers…. (p. 32). Taken together these studies suggest that happiness does not just feel good but is also highly desirable in that cognitive and emotional positivity is associated with better health and longevity, more sociability, and higher achievement.

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Another major advance of positive psychology to date has been the establishment of applied interventions. These are cognitive and behavioral techniques for which there is evidence of a connection to human flourishing, particularly increases in happiness. Among these

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Original article

Biswas-Diener (cont'd)

interventions are expressing gratitude (Emmons & McCullough, 2003) and savoring (Bryant, Smart & King, 2005). The most highly cited publication on the topic, by Seligman and colleagues (2005), used a randomized control design to demonstrate the efficacy of identifying and using strengths as well as expressing gratitude. In more recent times, researchers have aspired to take such interventions to a new level of sophistication by emphasizing the need for person-activity fit (Sin et al, 2011) and a need for more sustainable interventions that have the possibility of longer-term benefits (Waugh et al, in press).

Despite the recent attention on improving positive psychology interventions the field struggles to rise to this call to action. Many practitioners of positive psychology continue to anchor their practice in discrete intervention techniques with little regard for contextual factors or the emergence of new research findings that might improve quality (Biswas-Diener, Kashdan & Minhas, 2011). For example, expressing gratitude is generally positive, and has received research support as a happiness enhancing intervention (e.g. Seligman, Steen, Park & Peterson, 2005). Unfortunately, we know very little about the differences in happiness that might be derived from verbal, written, or merely imagined expression of appreciation. Similarly, we know little about the ways in which specific types of relationships (e.g., friends, colleagues, spouses) might impact the emotional benefits derived from expressed gratitude. As a result, I offer three critiques here with regards to improving the practice of positive psychology in the future. These include: A) a change from a focus on individual to group level well-being, B) a shift in emphasis toward understanding personal and situational factors that might affect the effectiveness of interventions, and C) the need for greater synthesis of various levels of research information.

A change from individual to group-level well-being.

Recently, Martin Seligman, the founder of the modern positive psychology movement, made a call for positive psychologists to take an active hand in improving quality of life for the world's population (Biswas-Diener, 2011). This call is representative of an increasing understanding that positive psychology cannot simply be about individual happiness. Because subjective well-being (SWB) makes for a sensible outcome measure many of the interventions within positive psychology have used SWB to establish their outcome effectiveness (e.g. Seligman, Steen, Park & Peterson, 2005). It may be that one unintended consequence of the large body of research on SWB is that it has focused practitioner attention on an individualistic pursuit of happiness (Biswas-Diener, Linley, Govindji & Woolston, 2011). By contrast, some interventions, such as Appreciative Inquiry (Cooperrider & Whitney, 2005), work on the group level. For positive psychology to fulfill its own potential we must create and test new interventions that are specific to group, rather than individual level well-being. This should include interventions targeting families, workplaces and communities. The development and implementation of such interventions will also necessitate a shift in focus away from happiness as an outcome to include other desirable outcomes such as intimacy, increased social capital, or group level empowerment (Biswas-Diener & Patterson, 2011).

A shift in emphasis toward understanding contextual factors (personal and situational)) that might affect the effectiveness of interventions.

Although progress has been made to establish a variety of positive psychology interventions most of the research has employed controlled laboratory studies (e.g. Seligman, Steen, Park & Peterson, 2005). There is increasing recognition, however, that positive psychology interventions need to be better ensconced in an understanding of personal and situational factors that might affect their effectiveness. Sin and colleagues (2011) argue that factors such as duration of intervention, continued practice, person-activity fit, and motivation—among others—can affect the overall effectiveness of interventions for individuals. Similarly, Biswas-Diener, Kashdan and Minhas (2011) argue that many positive psychology concepts such as strengths can best be understood in the context of individual interests and values, as well as within the context of situations. Linley (2008) offers the counter-intuitive advice that strengths, in particular, should sometimes be used less rather than more as might be appropriate to situations. As a profession, we are ready to take the examination of interventions beyond the laboratory and test them in more nuanced ways. Future interventions, then, need to be thought of in terms of regulation and flexibility rather than as "one size fits all" techniques.

The need for greater synthesis of various levels of research information.

The integration of various levels of research information is an issue that confronts the entire field of psychology. As advances are made in the study of neuropsychological processes, for instance, we are called upon—as a profession—to synthesize information from the studies of brain function with more complex, real-world social behavior (Rothbart, Sheese & Posner, ▶

Original article

Biswas-Diener (cont'd)

2007). A good example of this within positive psychology is Haidt's (2007) synthesis of research to present a new, more comprehensive understanding of morality that includes neuroscience, animal models and evolutionary theory, as well as social psychological study. Increasingly, practitioners are calling for a similarly increased integration of neuropsychological, social and personality sciences (Rock & Page, 2009). Future positive psychology interventions must include attention to neurological and physiological dimensions as research and technology on these topics improves.

Conclusion

As positive psychology advances it is important that we continue to anchor interventions in empirical science and that this science represents the best synthesis of available levels of analysis, technologies and statistics. In addition, it is important to continue to improve interventions so that they can be employed with attention to personal and situational factors that might affect their effectiveness. This will ensure that positive psychology does not stagnate intellectually or clinically. ■

References:

Biswas-Diener, R. (2009). Personal coaching as a positive intervention. *Journal of Clinical Psychology*, 65, 544-553.doi:10.1002/jclp.20589

Biswas-Diener, R. (2011). Editor's Foreword. In R. Biswas-Diener (Ed.), *Positive Psychology as Social Change* (v-xi). Dordrecht, Netherlands: Springer. doi:10.1007/978-90-481-9938-9

Biswas-Diener, R. & Patterson, L. (2011). Positive psychology and poverty. In R. Biswas-Diener (Ed.), *Positive Psychology as Social Change* (125-140). Dordrecht, Netherlands: Springer.

Biswas-Diener, R., Kashdan, T.B., & Minhas, G. (2011). A dynamic approach to psychological strength development and intervention. *Journal of Positive Psychology, 6*, 106-118. doi:10.1080/17439760.2010.545429

Biswas-Diener, R., Linley, P. A., Govindji, R. & Woolston, L. (2011). Positive psychology as a force for social change. In K. M. Sheldon, T. Kashdan, & M. Steger (Eds.), *Designing positive psychology: Taking stock and moving forward* (410-419). Oxford, UK: Oxford University Press.

Bryant, F., Smart, C. & King, S. (2005). Using the past to enhance the present: Boosting happiness through positive reminiscence. *Journal of Happiness Studies, 6*, 227-260. doi:10.1007/s10902-005-3889-4

Cooperrider, D. & Whitney, D. (2005). *Appreciative Inquiry: A positive revolution in change.* San Francisco, CA: Berrett-Koehler Publishers

Diener, E. & Diener, C. (2011). Monitoring psychosocial prosperity for social change. In R. Biswas-Diener (Ed.), *Positive Psychology as Social Change* (53-72). Dordrecht, Netherlands: Springer.

Diener, E., & Chan, M. Y. (2011). Happy people live longer: Subjective well-being contributes to health and longevity. *Applied Psychology: Health and Well-Being, 3*, 1-43. doi: 10.1111/j.1758-0854.2010.01045.x

Emmons, R. & McCullough, M. (2003). Counting blessings versus burdens: An experimental investigation of gratitude and subjective well-being in daily life. *Journal of Personality and Social Psychology, 84*, 377-389. doi:10.1037/0022-3514.84.2.377

Garcea, N. & Linley, P. A. (2011). Creating positive social change through building positive organizations: Four levels of intervention. In R. Biswas-Diener (Ed.), *Positive Psychology as Social Change* (159-174). Dordrecht, Netherlands: Springer.

Gil, K., Carson, J., Porter, L., Scipio, C., Bediako, S. & Orringer, E. (2004). Daily mood and stress predict pain, health care use, and work activity in African American Adults with Sickle Cell Disease. *Health Psychology, 23*, 267-274. doi: 10.1037/0278-6133.23.3.267

Haidt, J. (2007). The new synthesis in moral psychology. *Science, 316*, 998-1000. doi:10.1126/science.1137651

Linley, P. A. (2008). *Average to A+*. Coventry, UK: CAPP Press.

Lyubomirsky, S., King, L. & Diener, E. (2005). The benefits of frequent positive affect. *Psychological Bulletin, 131*, 803-855. doi:10.1037/0033-2909.131.6.803

Oishi, S., Diener, E., & Lucas, R.E. (2007). Optimal level of well-being: Can people be too happy? *Perspectives on Psychological Science, 2*, 346-360. doi:10.1111/j.1745-6916.2007.00048.x

Pressman, S. & Cohen, S. (2005). Does positive affect influence health? *Psychological Bulletin, 131*, 925-971. doi: 10.1037/0033-2909.131.6.925

Rock, D. & Page, L. (2009). *Coaching with the brain in mind: Foundations for practice*. Hoboken, New Jersey: John Wiley and Sons.

Rothbart, M. K., Sheese, B. & Posner, M. (2007). Executive attention and effortful control: Linking temperament, brain networks and genes. *Child Development Perspectives, 1*, 2-7. doi:10.1111/j.1750-8606.2007.00002.x

Seligman, M. E. P. & Csikszentmihalyi, M. (2000). Positive psychology: An Introduction. *American Psychologist, 55*, 5-14. doi:10.1037/0003-066X.55.1.5

Seligman, M. E. P., Rashid, T. & Parks, A. (2006). Positive psychotherapy. *American Psychologist, 61*, 774-788. doi: 10.1037/0003-066X.61.8.774

Seligman, M. E. P., Steen, T., Park, N. & Peterson, C. (2005). Positive psychology progress: Empirical validation of interventions. *American Psychologist, 60*, 410-421. doi: 10.1037/0003-066X.60.5.410

Sin, N., Della Porta, M. & Lyubomirsky, S. (2011). Tailoring positive psychology interventions to treat depressed individuals. In S. Donaldson, M. Csikszentmihalyi, & J. Nakamura (Eds.), *Applied positive psychology: Improving everyday life, health, schools, work and society* (79-96). New York: Routledge.

Waugh, C.E., Wager, T.D., Fredrickson, B.L., Noll, D.C., Taylor, S.F. (in press). In search of durable positive psychology interventions: Predictors and consequences of long-term positive behavior change. *Social Cognitive and Affective Neuroscience.*

Original article

Going Mobile: Delivering Behavioural Support via SMS Text Messages

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Health organisations, charities, pharmaceutical companies, and health services are increasingly delivering information and support by SMS text message to help us change our health behaviours. For example, the British Heart Foundation provide a 'Heart Health' texting support service for people wanting to either become more active, eat healthier or give up smoking. So what do we know about the potential of text messaging to deliver behavioural support?

Why text messaging?

Text messaging has a number of advantages over other media for delivering behavioural support. First, most people in developed countries own a mobile phone. According to Nokia, there are currently 13 mobiles for every 10 people in Europe. Furthermore, in the UK ownership is high across the social class spectrum (Ali et al., 2007). Second, text messaging is becoming increasingly popular in Western Europe and other developed countries (Gartner, 2007). In 2009 in the UK, 96.8 billion texts were sent (Mobile Data Association, 2009) – averaging out at over four texts per day sent for every member of the population. As a result, text messaging interventions could have a high reach. There is also evidence that, among adolescents at least, those who engage in health compromising behaviours such as drinking and smoking have higher mobile phone usage (Leena et al., 2005), suggesting that mobile phone interventions may be a particularly good way of targeting these behaviours. Third, sending text messages is relatively inexpensive, particularly if delivery is automated. Finally, text messages allow for the delivery of support in real time, as mobile phone owners usually have them on their person, while still providing an asynchronous mode of communication i.e. receivers can read them in their own time.

However, text messaging also has several limitations. Unlike other services such as email or instant messaging, text messages have a 160 character limit. Although most modern phones allow you to send multiple text messages combined as a single message, the convention is to keep text messages brief. This limits how long and complex a behaviour change text message can be. Another potential issue is that you cannot fully control when a recipient reads their text message, such as when they have their phone switched off, or when they respond if a reply is requested. This might lessen its appeal for data collection where the timing of data capture is important.

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Overview of the text message health behaviour change literature

Text message based health behaviour change interventions reported in the literature can be split into three main categories: medication adherence e.g. medication reminders, disease management e.g. diabetes self-management, and disease prevention e.g. weight management. A recent narrative review focusing on randomised controlled trials of text message interventions covering these three intervention categories (Cole-Lewis & Kershaw, 2010) report that eight out of nine sufficiently powered studies (total number of studies

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Original article

Naughton & Sutton (cont'd)

reviewed = 12) found significant differences between trial arms in favour of the text message interventions.

For some of the interventions reviewed it is difficult to isolate the effect of the text messages from the other types of additional support provided, such as written materials or access to specialised websites. Furthermore, the comparison arms received various levels of support. Ultimately the text messages were reported as the primary mode of intervention delivery for all intervention arms. Overall the results suggest that text message support can have a positive impact on health behaviour change, at least in the short to medium term (3-12 months).

There is also evidence that the effectiveness of other types of behaviour change interventions might be increased when text messages are used to supplement the main intervention. A systematic review published by Webb and colleagues (Webb et al., 2010) found internet based health behaviour change interventions that used text messages to deliver supplementary support reported much larger intervention effects (Cohen's $d = 0.81$) than those using other modes of delivery such as telephone ($d = 0.35$) or email ($d = 0.18$). Of course, the difference in effect size may be explained by other differences between these trials.

Text message interventions for smoking cessation

Our specific interest is in smoking cessation. A recent Cochrane review evaluated the impact of mobile phone based interventions for smoking cessation (Whittaker et al., 2009). Four studies were included, two of which used text messaging exclusively and both used the same general texting system. While there was evidence of a short-term impact on smoking abstinence at approximately six weeks post-randomisation when these two studies were pooled (Risk Ratio = 2.18, 95% CI 1.80-2.65), the impact at six months was difficult to assess due to substantial heterogeneity between the trials. Clearly more trials are required to establish the longer-term effectiveness of these types of interventions for smoking cessation. However, what these trials do not provide much insight into is what people think of receiving behaviour change support by text message.

One qualitative interview study we undertook explored this issue (Naughton & Sutton, 2009). The sample consisted of 33 women who had smoked during pregnancy and included those who had received a brief tailored text message intervention and those who had not. We found that for every perceived benefit of text messaging there was a parallel drawback. For example, the convenience of text messaging and being able to get support wherever you are was a clear benefit. However, several participants highlighted that receiving a smoking cessation text message had the potential to cue them to think about smoking when they were not currently thinking about it. Another benefit highlighted was that they felt receiving a support text message would make them feel less on their own, as if there was someone looking out for them. However, as a result, some had high expectations for support to be delivered in real time, so it would immediately precede the tempting situations they found themselves in. The text message interventions we have developed are not currently sophisticated enough to meet such expectations. But the technology is there in many of our phones to deliver support that is tailored to real-time events as described in the final section.

A current text messaging intervention for smoking cessation

We have developed a smoking cessation text message system that tailors support and advice to individual characteristics, elicited by a questionnaire. This support program is for pregnant smokers (MiQuit) and targets theory-specified cognitive determinants of smoking cessation as well as providing general quitting support. The system delivers approximately 80 tailored text messages of support and advice over 11 weeks. The type of messages participants receive is also tailored to their smoking status, assessed at two time points by text message. In addition to these 'push' text messages, recipients can activate 'pull' text messages, which provide instant support at any time of day or night. Recipients also receive a tailored advice leaflet as a supplement to the text messages. The preliminary findings from a randomised controlled trial evaluating the acceptability and feasibility of MiQuit ($N = 207$) were that the system had high acceptability among participants and that those receiving MiQuit reported higher levels of the three key cognitive determinants targeted in the intervention (self-efficacy, harm beliefs and motivation) and increased quitting initiation compared to controls. Controls received standard self-help. While the trial was underpowered to detect group differences in smoking abstinence, the effect sizes observed favoured the intervention, although the comparisons were statistically non-significant.

Future innovations

Another of our interests is in tailoring self-help support to the individual. At present, the text message behaviour change systems reported in the literature, in-

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Naughton & Sutton (cont'd)

cluding ours, either do not individualise support or do so based on characteristics collected primarily at baseline. But there is another level of tailoring that could greatly enhance the power of a text message intervention and turn it from a drip-feed tool into a precision instrument: real-time tailoring using mobile sensing. Picture a smoker approaching the house of a friend or family member who smokes and as soon as he or she gets close, a proximity alert triggered by their phone's GPS sensor activates an individualised support message to be sent straight to their phone. This could remind them of their reasons for quitting to boost motivation or could provide situation-appropriate strategies of what to do instead of smoking. This location trigger could be a pub, a workplace, or anywhere the individual identifies as a smoking hotspot. Another scenario is a smoker's phone using a program such as the pilot system EmotionSense (Rachuri et al., 2010) to analyse voice input via the in-built microphone to identify specific emotions. If the program identifies anger or frustration, say, then this could activate the delivery of relaxation strategies to their phone as alternatives to smoking or could simply warn the individual of the risk of relapse. There are a multitude of ways in which the sensing technology inside modern smart phones—GPS, microphone, accelerometer, Bluetooth, camera—could be used to deliver real-time tailored support for all types of behaviours. However, as this type of support could be perceived as intrusive and is at risk of generating false positives, it is vital that the acceptability of tailoring support in real time is assessed and understood before too much investment in intervention design is made.

Conclusion

As with all areas of intervention research there are still many questions left unanswered. What types of support message are likely to be most effective when delivered by text message and for whom? Which variables should be used to tailor the messages? How should the frequency of push messages be managed or triggered? How interactive should such interventions be? Text messaging is likely to remain a popular and convenient method of communication for the foreseeable future, and offers the potential to be an important component of future behaviour change programmes. ■

References:

Ali, R., Binmore, R., Dunstan, S., Greer, J., Matthews, D., Murray, L. et al. (2007). *General Household Survey 2007.* Newport: Office for National Statistics.

Cole-Lewis, H. & Kershaw, T. (2010). Text messaging as a tool for behavior change in disease prevention and management. *Epidemiological Reviews, 32*, 56-69. doi:10.1093/epirev/mxq004

Gartner (2007). Market Trends: Mobile Messaging, Worldwide, 2006-2011. http://www.gartner.com/it/page.jsp?id=565124 [On-line].

Leena, K., Tomi, L., & Arja, R. R. (2005). Intensity of mobile phone use and health compromising behaviours—how is information and communication technology connected to health-related lifestyle in adolescence? *Journal of Adolescence, 28*, 35-47. doi:10.1016/j.adolescence.2004.05.004

Mobile Data Association (2009). The Q4 2009 UK Mobile Trends Report. http://www.themda.org/mda-press-releases/the-q4-2009-uk-mobile-trends-report.php [On-line].

Naughton, F. & Sutton, S. (2009). Tailoring the delivery of behaviour change messages: the acceptability of mobile phone text-messages. Poster presented at the annual EHPS conference, Pisa, Italy, 23-26 September 2009. Abstract published in *Psychology & Health, 24* (suppl 1), pg 287.

Rachuri, K. K., Musolesi, M., Mascolo, C., Rentfrow, P. J., Longworth, C., & Aucinas, A. (2010). EmotionSense: A Mobile Phone based Adaptive Platform for Experimental Social Psychology Research. In *Proceedings of 12th ACM International Conference on Ubiquitous Computing* (UbiComp'10). Copenhagen, Denmark. September.

Webb, T. L., Joseph, J., Yardley, L., & Michie, S. (2010). Using the internet to promote health behavior change: a systematic review and meta-analysis of the impact of theoretical basis, use of behavior change techniques, and mode of delivery on efficacy. *Journal of Medical Internet Research, 12*, e4. doi:10.2196/jmir.1376

Whittaker, R., Borland, R., Bullen, C., Lin, R. B., McRobbie, H., & Rodgers, A. (2009). Mobile phone-based interventions for smoking cessation. *Cochrane Database of Systematic Reviews*, CD006611.

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Why Health Psychology Needs to be Mindful About Mindfulness

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The nature of the mind and its intricate relationship with the body has been the question man by his very cogitating nature, has searched for throughout the ages. Cogito ergo sum thus became the first certainty of the individual, upon which he based all his investigations of the self. Traditionally, disease and illness has been approached from the somatopsychic and sensory side; meaning the physical side, rather than from the psychosomatic angle. The mind has an important place within the realm of disease and illness. When calmed by mindfulness meditation and awareness, we are more able to find solutions to health problems and pain.

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Mindfulness is….

Mindfulness is defined as the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment to moment (Kabat-Zinn, 1981). Initially, mindfulness involved cultivating self-awareness and noticing new things in each action we are performing. For example, when we drive, wash, work, learn, watch, feel, act, perform, etc. (Langer, 1989). Langer has separated the idea of mindfulness from meditation. Instead, she defines mindfulness as including situational awareness, sensitivity to changes in the context and control over our thoughts. "Mindfulness doesn't mean simply being optimistic or thinking will make it so" (Langer, 1989). At a secondary level, mindfulness can be achieved through meditation which aims to develop awareness and tuning ourselves into a positive vibe (Kabat-Zinn, 1981). There are two types of awareness: internal and outward. Internal awareness involves attention towards the activities of the mind. Outward awareness involves observation of sense experiences or the activities of the body. Awareness is related to practically every experience in life. The body is here. The mind and senses are active in the body. The faculties, perceptions and expressions of the body and mind are active. Self-awareness refers to what Socrates stated as "know thyself." Shakespeare said "to thine own self be true." There are dormant centres of perception and energy, which we can know and tap into. The aim of mindfulness practice is to become fully aware. Such awareness is not superficial. Even the simple concept of developing physical awareness is very difficult in practice. Full awareness is developed by deepening internal awareness. Both types of awareness are required for our everyday life. However, the main problem is that consciousness is either on one or the other mode of awareness which causes distraction and ailments in the mind.

How is mindfulness related to health?

Today's fast-paced modern society means that we can all experience stress in all facets of life from the work-place to the household, from our graduation day to our retirement day, in all kinds of interactions. The prevalence of anxiety and depression stems from dissatisfaction and imbalance (Teasdale et al., 2000). The research of Teasdale et al. (2000) showed that for patients with three or more previous episodes of depression, MBCT (Meditation based Cognitive therapy) reduced a relapse or recurrence. MBCT offers a promising cost-efficient psychological approach to preventing relapse/recurrence in recurrently depressed people (Goyal et al, 2010; Teasdale et al. 2000). The occurrence of physical, mental and psychosomatic disorders is a clear manifestation of stress exhibiting itself as a concrete form via our bodies. Hence the solution should lie in something practical and substantial. To be healthy, mentally and physically, one must be aware of the body-mind complex, its needs and requirements, just as a car requires a good driver; as well as servicing, oiling, petrol, grease, tyre adjustment and so on. Mindfulness is designed to help people maintain our body-mind vehicle in top running condition for as long as possible so that life can be fulfilling and joyful. The three main system-

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Original article

Lazaridou (cont'd)

atic reviews that have looked at the effectiveness of MBCT on depression and anxiety disorders indicate significant reductions in relapse rates (Ivanovski & Malhi, 2007; Toneatto & Nguyen, 2007; Arias, Steinberg, Banga, & Trestman, 2006). However, as one commentator has noted (Pilkington, 2007) such reviews do not always reach the same exact conclusions. The reviews show us trends, but a detailed reading highlights differences.

The western tradition of humanistic psychology examined by Maslow, Jung and Rogers has highlighted the presence of a positive potential within the self that needs to be realized and subsequently developed. The experiences of mindfulness also brings to us the fact that the path of evolution to self- realization does not lie in the outside world, but within our own being waiting to be discovered. The individual can fulfil his/her aspirations by supplementing their efforts with the practice of mindfulness. The practices of yoga in mindfulness interventions called 'asanas' mean the postures that we are comfortable in, and those which develop in us, a heightened state of awareness. These practices have already been validated scientifically for their profound benefits on the physical, mental and emotional well-being of man. Individuals with persistent pain or stress are more likely to benefit from intensive meditation (Godfrin & Van Heeringen, 2010). An argument against mindfulness is that it is effortful and difficult and it involves a lot of extra energy. However, such a perception is false. Mindfulness is simply thinking and noticing new things. Mindfulness can play a vital role in therapists' and healthcare professionals' performance as it allows them to avoid making mistakes. As a result, for obvious reasons, it can have a lot of applications in both the delivery of care as well as the treatment of individuals (Fortney & Taylor, 2010). Interestingly, there is evidence that we do not actually learn from our mistakes (Jacobson & Petrie, 2009). Mindfulness is a way of reducing errors either by experiencing the same event in a different way or by noticing changes in their environment (Carson & Langer, 2006). Mindfulness prompts us to: 1) Focus on accepting new things that come to our perception. This means participating actively in the stimulus and accepting them with awareness without judgment. 2) Focus on context by creating new categories. Mindfulness creates sensitivity to new contexts, differences and perspectives (Langer, 1989).

Meditation and health

One main component of mindfulness is meditation. Meditation implies relaxation both mentally and physically at a level very few people experience even when they are sleeping. Through meditation the mind is trained to cure the ailment. The first step is to become aware of the inner processes of the mind and body, and thus one can direct energies where they are most needed. This is achieved in various stages. Individuals are trained to quieten the mind and relax the tensions, so that one can begin to see just what is going on around us. Individuals should become aware of the conditioning that causes us to react to pain in certain ways (Varni, 1981). Mindfulness meditation generally includes observation of thoughts, awareness of breathing and bodily sensations while sitting. The purpose is to observe without judgement or hold on to thoughts or perceptions with detachment. Mindfulness is often described as the process of being attentive to one's experiences. This practice of being mindful may also extend into daily activity, as one adheres to dispassionate observation of thoughts and actions in order to be more fully present in the moment and not overwhelmed by past turmoil (Mills & Farrow, 1981). Through this process people unwind easier after work and avoid ruminations on work problems. The practice of mindfulness takes place in what psychologists and neuroscientists generally call the waking state of consciousness. During meditation awareness is always present, unlike sleep in which we don't have control of our thoughts. According to Baer's review (2003), mindfulness-based interventions are helpful in a variety of mental health problems and psychological ailments. The review also suggests that many people who enrol in mindfulness-based programs will complete them, in spite of high demands for homework practice. As we progress, gaining relaxation and improving health, meditative discipline teaches an individual to sense the purpose of pain, to 'wake up' in the spiritual sense. We see that most of our pain is caused by lack of awareness and basic ignorance (Zeidan, Johnson, Diamond, David, & Goolkasian, 2010). Using meditative awareness, we develop greater insights into our own weaknesses and failings as well as into the workings of life. We become more skilful. Deeper meditative insight teaches detachment and forbearance, especially by withdrawing the mind from the senses. This frees the mind from dependence on medication for every little pain in our lives. We become more willing and more able to stay with pain, to try to see into it, its cause, and what it is trying to teach us.

Some basic steps in cultivating mindfulness

It very common for an individual's awareness to appear in a negative way. A simple exercise to experience mindfulness is through sense awareness. For example, at the start of your week begin with focusing on hearing. Try to listen to the sounds in each moment without effort to find their source by becoming the ▶

Original article

Lazaridou (cont'd)

observer. Then continue on Tuesday by trying to watch all new things with concentration. Try to observe people in the bus, street, supermarket etc., without getting involved in any situation. Continue with the sense of taste by tasting mindfully each meal and touch by feeling anything that you touch. Additionally, another helpful technique is to devote 20 minutes at the end of each day by becoming still and non-doing. Try to reflect on the thoughts that pass by and then let them go. Try to remain the observer, without letting any thought distract you. Imagine that you are watching a movie—thoughts come and let go one after the other without influence on you.

Concluding remarks

In the light of the above, mindfulness meditation has enormous potential for its use as a tool by therapists, practitioners and researchers. Mindfulness skills can help patients reduce self critical chatter, find clarity of mind and act rather than react (Wilkinson-Tough, Bocci, Thorne, & Herlihy, 2010). Mindfulness techniques could be a powerful tool for therapists and doctors as its effective applications have already been explored and justified. The recent systematic review of Mars & Abbey (2010) show that Mindfulness based meditation therapies have produced significant results across a wide range of non-clinical and patient populations, including those who are suffering from depression, stress, burnout, and severe pain. For patients suffering from any type of disease, the initial but most difficult step in a disease is self acceptance and non-striving which are the most important components to overcome. This step involves the state of not doing anything, just simply accepting that things are happening in the moment just as they are supposed to. For doctors, awareness could be a very powerful tool to reorientate their daily activities. Through awareness their relationships with patients could be improved and refreshed as well as their capacity to provide compassion and strength. Mindfulness-based skills are becoming an essential tool for therapists who want to support greater well-being, wise action and a sustained sense of greater mental and emotional freedom. Nowadays, health service organisations globally are adopting mindfulness-based approaches to therapy, patients and employee well-being. Training patients and therapists to be mindful can harness their energies for creative and constructive purposes. ■

References:

Arias, A. J.,Steinberg, K.,Banga, A., & Trestman, R. L. (2006). Systematic review of the efficacy of meditation techniques as treatments for medical illness. *The Journal of Alternative and Complementary Medicine, 12*, 817-832. doi:10.1089/acm.2006.12.817

Baer, R. A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology: Science and Practice, 10*, 125–143. doi:10.1093/clipsy.bpg015

Carson S. H., Langer E. J. (2006) Mindfulness and self-acceptance. *Journal of Rational-Emotive and Cognitive Behavior Therapy 24*(1), 29-43. doi:10.1007/s10942-006-0022-5

Fortney, L. & Taylor, M. (2010). Meditation in medical practice: A review of the evidence and practice. *Primary Care, 37*(1), 81-90. doi:10.1016/j.pop.2009.09.004

Godfrin, K. A. & van Heeringen, C. (2010). The effects of mindfulness-based cognitive therapy on recurrence of depressive episodes, mental health and quality of life: A randomized controlled study. *Behaviour Research and Therapy, 48*(8), 738-746. doi:10.1016/j.brat.2010.04.006

Goyal, M., Haythornthwaite, J., Levine, D., Becker, D., Vaidya, D., Hill-Briggs, F., & Ford, D. (2010). Intensive meditation for refractory pain and symptoms. The Journal of Alternative and Complementary Medicine, 16(6), 627-31. doi:10.1089/acm.2009.0372

Ivanovski B. & Malhi G. (2007). The psychological and neurophysiological concomitants of mindfulness forms of meditation. Acta Neuropsychiatrica, 19, 76-91. doi: 10.1111/j.1601-5215.2007.00175.x

Jacobson S. & Petrie R. (2009). Learning from mistakes: what inconsistent choices over risk tell us? *Journal of Risk Uncertainty, 38*, 143-158.doi:10.1007/s11166-009-9063-3

Kabat-Zinn J. (1981). An outpatient program in behavioral medicine for chronic pain patients on the practice of mindfulness meditation. *General Hospital Psychiatry, 4*, 33-42. doi: 10.1016/0163-8343(82)90026-3

Langer E. (1989). *Mindfulness*. Reading, MA: Addison-Wesley.

Mars, T. S. & Abbey, H. (2010). Mindfulness meditation practice as a healthcare intervention: A systematic review. *International Journal of Osteopathic Medicine, 13*(2), 56-66. doi:10.1016/j.ijosm.2009.07.005

Mills W. & Farrow J. (1981). The transcendental meditation technique and acute experimental pain. *Psychosomatic Medicine, 43*(2), 157-164.

Pilkington, K. et al. (2007) Acupuncture for anxiety and anxiety disorders – a systematic literature review. *Acupuncture in Medicine, 25*, 1-2, 1-10.

Teasdale, J. D., Segal, Z. V., Williams, J. G, Ridgeway, V. A., Soulsby, J. M., & Lau, M. A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting & Clinical Psychology, 68*, 615-23. doi:10.1037/0022-006X.68.4.615

Toneatto, T., & Nguyen, L. (2007). Does mindfulness meditation improve anxiety and mood symptoms? A review of the controlled research. *Canadian Journal of Psychiatry, 52*, 260-266.

Wilkinson-Tough, M., Bocci, L., Thorne, K., & Herlihy, J. (2010). Is mindfulness-based therapy an effective intervention for obsessive-intrusive thoughts: A case series. *Clinical Psychology & Psychotherapy, 17*(3), 250-268.

Varni. J. W. (1981). Self-regulation techniques in the management of chronic arthritic pain in hemophilia. *Behavior Therapy, 12*, 185-194. doi:10.1016/S0005-7894(81)80071-8

Zeidan, F., Johnson, S. K., Diamond, B. J., David, Z., & Goolkasian, P. (2010). Mindfulness meditation improves cognition: Evidence of brief mental training. *Consciousness and Cognition, 19*(2), 597-605. doi:10.1016/j.concog.2010.03.014

CREATE

CREATE Visiting Scholar Grant Report

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The Call

In September 2010, I happily attended my first EHPS conference in Cluj, Romania. Although I had met Michelle Fine before the EHPS, her keynote address on the Polling for Justice project using Participatory Action Research (PAR) methods inspired me to want to learn the method more closely. As such, when the call for the Create Visiting Scholar grants went out, I excitedly put together an application to visit with her at the Graduate Center, City University of New York in February of 2011.

As a postdoctoral fellow working in a medical setting, I rarely get the opportunity to be trained in alternative research methods for my health psychology projects. As I outlined in my application, there were two health psychology research initiatives I had planned for the upcoming year and my hope was to be able to talk through and develop them with Michelle.

The first project had to do with developing a study on the grief of healthcare professionals and how it affects patient care. The second was a project that is an offshoot of a series of meetings I had organized on grief and loss as a public health issue. Michelle is one of the collaborators on this project, and I had decided to write a book proposal for an academic volume from the proceedings of these meetings and was hoping to gain instruction in this process.

Michelle Fine and The Graduate Center

"*Setting an example is not the main means of influencing another, it is the only means.*"
Albert Einstein

Michelle is a distinguished professor at City University of New York, The Graduate Center in the Social Personality Psychology Program. It is one of the few institutions in North America to have a designated participatory action research (PAR) center called the Public Science Project (PSP) that is dedicated exclusively to engaging community members in research.

The very first thing Michelle said in her EHPS keynote address is that PAR is not a method, but an epistemology—it's a way of doing, thinking, engaging, and approaching research that is more holistic and process-oriented than a rigid, step-by-step methodology.

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Leeat Granek and Michelle Fine

In much the same way, Michelle does not impart knowledge by delivering set content; she teaches through process, dialogue, and example. Anyone who has ever met Michelle knows that she is the archetypal teacher we all dream of having. Indeed, I had first heard her speak at the American Psychological Association conference in Toronto where I was captured by her incredible ability to teach without preaching, guide without directing, and inspire deep, complex thinking in the listener without lecturing. It was with this in mind—a mixture between awe at her intellectual prowess and sheer excitement about learning new things—that I approached my trip to The Graduate Center.

Michelle is as warm and welcoming as she is witty and intelligent. She is searingly smart and exquisitely sensitive. Most importantly, her influence is profoundly felt by her example—in every instance of our work together, whether in our one-on-one meetings or in her comments and feedback during the events taking place over the month, she consistently brought me back to the importance of linking theory and action, research and social justice, and the perennial question of 'what is our research project?' and 'who is it serving?'

The Work Together

Meetings

One of the reasons I wished to visit with Michelle is to learn from her expertise on how to design, develop and execute PAR projects and to spend some time with members of the PSP in order to consult on my research proposal. As such, Michelle and I met once a week for the month of February to talk through project ideas. ▶

CREATE grant (cont'd)

Through our conversations, I learned about different approaches to objectivity, ethics, and research design and got to ask specific questions about how to best incorporate elements of PAR in my own developing studies. The one-on-one was especially important given how different medically-oriented research settings are. Those of us working in hospitals can attest to the stringent rules around patient involvement, making PAR with its participatory approach and labor-intensive demands particularly difficult to incorporate in these settings. At these meetings, we also talked through the different possibilities of writing a book proposal for my Grief and Loss Project. Since Michelle had been involved in this initiative, the synergy of her extensive knowledge of the book publishing process from her own experience and the topic of the proposed volume was invaluable.

Events

As a visiting scholar at the Graduate Center, I was invited to attend several events pertaining to PAR methods to further my education. One conference called "Evaluation as a Tool for Social Justice" was sponsored by the Public Science Project and Full Frame Initiative and included philanthropists and community and academic researchers who spent the day talking about alternative approaches to evaluation in the fields of public education, community welfare, and public health. I also attended weekly "Brownbag" research seminars. One particularly noteworthy meeting entitled "Suppression, Oppression, and Activist Scholarship in 20th Century American Psychology" involved a series of talks on what Michelle calls 'forgotten alternatives', or the history of psychologists participating in politics and engaging in social justice research in, and through the academy.

PSP

The Public Science Project (PSP) is housed at The Graduate Center and is directed by Maria Elena Torre. The PSP takes the view that "social science can play an important role in the struggle for social justice" and that "Participatory Action Research (PAR) provides a critical framework for making science—systematic inquiry and analysis—a public enterprise." (See website link end of this article).

During my month at the Graduate Center, I got to 'hang out' with Maria Elena Torre and Maddy Fox in an informal setting and to meet with them more formally to consult on my work. During these meetings, I both got to witness the PSP at work—seeing youth researchers come in and out of the office, talking through problems related to setting up research meetings and events—and to consult, and ask questions about my own developing research projects.

Academic Exchange

Finally, since Create is ultimately about knowledge and scholarly exchange, I was also able to contribute to Michelle's research community during my month there. Many of the students at The Graduate Center are engaged in research on grief and loss. As a Visiting Scholar, I not only got to participate in ongoing weekly research seminars but also had the opportunity to consult with students on projects related to my area of expertise. These conversations now continue over email, Skype, and phone.

The Future

As with the afterglow of Michelle's talks, I left our one-on-one meetings and The Graduate Center feeling inspired, engaged, motivated and yearning for more. More education and knowledge about PAR; more inspiration to expand my own research to include alternative methods, specifically in my own health field; and more desire to spend time with Michelle and the members of the PSP.

With this in mind, out of all the wonderful things that happened over the month, the best part of being awarded the Create Visiting Scholar Grant is the cultivation of wanting to learn more! ■

References:

Public Science Project: See: http://www.publicscienceproject.org/