Editorial

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Editor

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Editor

Dear Readers,

Welcome to the conference issue of the European Health Psychologist (EHP), which most of you will be reading in Hersonissos, Greece during the 25th European Health Psychology Conference. This year's conference focuses on the need for collaboration between psychologists and other health professionals in order to gain a better understanding of health and illness and to facilitate appropriate and more effective interventions.

We are particularly pleased with the contribution of three keynote speakers in this issue. First, Professor Lucy Yardley (University of Southampton, UK) provides insight into the potential of internet-delivered behaviour change interventions. Second, Professor Christina Maslach (University of California, US) discusses burnout and engagement in the workplace. Third, Panagiota Pervanidou and Professor George Chroussos (University of Athens, Greece) present a clinician's perspective on emotional and behavioural disorders in relation to childhood obesity. These contributions reflect the diversity of work in health psychology and stress the need for collaboration with other health professionals, which is in line with the conference theme.

Our editorial team (co-editors: Richard Cooke, Anthony Montgomery, Jana Richert) have attracted a range of articles over the past year

and our editorial manager (Natalie Schüz) experimented in this issue with a new layout to improve the readability of the EHP. Authors of the highest international standing have continued to write for the EHP. It needs to be stressed that these contributions do not go unnoticed. A contribution by Ryan and colleagues, for example, has been cited 42 times since its publication in 2008. We would ask all of you potential authors to keep this in mind for the coming year and to get those contributions submitted to the EHP.

We look forward to receiving and publishing new thought-provoking pieces in the (near) future. Last but not least, we wish you a fruitful conference and wonderful stay in Greece!

Rik Crutzen and Emely de Vet, Editors

President's message

Dear EHPS members and colleagues,

Welcome to the conference issue of the *European Health Psychologist* which has been printed with the support of the publisher of our journals, Taylor and Francis. The European Health Psychologist provides an excellent outlet for societal news as well as a forum for scientific discussion and information. The current editors, Rik Crutzen and Emely de Vet, who started their term of office earlier this year have continued to build on the hard work and success of their predecessors. As a society, we are fortunate to have such a well-produced and innovative publication. This issue provides an opportunity to introduce members of the new Executive Committee and to summarise some of the activities of the EC as we approach the end of the first year of the term of the current EC. You will also receive more detailed formal reports from all EC members in advance of the Members' Meeting in Crete.

The society's annual conference is our "flagship event". Accordingly, the EC devotes a lot of its time to ensuring that our conferences not only run smoothly but also provide an opportunity for researchers to present some of the very best research in European health psychology. In addition to evaluating past conferences, the EC liaises closely with the hosts of upcoming conference, and reviews proposals for future conferences. In order to ensure continuity of information and procedures the EC has a Conference Officer, and I am very pleased that our Past-President, Irina Todorova, has taken on this role. She has a wealth of experience of conference organisation and long-standing experience of EHPS.

This year's conference marks a special point in the development of the society as it is the 25th Conference of the EHPS. We are very pleased to be holding the conference in Crete at the Creta Maris conference centre in Hersonissos. As well as occupying a beautiful setting, the conference centre provides us with excellent facilities for our conference. The success of the conference depends on the hard work and enthusiasm of a large number of people. In particular, I would like to thank the Conference President and Chair of the Local Organising Committee, Evangelos Karademas, who has worked tirelessly to ensure that preparations for the conference have progressed so smoothly. This year's conference will be one of largest to date. The Chair of the Scientific Committee, Efharis Panagopoulou, also deserves special thanks as she had the unenviable task of processing over 1000 abstract submissions. The Scientific Committee has produced an exciting and high quality programme of symposia, themed sessions, poster presentations, and workshops as well as keynote presentations from George Chrousos, Christina Maslach, Tracey Revenson and Lucy Yardley. 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 review, meta-analysis and qualitative meta-synthesis*. The Synergy

Paul Norman
EHPS president

workshop, facilitated by Marie Johnston, Derek Johnston and Diane Dixon, is on *Theory and Intervention with Individuals*.

Preparations for the 2012 conference in Prague are well underway, expertly facilitated by Vladimir Kebza as Chair of the Local Organising Committee, Alex Luszczynska as Chair of the Scientific Committee and Ralf Schwarzer as the EC Liaison Officer. I am pleased to report that the keynotes have been confirmed as Charles Abraham, Johan Denollet, Carol Ryff and Kavita Vedhara. The conference will take place from 21-25 August 2012. As with Crete, the opening ceremony will be on the Tuesday evening with a full conference day on the Wednesday. Vladimir Kebza and his colleagues will be hosting a reception at the end of the Crete conference to introduce Prague and encourage you to attend. Initial discussions with Bruno Quintard have also started for the 2013 conference in Bordeaux which will take place in July, aided by Holger Schmid as the EC Liaison Officer.

The EHPS conference has grown considerably since the first meeting organised by Stan Maes that was held in Tilburg, The Netherlands in 1986. The conference now regularly attracts over 600 delegates. The society itself has also grown considerably since being founded. Our Treasurer and Membership Officer, Amelie Wiedemann, reports that for the first time the society has over 500 members from over 40 countries in Europe and beyond. We have a strong network of National Delegates, ably supported by Efrat Neter as National Delegate Convenor. One issue that we plan to work on with the National Delegates is the provision of Masters levels courses in health psychology across Europe and the extent to which it is possible to identify a 'core minimum curriculum' that could be used to describe current provision and provide a framework for the development of new courses.

With such a large membership, the EC has been considering ways in which the society can function more efficiently. In particular, Manja Vollmann and Amelie Wiedemann are overseeing an update of our website to further automate the processing of membership applications and renewals. This will also allow us to maintain a more accurate and up-to-date membership directory which could be organised/searched by keywords (e.g. research interests), which may facilitate research collaborations between members. On a related matter, the EC have proposed changes to the society's Bylaws to introduce electronic voting for future EC elections.

The financial position of the society is strong due to the increasing size of the membership and the success of recent conferences. As a result, the EC has been able to continue to invest in a number of recent initiatives to support training and collaboration. In addition to the annual conference and workshop grants, we were able to fund six visiting scholar grants in the past year for early career researchers to visit and work with a more senior colleague in another country. We also awarded our first Networking Grant to support colleagues from different European countries to meet to develop research ideas. I would like to congratulate all the recipients of these grants and thank Holger Schmid and Gerry Molloy who co-ordinated the administration of these schemes.

The society has continued to develop its links with other organisations in order to promote health psychology in Europe. First, I have attended a number of meetings at EFPA (European Federation of Psychologists' Associations) with other European psychology societies to discuss common issues of interest and ways in which associations between societies might be strengthened. To this end, EFPA has recently amended its statutes to allow

societies such as EHPS to become Associate Members. Given the close links between EFPA and the EU, this will strengthen the voice of European health psychologists and their influence on policy. Second, EHPS is now associated, for an initial period of two years, with the Division of Public Information/NGO Section of the United Nations. I would like to thank our Past-President, Irina Todorova, for all her work and persistence in ensuring that our application was successful. EHPS members have already attended briefing events at the UN and the 64th Annual UN/NGO Conference in Bonn on "*Sustainable Societies, Responsive Citizens*".

The society's official journals, *Psychology & Health* and *Health Psychology Review*, are both performing strongly. Earlier this year Mark Conner and Daryl O'Connor started their term as the new Editors-in-Chief of *Psychology & Health*. The success of the journal has resulted in a marked increase in submissions over recent years, with an associated increase in the publication lag. One of the key goals of the new editorial team is to reduce the size of the publication backlog so that authors' work is published more quickly. To this end, the journal has been increased in size from 10 to 12 issues per year with an additional "one-off" 13th issue for 2011, partly funded by EHPS. The journal continues to be one of the best journals in health psychology with a current impact of 1.591. *Health Psychology Review*, under the stewardship of Martin Hagger, continues to grow. The journal has quickly established itself as an important journal in the field, providing an outlet for reviews of empirical work as well as a forum for theory and conceptual development. The journal now has a steady flow of submissions and has applied to be indexed in SSCI which would provide it with an impact factor.

The Fellowships Committee, chaired by John Weinman, has been considering nominations for new EHPS Fellows and will be reporting their decisions in the Members' Meeting in Crete. We encourage EHPS members to nominate (or self-nominate) new Fellows—colleagues who have made an important contribution to the development of health psychology in Europe. A new call will be made later this year. In addition, our President-Elect, Falko Sniehotta, and Efrat Neter have been working on a proposal for the introduction of an early career award. The EC would welcome members' comments on this proposal.

In conclusion, I would like to thank all members of the EC for their valuable contributions to the work of the society over the past year. In particular, I should acknowledge the work of our Secretary, Karen Morgan, who is at the hub of almost all of the EC's activities. In addition, I extend my thanks to a large number of people whose work contributes to the vibrancy of the society, especially those involved in Create and Synergy. Over the past year I have been fortunate to work with such an enthusiastic and committed team both within and beyond the EC.

I would like to encourage all members to attend the *EHPS Members' Meeting in Crete* on Thursday 22nd September 2011 at 1240—we value your input. I look forward to seeing you in Crete.

Best Wishes,
Paul Norman
EHPS President

The potential of internet-delivered behaviour change interventions

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The Internet is set to play a crucial role in the delivery and evaluation of behaviour change interventions in the near future. Behavioural interventions—packages of advice and support for behaviour change—have traditionally been delivered principally face-to-face, and this continues to be the overwhelmingly dominant method of delivery, whether by therapists, teachers, coaches or other professionals. A major problem with this mode of delivery is that it is extremely resource intensive, severely limiting the scope for cost-effective interventions; clearly, it is not feasible to provide every individual with 24 hour access to personal advice and support for managing all aspects of their lives. In contrast, internet-based behavioural interventions can be made available to most of the population for little more than the cost of development (Griffiths, Lindenmeyer, Powell, Lowe, & Thorogood, 2006). Whereas the quantity and timing of information, advice and support that can be delivered face-to-face is very restricted, internet-based behavioural interventions can be accessible at all times and provide extensive and intensive advice and support. Currently delivered principally by PCs, digital interventions will increasingly be flexibly accessible through mobile phones, interactive digital TV etc.

The 'motivational' dimension of interventions involves providing relevant information, advice, education and decisional aids in order to promote knowledge, beliefs, attitudes and intentions consistent with the desired behaviour. Interactive internet-based behavioural interventions can provide information and advice specifically 'tailored' to address the particular situation, concerns, beliefs and preferences of the individual, and may therefore be more persuasive than generic printed information. Additionally, a 'volitional' dimension is often vital in order to help people translate good intentions into behaviour. Consequently, effective internet-based interventions provide a variety of techniques to support and sustain behaviour change, such as aids to goal-setting, planning and self-monitoring, skill and confidence-building, cues and reminders, and systems of incentive and social support (Webb, Joseph, Yardley, & Michie, 2010). Interactive internet-based behavioural interventions can provide a rich, stimulating, engaging and actively supportive environment, with audiovisual illustrations, reminders, personalised feedback regarding progress and concerns, and opportunities for peer-to-peer support and comparison (Danaher, Boles, Akers, Gordon, & Severson, 2006; Kerr, Murray, Stevenson, Gore, & Nazareth, 2006). Supporting long-term maintenance of desirable behaviour changes is a major problem that has not yet been solved. Internet-based behavioural interventions may for the first time offer a cost-effective means of providing long-term support.

How *you* can create internet-delivered interventions: the LifeGuide

Until very recently, it has been necessary to programme the software infrastructure for each intervention individually. This has restricted the number of interventions that can be developed and evaluated, thereby limiting the accumulation of knowledge about intervention effective-

ness, and the relative effectiveness of intervention components and the causal mechanisms on which they are based. Using this traditional development method, the initial development costs are typically greater for digital interventions than for traditionally delivered interventions, and once programmed they cannot easily be modified, acting as a barrier to innovation and enhancement of interventions. Lack of access to resources for programming interventions has also restricted the numbers of researchers that have been able to engage in developing and testing digital interventions, and in particular has made it more difficult for postgraduate students and junior researchers to engage in this type of research. Commercial software packages have been developed recently that allow professional users some scope to enter the content for the particular intervention that they wish to create, but these restrict the researcher to those components pre-selected by the developers, and do not offer the research community the crucial advantages of free access and the ability to innovate methods and integrate findings.

Since the essential components, functions and underlying infrastructure required for Internet interventions are common to a vast range of applications, it makes sense to develop an open-access set of shared software resources that researchers can use to easily create and modify different interventions themselves. For this reason we have developed the LifeGuide, which is a set of open source software resources designed to allow people with no programming skills to create interactive digital interventions themselves. The LifeGuide is embedded in a virtual research environment that provides the research community with facilities to collaboratively devise complex interventions, with immediate access to components that have been validated in previous LifeGuide projects, that can then be utilised in new applications (copied and modified as necessary, and only with permission of the authors).

The research community can then work together to rapidly recruit participants from geographically dispersed locations, and integrate the data to form very large data-sets that can be used to carry out more powerful analyses than have hitherto been possible, such as mediator and moderator analyses of intervention effects.

As Internet interventions become very widely used in many spheres of life, this platform could in the future provide the basis for national and international 'population laboratories' for the continuous further refinement of interventions. Ultimately, a semantically enriched and adaptive LifeGuide system should be able to continuously and semi-autonomously model and refine interventions, based on the preferences and outcomes of lay users. We also plan to ensure that LifeGuide interventions can interface with existing medical systems (e.g. patient records), and with remote monitoring devices (e.g. monitoring blood glucose levels, physical activity, heart functioning etc.), and can be delivered via a range of digital media (e.g. mobile phone, television).

The LifeGuide: where we are now

We have used a co-design approach to ensure that the LifeGuide offers the flexibility needed to deliver a very wide range of interventions with different formats and ingredients, and is sufficiently user-friendly that novice researchers can readily use it to develop interventions, with the aid of the basic online manual and demos we have also developed. LifeGuide interventions can include features for: creating questionnaires and quizzes; delivering advice tailored to the individual based on their responses to questions; adding images and videos; monitoring users' progress over time; sending automated emails and texts (e.g. for sending reminders, motivational messages and feedback on progress). Intervention authors create their own 'look and feel' for the intervention, using templates and a flexible

drag and drop interface to alter background, layout, font, colours etc. LifeGuide is designed to run experimental evaluations (typically randomised controlled trials of interventions), and authors can create interventions that create user accounts and automatically stratify, randomise and follow-up participants. All data (including user inputted data and which pages were viewed by the user for how long and in which order) are securely stored in encrypted form and can be exported to Excel. To future-proof the LifeGuide we have adopted open standards that are technology independent, facilitating easy updating.

An international network of nearly 500 researchers has been recruited through our workshops, demonstrations and website. Some of these researchers are independently developing their own interventions, others are collaborating with us in evaluating and developing the LifeGuide by applying it to a range of very different health problems. Examples of interventions that are already being developed and trialled using LifeGuide include: interventions to provide people suffering from common conditions (e.g. colds and flu, bowel symptoms) with tailored advice that enables them to cope with their symptoms; a twelve session eating and physical activity programme for obese people seeking to lose weight; an intervention to promote and support hygienic behaviour to reduce the spread of infection, especially during pandemic flu; an NHS e-learning and assessment programme that has been used by thousands of smoking cessation trainers nationally and a web-based smoking cessation programme; an eight session cognitive-behavioural programme for people with irritable bowel syndrome; and an intervention to support people who have just had a stroke to carry out rehabilitation in their own home. The first (beta) version of the LifeGuide software was only released in January 2010 and so there are not yet many published evaluations of LifeGuide interventions, but early accounts of successfully piloting these interventions are now starting to appear (Miller, Yardley, & Little, 2011; Yardley, Morrison, Andreou, Joseph, & Little, 2010; Yardley et al., 2010), and large-scale trials are underway.

Our hope is that LifeGuide will not only provide a tool for developing interventions, but will also support and encourage more productive collaboration and prove a catalyst to more rapid advances in the science and practice of technology-supported behaviour change. More details of LifeGuide and how you can access it can be found at: www.lifeguideonline.org

The future: UBhave

The next phase of research and software co-design to be led by the LifeGuide team is UBhave, a three year collaboration commencing autumn 2011. UBhave will build on three existing programmes of work: the LifeGuide; EmotionSense, a pioneering system created at University of Cambridge for using phones to collect real-time data about phone users' social activities, contexts, locations, and emotional states; and MyPersonality, a Facebook application in which 3 million users have already completed psychological surveys.

Previously, digital behaviour change interventions have mainly been delivered by PCs and provide advice based on users' answers to questions about their past or future activities and feelings. Our aim is to investigate how mobile phone technology and online social networking applications can gather this kind of information during daily life without the need for users to answer questions. Mobile phones can sense the user's activities, mood, location, and who they are with or talking to, while online social networks can provide information about users' attitudes and social contacts. This information can then be used to deliver exactly the right kind of messages to users at the right time, depending

on what the user is doing and feeling. We will demonstrate and experimentally test the capabilities, performance and effectiveness of our tools and techniques by developing a range of intervention components designed to address the major public health problem of weight management. We will investigate the use of Facebook to recruit very large samples of people to try these intervention components, and will examine how social networking data can be integrated with the data sensed by phones and used to create a supportive virtual community.

Clearly, this kind of intervention raises important issues about privacy and intrusiveness, and from the start we will work closely with users to develop ethical, acceptable and practical methods of phone-based measurement and behavioural intervention. Finally, we will start to develop new methods to analyse the vast amount of information we will be gathering across time and space from a very large number of people. We will also have a programme of activities for disseminating the tools we are developing for immediate use by the public, private and third sector for different types of behaviour change—so we hope that our current network of LifeGuide researchers will soon become enthusiastic members of the UBhave network too. ■

Acknowledgements

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Burnout and engagement in the workplace: new perspectives

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A personal perspective on the work being done on burnout and engagement calls for a more active focus on developing interventions at social and organizational levels. Preventing burnout can be accomplished by a focus on building engagement and utilizing organizational assessments that include tools for early detection.

In this article, I want to share a new perspective on burnout and engagement, in terms of intervention—what can we do about these issues to improve the work experience of many people? Thus, I will not be providing a literature review, or a discussion of the latest empirical findings, but instead I will be focusing on how best we can translate what we know into successful solutions. For many years, my colleagues and I have been conducting research to try and understand both the sources and outcomes of this psychological syndrome. And for just as many years, people who experience burnout, or deal with its consequences in the workplace, have been asking for some solutions to this problem. We may not have the final answers, but I do think that we are in a position to work more proactively, and more collaboratively, with practitioners to develop new interventions, evaluate their effectiveness, and develop ways to disseminate the successful ones to more people and organizations.

One of the most important arguments I want to make is that we need to pay greater attention to the social and organizational environment in which individuals work, and to be more creative about solutions at those levels, rather than just at the individual one. People often work in small groups or teams, which are part of a larger unit that is embedded within a larger organization. More importantly, organizations are designed and managed around work units. Managers are held accountable for large groups of employees, not individuals, and their performance as managers is evaluated on the basis of aggregated indicators, such as productivity and turnover. Interventions are often implemented across entire departments or business units. So our work on psychological issues, such as burnout and engagement, needs to address the question of how our findings can be relevant to interventions on multiple social and organizational levels. In particular, I want to focus on work that I have done with Michael Leiter, using two measures, the Maslach Burnout Inventory (Maslach & Jackson, 1981; Schaufeli, Leiter, Maslach, & Jackson, 1996) and the Areas of Worklife Scale (Leiter & Maslach, 2004). Our basic mediation model for burnout, and its positive opposite of engagement, has assumed that the worker's internal experience of burnout plays a mediating role between the impact of external job stressors and work-related outcomes (such as absenteeism or illness). We have also focused on six key domains of worklife—workload, control, rewards, community, fairness and values—which are predictive of burnout and engagement. A consistent theme throughout this research literature is the problematic relationship between the person and the environment, which is often described in terms of imbalance or misalignment or misfit. For example, the demands of the job exceed the capacity of the individual to cope effectively, or

the person's efforts are not reciprocated with equitable rewards.

Given all of the research that has been done on burnout, what do I think we have learned about how to deal with it? In my opinion, there are three principles that should be guiding our future work on interventions. First, preventing burnout is a better strategy than waiting to treat it after it becomes a problem. The personal, social, and organizational costs of burnout can be considerable in terms of physical health, psychological well-being, and work performance, so it does not make sense to incur those before taking any kind of ameliorative action. Instead, taking steps to minimize the risk of burnout before it happens is a more rational and prudent strategy. This does not, of course, argue against the use of treatment for people who are actually experiencing burnout; rather, it argues that the primary strategy should be to reduce the likelihood that burnout will occur.

Second, building engagement is the best approach to preventing burnout. People who are engaged with their work are better able to cope with the challenges they encounter, and thus are more likely to recover from stress. So building an engaged workforce, before there are major problems, is a great prevention strategy. I also find that framing issues around the positive end of the continuum, i.e., the goal of "where we would like to be" is a more effective way to start the conversation about solutions to the problem of burnout. How do we make this a great place to work, and a "workplace of choice"? What would make people want to work here and be fully engaged with their job? In other words, it is easier to get people focused on how to make things better, rather than just talking about the problems.

Third, organizational intervention can be more productive than individual intervention. If improvements can be made in job conditions

that affect a lot of employees, then those interventions will have a much larger effect. And to the extent that such interventions make changes in the way the organization works, they can begin to change the organizational culture, or climate. As I mentioned earlier, people rarely work in total isolation from others – instead, they are embedded within a social network. Each person is affected by this social environment, but each person is also part of the environment that affects everyone else. There is a lot of ongoing social interaction, and reciprocal exchanges, which can either contribute to a supportive and engaging environment, or produce the downward spiral of an uncivil and mean-spirited work community that can lead to burnout.

Focus on engagement

So what are the implications for prevention strategies? First, the goal needs to focus on moving people from burnout to engagement. The practical significance of the burnout-engagement continuum is that engagement represents a desired goal for any burnout intervention. Such a framework leads people to consider what factors in the workplace are likely to enhance employees' energy, vigor and resilience; to promote their involvement and absorption with the work tasks; and to ensure their dedication and sense of efficacy and success on the job.

An innovative example of this approach is a project on civility among coworkers. Incivility is characterized by a lack of consideration and by demonstrations of disrespect. Because of its milder nature and greater frequency, incivility provides a better research or intervention focus than relatively rare instances of abuse or aggression. A structured process, CREW (Civility, Respect, and Engagement at Work; Osatuke et al., 2009), has been demonstrated to improve civility among coworkers; these positive results suggested that improved civility would in turn affect employee burnout. Using a waiting list control

design, Leiter, Laschinger, Day, & Gilin-Oore (in press) demonstrated that CREW not only improved civility (replicating the Osatuke et al, 2009 findings), but that improvements in civility mediated improvements in the cynicism dimension of burnout, job satisfaction, organizational commitment, and management trust. This analysis provided strong support for the assertion that improving working relationships plays an important role in alleviating burnout. Furthermore, interventions at the organizational level can effectively alter the organization's culture and improve civility among employees.

Organizational assessments

Second, there is a real value in providing organizations with the tools to carry out regular organizational assessments. Our research usually requires that we set up a contractual arrangement with an organization that is willing to collaborate with us and that meets our research requirements (e.g., large number of employees, repeated measures). Our collaborative process follows ethical research guidelines (e.g., confidentiality, full disclosure of results to all participants), but is also designed to provide added value to the organization and its employees, in return for their involvement in the process. What has emerged out of these repeated organizational collaborations is an organizational "check-up" process that provides evidence on the overall health and well-being of the organization, as well as indicators of areas of strength and areas of possible problems that need to be addressed (Leiter & Maslach, 2000). The organizations can use this information to determine how well they are doing, and where they could improve.

In particular, the six areas are critical for identifying areas of improvement. I have found that people often think of burnout simply in terms of exhaustion and work overload—and indeed, those two elements show a consistent rela-

tionship. Bur burnout is more than just exhaustion, and there are five more domains of job stressors than workload—and the organizational checkup process is one effective way of showing organizations what the other possibilities are. Although most people predict that workload will be the primary factor for burnout, it usually is not—other areas, such as fairness, or control, or workplace community, often turn out to be the more critical points of strain in the organization. The advantage of the AWS data for the six areas, both for the overall organization and for separate units within it, is that it provides a more individualized indicator of strengths and weaknesses, and points to more customized intervention strategies (rather than a "one-size-fits-all" approach).

Not only have organizations found this checkup process to be useful (one of the first organizations to work with us has now been doing these checkups annually for over ten years), they have found ways to adapt our research process to one that better suits their practical needs. For example, one organization came up with an innovative way of presenting the aggregate results, using percentage of positive scores and a color coding, so that all employees could immediately understand the message of what was working well and what was not.

Early detection strategies

Third, any attempt to prevent burnout has to rely on some sort of process to detect early signs of potential problems before they develop into major issues. Some of our research studies have found that the MBI and AWS measures have that kind of predictive power, in that certain patterns of scores at Time 1 can predict what will happen a year later. More specifically, we found that high scores on one dimension of burnout (i.e., either cynicism or exhaustion) were "early warnings" that those people were in a state of transition and change, but that if these people also

showed mismatch scores ("tipping points") on at least one of the six areas, then their transition was to burnout (Maslach & Leiter, 2008). In another study, we found that exhaustion scores at Time 1 were predictive of unit injury rates a year later (Leiter & Maslach, 2009). The predictive power of these two measures was demonstrated very dramatically to us when we were in the midst of a longitudinal assessment with an organization. When we looked at the Time 1 scores by unit, we were struck by the pattern of multiple "tipping points" in one of them, and we asked the organization what was going on there. Their response (after a long silence) was "how did you know?" It turned out that this particular department was having major problems, and that several employees were being dismissed.

The possibility of adapting our research measures into indicators of practical use is a very exciting one; although the measures were designed and tested for a different purpose, it would be a great example of "giving psychology away" if we could establish how these measures could best be interpreted at Time 1 so that interventions could be put in place to prevent the predicted negative outcome.

Conclusion

The goal of preventing burnout and building engagement is one of major importance, and one that researchers should be actively working to achieve. We already have knowledge and tools to contribute to this cause, but we need to be developing new partnerships with practitioners and conceptualizing our work on multiple levels, especially the social and organizational. ■

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The program for organizational renewal, and all versions of the MBI, including the MBI-GS are now published online by Mind Garden, mindgarden.com

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Emotional/behavioral disorders and obesity in childhood: a clinician's perspective

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Associations between emotional and behavioral disorders and weight status have been reported in adults and children. Depression and anxiety are the most frequently reported manifestations among obese individuals. In the other direction, weight change is a common characteristic of emotional/behavioral disorders. Though the direction of causality between emotional-behavioral symptoms and obesity is not always clear, both behavioral and biologic pathways are believed to mediate these relations.

Childhood obesity epidemic

Obesity is generally defined as the excessive accumulation of fat in the adipose tissue, to the extent that health may be impaired. Obesity results from an imbalance between caloric intake and energy expenditure and it is a consequence of our modern lifestyle (Barlow & and the Expert Committee, 2007). A child's cognitive and emotional development, together with health-related behaviors, constitute an important factor in the development of obesity. In addition, familial factors such as family structure, lifestyle, nutritional environment, meal patterns and family stressors are equally important in the development and maintenance of obesity (Bathrellou et al., 2010). During the last decade, the rapid worldwide increase in the prevalence of childhood obesity has alarmed clinicians, health care researchers, public health services and the general public. Evidence from nationally representative samples of US children, assessed every 5 years, has shown that obesity prevalence has in-

creased from 5% between 1963 and 1970 to 17% between 2003 and 2004 (Ogden et al., 2006), whereas comparable increases have been noted more recently in European countries (Pigeot et al., 2009). In parallel to the obesity epidemic, an increase in obesity-related morbidity has been reported in children, including metabolic syndrome manifestations, diabetes type 2 and non-alcoholic fatty liver disease (Kassi, Pervanidou, Kaltsas, & Chrousos, 2011; Weiss et al., 2004). At the same time, psychological symptoms and disorders related to obesity, such as depression, anxiety, low self esteem, chronic fatigue and sleeping difficulties are expected to increase, as well. Clinicians working with children and adolescents are now faced with a large number of obese children with concurrent obesity-related physical and psychological symptoms and signs, as well as frank metabolic and behavioral disorders.

Childhood obesity and emotional/behavioral disorders: epidemiologic and clinical findings

There is evidence today that obesity, anxiety and depression may commonly co-exist in youths (Reeves, Postolache, & Snitker, 2008). In a general population sample of children 9-16 years old, studied longitudinally, chronic obesity was associated with psychopathology, more specifically, oppositional defiant disorder in boys and girls and depressive disorders in boys (Mustillo et al., 2003). Another study revealed that childhood overweight may increase the risk for mood disorders in adulthood, especially among overweight girls who become obese women (Sanderson, Patton, McKercher, Dwyer, &

Venn, 2011). Furthermore, children and adolescents at the highest quartiles of Body Mass Index (BMI), have a higher prevalence of concurrent depression, suggesting that associations between these two conditions are more likely to exist in individuals with more severe obesity (Onyike, Crum, Lee, Lyketsos, & Eaton, 2003). On the other direction, a large prospective study in children followed up into adulthood, showed that anxiety disorders and depression were associated with a higher weight in females than in girls without anxiety and depression and that differences in BMI z-scores were largest in adolescents and young adults in whom depression was present at an early age (Anderson, Cohen, Naumova, & Must, 2006). In addition to emotional problems, externalizing behaviors (the group of behavior problems that are manifested in childrens outward behavior, such as hyperactivity, aggression or delinquency) also have been associated with an increased BMI in children as young as 24 months of age (Achenbach, 1978; Anderson, He, Schoppe-Sullivan, & Must, 2010). This study in two-year old children, showed that irrespective of race, an average difference of three quarters of a BMI unit was predicted between children with high and low levels of externalizing behavior. In addition, this average difference in BMI was stable through the age of 12 among white children, and gradually doubled with age among non-white children. Other epidemiologic studies produced similar results: in a longitudinal Australian study, higher teacher-reported conduct problems were more noted in overweight preschool children than in their normal-weight peers, (Sawyer et al., 2006). An earlier study had revealed no association between behavioral problems and obesity at the age of 5 years, however, at age 14 overweight girls had over twice the odds of concurrent total behavioral poblems; no such association was noted in boys (Lawlor et al., 2005). Attention Deficit Hyperactivity Disorders (ADHD) is the most common behavioral disorder in children, affecting 5-10% of school

aged kids, especially males. Furthermore, ADHD is highly comorbid with other emotional (anxiety, depression) and behavioral (oppositional-defiant disorder, conduct disorder) disorders in the lifespan. During the last decade, a number of studies investigated associations between ADHD and obesity in young age groups. These studies examined both the prevalence of ADHD in obese individuals and the weight status of patients with ADHD. The majority of these studies revealed that a) ADHD patients had higher BMI scores than subjects free of any symptoms (Cortese et al., 2008; Spencer et al., 1996) and b) obese individuals had a higher prevalence of ADHD than normal weight subjects and this prevalence was higher in those in the higher quartiles of BMI (Lawlor et al., 2005; Sawyer et al., 2006). Evidence from a large study in children and adolescents aged 5 to 17 years, from the 2003-2004 National Survey of Children's Health, showed that children and adolescents with ADD/ADHD had approximately 1.5 times the odds of being overweight (Waring & Lapane, 2008). In a clinical population of obese children followed at the outpatient obesity clinic of our Pediatrics Department, we found a high prevalence of symptoms of anxiety and/or depression: children were almost five and four times more likely to report symptoms of anxiety and depression, respectively, than children in the general population. Among these kids, BMI z-scores were higher in those with anxiety and/or depression than in those free of any symptoms. Symptoms of Attention Deficit Disorder (ADD) were also higher in this cohort than in the general population. Children with a high level of ADD symptoms had a higher BMI z-score and a greater number of Metabolic Syndrome parameters than obese children without such symptoms (Pervanidou & Chrousos, in press).

Mechanisms linking obesity to anxiety and depression

A number of behavioral and emotional para-

meters connect obesity to anxiety and depression in children. Similarly to adults, children suffering from anxiety and/or depression are typically characterized by poor adherence to self-care activities, by sedentary habits and lack of physical exercise, excessive television and internet viewing and disturbed eating behaviors, such as emotional eating and consumption of comfort foods (Pervanidou & Chrousos, in press). Indeed, a study in overweight children and adolescents, 8-18 years old, showed that increased anxiety and depression were associated with emotional eating and loss of control over eating, whereas in the same study, emotional eating mediated relations between anxiety and loss of control (Goossens, Braet, Van Vlierberghe, & Mels, 2009). The researchers assumed that in overweight children, emotional eating is a way of coping with anxiety, because it provides distraction and comfort from painful negative emotions. Recent research has also indicated that less sleep time is associated with a higher BMI, while disordered sleep is another common characteristic of both emotional disorders and obesity. Sleep problems are prominent in adult and adolescent anxiety and depression, and, on the other hand, obese children are at risk of developing sleep apnea and the obesity-related hypoventilation syndrome, which are associated with decreased nighttime sleep. Lastly, low self esteem and feelings of guilt and failure characterize both obesity and emotional disorders and contribute to the vicious cycle between stress and obesity (Pervanidou & Chrousos, in press).

In addition to abnormal behaviors, biological pathways may contribute to the development of obesity in children and adolescents. Anxiety disorders and depression are characterized, in most cases, by dysregulation of the stress system, through increased secretion of the stress hormones corticotropin-releasing hormone (CRH), cortisol and the catecholamines norepinephrine and epinephrine, a state that might lead to central obesity and the metabolic syndrome. This state of dysregulation, characterized by increases or decreases of CRH, cortisol, catecholamines, and other molecules, such as interleukin-6 (IL-6), affects also several organ systems of the body, leading to further behavioral and physical abnormalities. In developing organisms, chronic alterations in the secretion of stress hormones may have additional effects on the timing of puberty, cognitive development and physical growth (Chrousos, 2009; Chrousos & Gold, 1992; Pervanidou & Chrousos, 2010).

Mechanisms linking ADHD and obesity

Associations between ADHD and obesity, in both directions, as evidenced by epidemiologic and clinical studies, suggest that either ADHD symptoms contribute to obesity development and/or the reverse (obesity may lead to ADHD) or ADHD and obesity share a common mechanism that leads to both conditions (Cortese et al., 2008).

Impulsivity represents a cluster of symptoms that characterize individuals with ADHD, whereas impulsive eating behaviors have been reported in patients with both ADHD and obesity (Altfas, 2002). Disturbed eating behaviors, such as binge eating and emotional eating, have also been reported in ADHD patients, while a greater percentage of bulimia nervosa has been noted in women with ADHD compared to those without (Surman, Randall, & Biederman, 2006). Similarly, higher percentages of bulimic symptoms were found in children with ADHD, corrected for concurrent anxiety and depressive symptoms. Both deficient inhibitory control and delay aversion, basic mechanisms related to impulsivity in ADHD may explain abnormal eating behaviors leading to obesity. In addition to impulsivity, inattention problems and organizational difficulties may also cause difficulties in adherence to proper self health care.

Another mechanism through which obesity may lead to ADHD manifestations is sleep disordered breathing (SDB) (Cortese & Penalver, 2010). SDB is a group of disorders characterized by abnormalities of respiratory pattern (pauses in breathing) or the quantity of ventilation during sleep. Obstructive sleep apnea (OSA), the most common of this group of disorders describes the repetitive or partial collapse of the pharyngeal airway during sleep and the need to arouse to resume ventilation. There is some evidence that SDB, through disrupted sleep and the associated intermittent hypoxia and hypercapnia may lead to ADHD symptoms (Chervin, Ruzicka, Archbold, & Dillon, 2005). Since obesity is associated to SDB, especially OSA, it is possible that obesity is associated to ADHD through SDB in a subgroup of patients (Cortese & Penalver, 2010).

Regarding the common biological pathways leading to both obesity and ADHD, the reward deficiency syndrome has been proposed to underlie both disorders. The dopaminergic reward system is a brain circuit that normally provides the feeling of reward. When this system is insufficient, it can lead to the use of immediate rewards, such as substance use, risk behaviors and inappropriate eating, which are detrimental. Today, there is evidence that patients with ADHD as well as obese individuals with disordered eating may suffer from an insufficient reward system. The dopamine receptors D2 (DRD2) and D4 (DRD4) are normally involved in this circuit, while alterations in DRD2, and to a lesser extent DRD4, have been associated with the ADHD phenotype. Interestingly, similar alterations have also been associated with obesity (Cortese et al., 2008).

Implications for the clinical practice

From a clinicians perspective, screening for emotional-behavioral symptoms and disorders appears to be essential in understanding and treating childhood obesity. Implications of research linking emotional and behavioral symptoms and disorders with obesity extend beyond improving our understanding of the development of the metabolic syndrome and consequent atherosclerosis and cardiovascular disease. Research has shown that anxiety and depression are associated with an increased risk for diabetes type 2, partly through their association with obesity and the metabolic syndrome, whereas both behavioral and biological mechanisms mediate such relations. Findings from existing research suggest that a more comprehensive approach to pediatric patients with obesity may provide novel methods of obesity management. It is also of great importance to incorporate stress management techniques and coping skills in obesity prevention and treatment strategies. ■

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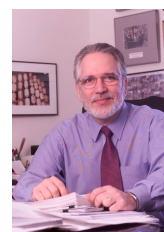
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# EHPS executive committee reports 2011

Gerard Molloy
Ordinary Member

I am a Lecturer in Psychology in the School of Natural Sciences at the University of Stirling in Scotland. My main research interests lie in the area of social support and adaptation to conditions related to cardiovascular disease in older adults. I have been a member of the EHPS since 2003 and I have participated in Create and Synergy workshops on a number of occasions over the last 7 years. I was an editor of the European Health Psychologist from 2008-2010 and I have joined the editorial board of Psychology & Health this year. I became an elected EHPS executive committee member at the last EHPS meeting in Cluj, Romania. Since then my two main roles have involved co-ordinating the 2010 Networking Grants scheme and being the EC liaison with the European Health Psychologist. I will also chair the Publications Committee meeting at the 2011 conference in Crete. This Committee will aim to co-ordinate the activities of all of the EHPS publications i.e. Psychology & Health, Health Psychology Review and the European Health Psychologist. My role on the EC incorporates both aspects of Education and Training and Communications and I look forward to getting involved in these and other new EHPS activities during my 2nd year on the EC.

I work as a Lecturer in Psychology at the Royal College of Surgeons in Ireland. In August 2011, I am moving to Perdana Medical University in Kuala Lumpur on a three year secondment. I have been a member of the EHPS since 2003 when I started my PhD studies. Prior to this I worked in the area of organisational psychology. My research interests are population health, chronic illness and ageing. Since becoming a member I have attended all but one EHPS conferences and have held a number of sub-committee positions include local liaison and president of CREATE and convenor of Synergy. In 2010 I was elected Secretary of EHPS. I am still learning about the role and I am very grateful for the support of the other members of the Executive Committee and the previous secretary (Yael Benyamini). The role of the Secretary is to keep records of all meetings of the Society; to conduct the official correspondence of the Society; to issue official calls and notices of meetings and to conduct elections and to notify new members of their election directly.

Karen Morgan
Secretary

I am a Senior Lecturer at Ruppin Academic Center in Israel. My research interests focus on health behaviours. I have been a member of the EHPS since 2003 and I became a member of the EHPS executive committee in 2010, taking on the role of National Delegates (ND) Officer. In this role I update ND about new developments, remind deadlines regarding application to EHPS grants, and encourage promoting EHPS activities in delegates' countries. The EHPS' National Delegates represent 33 countries. They include Rudolf Schoberberger (Austria), Marleen
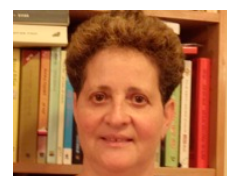
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Decruynaere (Belgium), Anna Alexandrova (Bulgaria), (Jasminka Despot Lucanin (Croatia), Theano Kalavana (Cyprus), Vladimír Kebza (Czech Republic), Thomas Iverson (Denmark), Jukka Marttila (Finland), Noëlle Girault-Lidvan (France), Maia Mestvirishvili (Georgia), Benjamin Schüz (Germany),George Koulierakis (Greece), Piroska Balog (Hungary), Niels Peter Agger (Iceland), Molly Byrne (Ireland), Rebecca Jacoby (Israel), Elvira Cicognani (Italy), Antanas Gostautas(Lithuania), Sophie Recchia (Luxembourg), Elaine Dutton (Malta), Maya Schroevers (Netherlands), Børge Sivertsen (Norway), Georgiy Korobeiynikov (Ukraine), Ewa Gruszczynska (Poland), Isabel Silva (Portugal), Catrinel Craciun (Romania), Elena Nikolaeva (Russia), Andrea Madarasova Geckova (Slovakia), Zlatka Rakovec-Felser (Slovenia), Marina Belendez (Spain), Sven Ingmar Andersson (Sweden), Holger Schmid (Switzerland), and Angel Chater (UK). Two National Delegates have stepped down this year (Martin Hagger from UK, and AnnMarie Groarke from Ireland). They have been succeeded by new ones: Angel Carter (UK) and Molly Byrne (Ireland). Over the past year national delegates have continued to update their country's sites on the EHPS Webpage. President-Elect Falko Sniehotta and I have devised a plan of acknowledging and supporting the contribution of early career researchers in the EHPS. The package is to be discussed in the next EC meeting and then will be presented to members' approval.

I am a Professor and head of the Institute of Social Work and Health at the University of Applied Sciences in Olten. I have studied psychology at the University of Freiburg in Germany and at the University of Freiburg in Switzerland. Between 1995 and 2007 I worked at the Swiss Institute for the prevention of alcohol and drug problems in Lausanne in the field

Holger Schmid
*Education and Training
Officer*

of health promotion and drug prevention in young people. My research interests are in health psychology, health and health behaviour of young people and in evaluation research. The EHPS conferences are excellent opportunities to update our knowledge, to develop new ideas and to exchange ideas with colleagues from all over the world. Education and training possibilities have enlarged the activities of the EHPS and became more and more important. The EHPS has always been dedicated to education and training. This has been an important part of the developments in Health Psychology to me since I first attended an EHPS conference in Leipzig in 1992. I am grateful that I can in some way contribute to this in my function as education and training officer. With the pre- and post-conference workshops, as well as the tremendous work of CREATE and SYNERGY the EHPS is strongly committed to developing members' research and professional skills. I personally was very happy to see so many good applications for the EHPS grants in 2010, with which the society can support early career researchers.

I am a Reader in Health Psychology at the Institute of Health and Society, Newcastle University in England. My research focuses on behaviour and behaviour change relevant for health and I am interested in theory of behaviour change as well as the development and evaluation of interventions to

Falko Sniehotta
President-elect

change behaviour in members of the public, patients and health care providers. I have been an EHPS member since 2001 and have been serving the society in a range of roles over the past decade. Currently, I am associate editor of Health Psychology Review. I am president elect. This means that for the time from 2010 to 2012 my role in the executive committee is to support the

current president and the EC as well as to familiarise myself with the procedures and long term activities in the executive committee. Together with the current EC we also work toward achieving the objectives I emphasised as part of my nomination as EHPS president, in particular further supporting our journals, improving training opportunities and access to our journals for PhD students and early career researchers and developing the internal structures and external affiliations the EHPS needs to facilitate cutting edge health psychology science to improve health and well-being.

I have been a member of the EHPS Executive Committee since 2002 and was editor of the EHPS Newsletter, now the European Health Psychologist (EHP) until 2006. I was President of the EHPS from 2008 – 2010, and am now a member of the Executive Committee as Past President. In this role I support the on-going activities of the EC. As current Conference Officer, I coordinate the calls, procedures and initial preparations for all upcoming EHPS conferences, specifically the 2012 Conference in Prague, and the 2013 Conference in Bordeaux, as well as talking with potential hosts for the 2014 Conference. I also coordinate the activities related to the new EHPS association with the United Nations. I direct the Health Psychology Research Center in Sofia, Bulgaria. My research interests are in the areas of gender and health, culture and health and social change and health. I am particularly interested in psychosocial aspects of health in Eastern Europe and committed to contributing to developing health psychology in that area of Europe, as well as expanding the involvement of psychologists from Central and Eastern Europe in the EHPS in joint research projects. One of our current projects,

Irina Todorova
Past President

which includes several colleagues from EHPS, is a Framework 7 Study ORCAB: Improving quality and safety in the hospital: The link between organisational culture, burnout, and quality of care; Coordinated by Aristotle University of Thessaloniki, Greece, partnering with Bulgaria, Croatia, FYROM, Ireland, Portugal, Turkey, Romania, UK.

I completed my PhD at the University of Greifswald, Germany in 2007. My main research focus is on antecedents and processes which promote well-being and health in chronically ill and healthy persons. More specifically, I examine the health effects of illness representations and personal resources such as optimism; and I explore possible mediators of the health effects, in particular social support processes and coping strategies. I became a member of the EHPS in 2003 and since then I have participated in several annual conferences and workshops. I was the EHPS office assistant (2003-2008), the webmaster of SYNERGY between (2003-2008), and the membership officer and treasurer (2008-2010). In the current EC, my main activities are in relation to the communication of information and updates. In particular, I am responsible for updating and expanding the content of the EHPS webpage and for circulating EHPS-related announcements, job adverts and other information among the EHPS members. At the moment, I am working together with a programmer on the upgrade of the online EHPS member database. The new functions of the database will facilitate the work of the membership officer and treasurer, will make an up-to-date membership directory with search options possible and will allow members to circulate information among the EHPS members.

Manja Vollmann
Communication Officer

I am a research scientist at the Department of

Amelie Wiedemann
Treasurer

Medical Psychology at the Charité-Universitaetsmedizin Berlin in Germany. My research focuses on self-regulatory and social exchange processes in health behaviour change and theory-based interventions for health promotion. In particular, I am interested in moderating and mediating relations between intention, planning processes, and social support. In one research project, we study self-regulation processes during the uptake and maintenance of health-relevant behaviour in patients following major tumour surgery. I have been a member of the EHPS for 7 years. As chair of CREATE and treasurer of Synergy (and CREATE) I have been involved in many EHPS activities. Since 2010 have served on the EHPS executive committee as EHPS membership officer and treasurer. As membership officer my main task is to support EHPS members during their application process and to recruit new members. Most readers of the European Health Psychologist have probably received an email from me since then, either as reminder of membership renewal, as response to a specific request or with regard to grants and reimbursements. As treasurer, my scope of duties stretches from overseeing membership payments and reimbursing grant winners to providing accounts of the financial situation by reporting the annual budget to my colleagues on the Executive Committee. Currently, we aim at rebuilding our electronic database management system to make it more flexible and interactive for our members.

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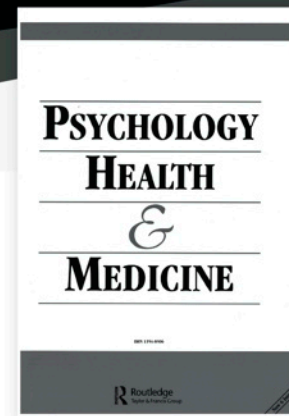
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