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original article

Rethinking the role of affect in health communication

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It is not difficult to find good examples of extreme scare tactics in health communication. Cigarette warning labels show images of diseased lungs and open heart surgery, anti-drinking campaigns use vivid images how drinking and driving may result in fatal car accidents, and medical professionals remind obese patients that their eating habit may end up getting them killed. Health campaigns and warnings often include highly threatening material based on the assumption that the right dose of fear may change the habits of long-term smokers, compulsive overeaters, and alcoholics. Making people feel the terrible consequences of their bad habits is thus supposed to change their minds, and get them on the right track toward a better health.

In spite of the good intentions of health education specialists, on most occasions risk groups appear completely unmoved by threatening health material and continue their bad habits in the face of imminent danger. Below I will describe the processes that drive defensive responses among risk groups and point to strategies that make them more receptive to threatening health information. Specifically, I will argue that making people feel good, rather than bad, may be more efficient in promoting health behavior change.

The truth about defensive responses

Most risk groups are well trained in warding off threatening health information. Young smokers may argue they will quit when they are

older, heavy drinkers say they have no problem abstaining from alcohol for a day or two, and individuals who had unsafe sex assume their chances of getting an STD from this one time are close to zero.

Perhaps the biggest misunderstanding about such defensive responses is that they are the result of extreme fear triggered by the imagery or threatening content of a health message. In reality, excessively fearful responses to threatening health message content are just as rare as teenagers' enthusiastic responses to being picked up by one of their parents after a night out in the town with their friends. Defensive responses to threatening health information are better defined as cognitive strategies designed to protect the self-system—or 'ego'—that is linked to beliefs and strongly held values (Steele, 1988). For instance, heavy smokers may respond defensively to evidence regarding the link between smoking and lung cancer to protect the belief that they need nicotine to relieve stress, e.g., "I really need my cigarette". Ironically, smokers may also respond defensively to threatening health evidence to protect strongly held negative, self-defeating beliefs such as: "I have too little self-constraint to quit". These beliefs may be buried deep inside the unconscious brain most of the time; much like sleeping giants blissfully unaware of personal weaknesses. When activated, however, they may prompt a vicious cycle of self-defeating thoughts and negative affect, much like the reciprocal influence of depressed moods and pessimistic thinking in depressed patients.

A second misunderstanding is that defensive responses to threatening health messages involve mostly passive strategies such as avoiding or ignoring the evidence. Defensive responses to threatening health information often involve active, cognitive attempts to discount the personal implications of a health message, e.g., by attacking the evidence, denying its personal relevance, downplaying its seriousness, or engaging in wishful thinking. Most defensive responses to health messages thus involve biased systematic processing of the evidence with the goal to arrive at a particular, preferred conclusion, e.g., “There is no need to take this information personally” (Das, de Wit, & Stroebe, 2003).

If defensive strategies are active cognitive attempts to defend (hidden) personal belief systems, how can health education specialists ever effectively reach target groups? Recent research suggests that the trick may be to make people feel good, rather than bad; positive moods may decrease the power of self-undermining tendencies and decrease the adoption of healthy actions.

Positive moods decrease defensiveness

In the past decade, research has confirmed that making individuals feel secure about who they are helps them confront adversity; there is now ample evidence that affirming an important aspect of the self-concept unrelated to health—e.g., ‘I am a kind person’—decreases defensive processing of threatening health information (Harris & Epton, 2009). More recently, researchers have also started examining the role of positive mood in diminishing defensive responses to threat. Several studies suggest that, much like self-affirmation, positive moods may increase risk groups’ openness to threatening health information.

One study showed that a positive mood

increased recall of the negative effects of caffeine intake and intentions to cut down caffeine intake among coffee drinkers (Raghunathan & Trope, 2002). Other research among different risk groups, i.e., coffee drinkers, or smokers, demonstrated that a positive mood decreased defensive processing of threatening health messages, and increased the adoption of healthy actions. In two studies, risk groups only processed a health message with a systematic, unbiased strategy after a positive mood induction; this strategy was absent under negative mood conditions. Importantly, beneficial effects of a positive mood were observed only for high risk groups; positive mood effects reversed for not at risk groups, leading to the use of less systematic information processing strategies (Das & Fennis, 2008; Das, Vonkeman, & Hartmann, 2012).

Finally, there is some evidence that a positive mood also works at the unconscious level; a positive mood speeded up reaction times to smoking-related threat words, compared with neutral words, among smokers who had just read a threatening health message about the negative health consequences of smoking (Das & Fennis, 2008). These findings suggest that a positive mood attunes the unconscious mind to threatening information that is relevant to the self; a capacity that may increase effective self-regulation.

In sum, happy moods promote implicit attention to and unbiased processing of threatening health information under highly particular conditions, i.e., only when the information is personally relevant. A positive mood may thus increase individuals’ flexibility in responding to incoming information, and help them decide when paying close attention may further personal goal attainment; a very helpful tool indeed in modern information-cluttered society. The finding that positive moods may

increase systematic information processing of aversive information stands in apparent contrast to previous findings regarding the relationship between positive moods and information processing. In the next section, I will discuss this relationship in more detail, and examine potential origins of mood-induced responses to self-threatening information.

Feeling good improves self-regulation

In- and outside the academic world happy moods have long been associated with shallow thinking; only negative moods were supposed to promote serious and contemplative thought. However, more recent studies suggest a different side to happy moods, positive affect, and positive emotions. Whereas it is true that negative moods are generally associated with systematic, narrow, focused, and analytic forms of processing (see Schwarz & Clore 1996 for a review), positive moods and positive emotions promote not only shallow, heuristic information processing, but also prompt a more flexible, intuitive, and broader state of mind (Fredrickson, 2001; Isen 1999). For instance, Alice Isen, pioneer in this particular research area, and her colleagues found that positive affect increased creative problem solving, the generation of unusual associations, and more efficient decision-making. More recent studies found that positive mood also increases cognitive flexibility and access to implicit, intuitive knowledge (Bolte, Goschke, & Kuhl, 2003).

Research also suggests a positive relationship between positive affect, intuitive knowledge, and self-regulation (Baumann & Kuhl, 2002). Positive affect and emotions increase coping resources that help individuals effectively deal with difficult situations. In addition, positive emotions predict resilience to adversity and the use of broad-minded coping strategies. Finally, positive emotions have also been related to

physiological recovery processes; compared with neutral conditions, positive emotion conditions enhanced cardiovascular recovery (see Fredrickson, 2001).

Feeling good may thus help individuals put things into a bigger perspective and deal efficiently with adversity. These findings may help explain why positive mood decreases defensive processing of self-threatening information. Consider again the example of the heavy smoker who strongly believes he has too little self-constraint to quit smoking and who starts a vicious cycle of ruminative, limited thought patterns and negative emotions whenever reminded of his bad habit. A positive mood may provide a way out of a vicious cycle by liberating him from the tight grip of self-defeating thoughts, and by increasing access to alternative—more flexible, creative—ways of thinking, and better ways of coping. In this new outlook on life, improving the situation at hand and taking the necessary steps toward a healthier life becomes a real possibility. Health messages that address this possibility may then find fertile ground.

Concluding comments

In this article I chose to focus on converging evidence and commonalities between different lines of research related to positive mood, information processing, and health, because I believe that a focus on the big picture may help further research in this area. Nevertheless, important differences exist between conceptualizations and consequences of e.g. mood, affect and discrete emotions; and these differences are worth mentioning and examining further. Barbara Fredrickson and her colleagues conducted groundbreaking work in examining effects of discrete positive and negative emotions and found, for example, that joy and contentment increased a broadened mindset, and that fear and anger narrowed this mindset,

compared with neutral conditions (Fredrickson & Branigan, 2005).

The commonalities and differences between self-affirmation and mood also need further investigation. Self-affirmation is different from positive mood in at least two ways: it involves some important aspect of the self, whereas the self is not necessarily implicated in mood, and it is unrelated to explicit measures of mood (e.g., Steele, 1988). Nevertheless, there is considerable overlap on the conceptual level. For instance, asking individuals to recall three happy experiences may improve mood but also affirm the self-concept at the unconscious level. Affirming an important self-related value may not affect explicit mood but, like mood, restore an individual's inner balance. It is plausible that self-affirmation and mood affect different processes at the explicit level but both increase access to implicit, intuitive self-relevant knowledge.

Communicating with risk groups involves conveying bad news most of the time, and health education specialists vary in strategy to achieve this goal: whereas some will try to shock risk groups into understanding the consequences of unhealthy lifestyles, others may try subtle strategies in order to prevent upsetting message receivers. Based on the available evidence, health education specialists do not have to cover up the facts, as long as they make sure risk groups are in the right mood to accept bad news without getting lost in it. Health education efforts that make sure message receivers feel comfortable before they process threatening health information stand a better chance of truly reaching a target audience. ■

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original article

Habit as automaticity, not frequency

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Many health behaviours are enacted repeatedly, with little forethought.

This has led research-

ers to question the utility of concepts and models based on conscious deliberation for understanding real-world health actions. There has been a resurgence of interest in the role of 'habits'—i.e. automatic responses to everyday contexts, learned through repeated performance in those contexts—in determining health behaviour (for a review, see Gardner, de Bruijn & Lally, 2011). Empirical work has demonstrated that, because habits are triggered directly and immediately in associated contexts, they tend to override deliberative intentions in directing behaviour in those settings: where habits and intentions conflict, behaviour is more likely to proceed in line with habit than intention (Gardner et al., 2011). This has implications for behaviour change: boosting motivation may be insufficient to disrupt health-risk behaviours controlled by learned cue-response links (i.e. 'bad' habits). Conversely, intervention developers should treat habit formation for health-promoting behaviours ('good' habits) as an outcome goal, because habitual behaviours are less likely to be disrupted by losses in motivation (for a review of habit formation and disruption techniques, see Lally & Gardner, in press).

Progress in habit theory and application depends on coherent conceptualisation and measurement of habit. In this piece, I argue that there are inconsistencies in how habit has been operationalised within health psychology and

propose that habit be viewed as a form of automaticity, independently of performance frequency. This generates ideas for future research and calls for greater precision in habit measurement.

'Habit as frequency' versus 'habit as automaticity and frequency'

Habit is an abstract concept, and consequently, can have no 'correct' or 'incorrect' definition. Definitions must be judged according to their coherence and usefulness for research purposes. In lay discourse, the term 'habit' is often used to refer to an action done frequently. This definition ('habit as frequency') is unsatisfactory to the psychologist: it proposes that people frequently do what they do frequently, but does not explain why this should happen. A psychological operationalisation of habit has emerged, which incorporates an explanatory mechanism: habits are actions that are frequently performed *because they are initiated automatically* ('habit as automaticity and frequency'; e.g. Verplanken & Orbell, 2003). Repeating an action in a particular context reinforces context-action associations in memory, and control over the initiation of the behaviour passes from a conscious reflective processing system (initiated by intentions) to an automatic impulsive system (initiated by environmental cues). Once a habit has formed, encountering the associated context is likely to directly trigger the behaviour with minimal deliberation. A recent study showed that repetition of a dietary or exercise behaviour in response to a salient once-daily cue prompted increases in self-reported behavioural

automaticity (Lally, van Jaarsveld, Potts & Wardle, 2010). In a qualitative study, participants repeating weight-loss actions within existing routines reported that the actions became 'pretty much second nature' and 'wormed their way into my brain', reflecting development of automaticity (Lally, Wardle & Gardner, 2011).

From a research perspective, 'habit as automaticity and frequency' is a more useful conceptualisation than is 'habit as frequency', because automaticity explains the persistence of habits, and discriminates between frequent actions done automatically (habits), and those done deliberately (not habits). 'Habit as automaticity and frequency' underpins the Self-Report Habit Index (SRHI; Verplanken & Orbell, 2003), which scores habit according to reflections on behavioural automaticity (e.g. 'Behaviour X is something I do without thinking') and performance frequency ('Behaviour X is something I do frequently')¹. The SRHI has become the most popular habit measure within the European psychology community (Gardner et al., 2011).

'Habit as automaticity, not frequency'

On closer inspection, the 'habit as automaticity and frequency' perspective is inconsistent. If an action is automatically activated by cues, frequency of enactment will be a function of the frequency with which cues are encountered. Where a habitual behaviour is performed often, this suggests only that the behaviour is associated with frequently encountered settings. Learned automatic responses need not be frequently performed: where contextual cues are rarely encountered, responses may continue to be automated by cue-response mechanisms, but automatic cue-responding will be infrequent. For example, the habit of saying 'amen' at the conclusion of public prayer will be enacted on a weekly basis for weekly churchgoers, but annually for those who

attend church only at Christmas. The behaviour would be automatic in both instances, but its frequency would differ considerably. Similarly, the frequency with which football fans automatically offer loud vocal support for their team within the stadium environment will vary with match attendance (see Neal, Wood, Labrecque & Lally, 2012), and will not be prompted at all during off-season months.

For these reasons, habits should be seen as a form of context-dependent automaticity which, once formed, are not necessarily enacted frequently unless the environmental triggers are frequently experienced ('habit as automaticity, not frequency'). This viewpoint is important for two reasons. First, it views automaticity as the essence of habit and explains the effects of established habits on action through automatic processes. It is because habits are automated that they can override effortful intentional responses. Development of automaticity is the aim of habit formation, and discontinuation of automatic responding the aim of habit disruption (Lally & Gardner, in press). Automaticity should be seen as the 'active ingredient' of a habit, and repetition frequency as its precursor and possible consequence (Sniehotta & Pesseau, 2012). Second, the definition rejects frequent performance as a necessary component of habit. Many habits are performed often (see Gardner et al., 2011), but this is because associated cues are frequently encountered, not because learned automatic responses necessarily have a propensity to be

¹ The SRHI also includes an item indicating the relevance of the focal behaviour to self-identity ('Behaviour X is something that's typically "me"). Identity-relevance is not however consensually agreed to be a central component of habit, and we recently showed that the self-identity item from the SRHI loads onto a conceptually distinct factor to other SRHI items (Gardner, de Bruijn & Lally, in press).

frequently activated regardless of context.

Dormant habits and habit recovery

Conceptualising habit as automatic processes allows for them to be performed infrequently, and this generates some interesting research ideas. Habit theorists have proposed that major context changes—such as moving home or starting a new job—can break habitual patterns of behaviour by discontinuing exposure to cues. Such changes offer ‘windows of opportunity’ during which behaviour will proceed in line with underlying intentions and new habits may form (Lally & Gardner, in press). However, such an approach may offer lasting behaviour change because associated cues are no longer encountered, rather than because cue-response associations are necessarily dismantled or overwritten. More work is needed to document the impact on health habits and behaviour of a temporary major context change followed by a return to previously habit-cuing settings. If mental representations of cue-response links remain intact despite discontinued exposure, habits may be recovered and reactivated upon reencountering cues, even after considerable time. In a seminal chapter on habit, James (1890) cited a wonderful anecdotal example of habit reactivation in a retired soldier:

“There is a story ... of a practical joker, who, seeing a discharged veteran carrying home his dinner, suddenly called out, ‘Attention!’ whereupon the man instantly brought his hands down, and lost his mutton and potatoes in the gutter.” (Huxley, 1866, cited in James, 1890, p120)

In enacting a learned response (standing to attention) associated with a rarely encountered cue (‘attention!’), the unfortunate veteran—or rather, his dinner—appears to have fallen victim to what might be termed a ‘dormant habit’, i.e. a propensity to act automatically in line with learned cue-response associations despite not

having done so for some time, because cues have not been encountered². The concept of dormant habits has potentially important implications for predicting and changing behaviour. Interventions based on context modification may fail to bring about lasting changes in behaviour because returning to previous contexts at the end of the intervention period may reactivate dormant habits, so undermining behaviour gains. Additionally, calls for habit formation to be treated as an intervention goal require qualification, because habits developed in settings that are subsequently infrequently encountered may not serve the purpose of eliciting frequent behaviour. Habit development will best support behaviour change where habits are formed in the presence of frequently encountered cues.

The Self-Report Behavioural Automaticity Index

Treating automaticity as primary also has implications for habit measurement. If habit-behaviour relationships are solely attributable to automaticity, then the inclusion of frequency in the SRHI poses a problem for the estimation of habit-behaviour relationships. Frequency measures capture both actions prompted by learned automatic tendencies for which the cue is frequently encountered (in my view, habits), and those arising from frequent deliberate action without a specific environmental cue. The inclusion of frequency items in the SRHI may therefore inflate true habit-behaviour relationships (Gardner et al, 2011). We have proposed elsewhere an automaticity-specific

² Of course, most habits are ‘dormant’ for most of the time; for example, even the most ardent habitual nail-biter will spend only a minority of her time biting her nails. I use the term ‘dormant’ here to crudely discern an established habit performed rarely due to rare encounters with associated cues from that which is performed frequently due to frequent cue encounters.

abbreviation of the SRHI: the 'Self-Report Behavioural Automaticity Index' (SRBAI). A content validity assessment of the SRHI showed that four items ('Behaviour X is something...' '...I do automatically', '...I do without having to consciously remember', '...I do without thinking', '...I start doing before I realise I'm doing it') were most consistently and strongly judged by a panel of researchers to match the definition of automaticity (Gardner, Abraham, Lally & de Bruijn, 2012). Applications to physical activity, unhealthy snacking and alcohol consumption showed that the SRBAI was at least as sensitive as the SRHI to the hypothesised moderating effect of habit on the intention-behaviour relationship. A subsequent meta-analysis of published SRHI applications, re-analysed using the SRBAI, generally replicated these findings (Gardner et al, 2012). The SRBAI was consistently less strongly correlated with behaviour frequency than was the SRHI, presumably because the inclusion of behaviour frequency within the SRHI inflates the purer habit-behaviour relationships revealed by the SRBAI. Habit is distinguished from other forms of automatic action—such as unconscious mimicry, priming, action prompted by the formation of implementation intentions—by its acquisition through repetition, and so it may be necessary to incorporate a measure of behaviour frequency where research questions focus on distinguishing habit from other forms of automaticity. However, the SRBAI, which captures the 'habit as automaticity, not frequency' conceptualisation, is better placed to estimate habit-behaviour relationships, and offers the most parsimonious measure available to track habit formation or disruption.

Conclusion

Progress in habit theory depends on a coherent conceptualisation of the term 'habit'. While habits arise through repeated performance, it is necessary to separate the

central quality of a habit (cue-dependent automaticity) from its cause (context-dependent repetition). Habit is therefore better conceptualised as a form of automaticity which, once formed, need not be defined by frequent performance. Research efforts could usefully be directed towards understanding the behavioural implications of automatic cue-responses that are infrequently elicited. ■

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original article

'Enjoy a delicious cake today and eat healthily tomorrow': Compensatory Health Beliefs and their impact on health

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Every day we are faced with temptations like drinking a beer after finishing work or eating a delicious cake. In such situations the immediate desire to indulge in the pleasant behaviour like eating the cake can interfere with our long-term goals (e.g., be healthy or lose weight). According to Muraven and Baumeister (2000) humans strive to achieve an ideal balance between the completion of their desires and the pursuit of their own goals. This search of the ideal balance between maximum pleasure and minimal disadvantage is called the hedonic principle. However, the interaction between our desire and our health goals can lead to a motivational conflict (Rabiau, Knäuper, & Miquelon, 2006), or so-called cognitive dissonance (Festinger, 1957), because of the incompatibility between both goals. This dissonance generates a state of pressure, whose resolution requires self-regulatory processes to deal with the aversive state of dissonance (Rabiau et al., 2006). According to the Compensatory Health Belief (CHB) Model one possible strategy to diminish this conflict is to use/employ Compensatory Health Beliefs (Knäuper, Rabiau, Cohen, & Patriciu, 2004).

CHBs are beliefs that the negative effects of an unhealthy (but pleasurable) behaviour can be compensated for or neutralised by carrying out a healthy behaviour (Rabiau et al., 2006, p. 140). To resolve the cognitive dissonance, people convince themselves that eating the cake or drinking a beer is ok because they exercise the following day, or they eat healthily and this

behaviour will compensate for the negative effects of alcohol or fatty food. Thus, CHBs seem to provide an ideal solution, since they allow us e.g., to eat unhealthily without feeling guilty about having counteracted our own goals. The activation of CHBs is an automatically motivated regulatory process to reduce cognitive dissonance, by justifying unhealthy behaviour with future planned healthy behaviour, as mentioned by Knäuper and colleagues (2004). Likewise, it seems also reasonable that the planned unhealthy behaviour in the future is cognitively neutralised by a healthy behaviour an individual already engaged in in the past. Thus, CHBs can be activated before or after the behaviour has been carried out. According to the CHB model, CHBs are activated when there is a high self-concordance of the health goals, and if the person fails to keep up the aspired goal (Knäuper et al., 2004; Kronick & Knäuper, 2010).

CHBs: good effects on dissonance, negative effects on health

According to Rabiau and colleagues (2006), CHBs can be correct, partly correct, or incorrect. The classification can be difficult, because oftentimes unhealthy behaviour causes several negative effects on health and the compensatory behaviour only compensates for some but not all adverse effects (cf., Knäuper et al., 2004). An example for a partial compensation is that the risk of developing cancer, which is elevated by smoking, can potentially be buffered but not completely neutralized by a healthy nutrition (Kuper, Adami, & Boffetta, 2002). Moreover, it is not guaranteed that people actually carry out the intended compensatory behaviour (Knäuper

et al., 2004), because too much time may have passed by between the activation of the CHBs and the planned implementation of the compensatory behaviour. Thus, the dissonant feeling and the necessity to compensate the unhealthy behaviour fades away. Consequently, CHBs interfere with successful adherence to health behaviour changes such as dieting or quitting drinking alcohol.

Overview of empirical results concerning CHBs

First evidence for the relatively new construct of CHBs comes from Knäuper et al. (2004) who developed a scale to measure CHBs in general. They found that CHBs are positively associated with health-related risk behaviours like alcohol consumption or smoking and with symptom reports. Further research also indicates that CHBs are associated with lower goal achievement (Rabiau, Knäuper, Nguyen, Sufategui, & Polychronakos, 2009). Results have shown that adolescents, who had been diagnosed with type 1 diabetes, hold compensatory beliefs concerning their glucose testing. As shown, these beliefs were associated with less regular testing of the glucose level and with poorer metabolic control. In line with this research, Nguyen, Knäuper, and Rabiau (2006) found that the more CHBs diabetic adolescents held, the less likely they were to control their glycemic level, monitor their blood-sugar, and adhere to their dieting rules. Furthermore, Monson, Knäuper, and Kronick (2008) showed that dieters spontaneously generate CHBs in response to temptation. This is in line with results from a study by Kronick and Knäuper (2010), which found that dieters had compensatory intentions on their mind when they were faced with the food temptation of a delicious cookie. In addition, the authors found support for the proposition that the existence of compensatory intentions is related to the decision to eat the high caloric cookie. It seems that compensatory intentions are one strategy to

cope with temptations when individuals allow themselves to indulge. Another study of a sample of coronary heart disease patients also revealed that nutrition style is best explained by CHBs in addition to self-efficacy (Taut & Baban, 2008). However, it is important to mention that in this study no other variables except for self-efficacy and CHBs were entered in the analysis.

CHBs in comparison to other psychological constructs

Even though the results mentioned above lead to the assumption that CHBs can be considered to be an important factor in unsuccessful self-regulation regarding health behaviour, none of the reported studies investigated CHBs in comparison to other health-psychological constructs. Therefore, and because the CHB model (Rabiau et al., 2006) mainly focuses on explaining the generation of CHBs, but not on the association of CHBs with intention formation and behavioural change, we conducted a study with adolescent smokers to investigate the CHBs within the framework of a theoretical model (Radtke, Scholz, Keller, & Hornung, in press).

Since results regarding the general CHB scale from Knäuper and colleagues (2004) indicate an unstable factor structure across different countries (Kaklamanou & Armitage, in press; Radtke, Scholz, Keller, Perren, & Hornung, 2011), we first developed a new smoking-specific CHB scale to overcome problems of the factor structure and to improve the matching on levels of specificity (Radtke, Scholz, Keller, Knäuper, & Hornung, 2011). This newly developed scale could be identified as relevant with regard to the readiness to change smoking patterns in adolescents (Radtke et al., 2011). Subsequently, we examined the added value of CHBs over and above factors of a health behaviour change model: the Health Action Process Approach (HAPA; Schwarzer, 2008). The sample consisted

of 224 adolescent smokers who filled in an online-questionnaire. All HAPA-specific variables like self-efficacy, outcome expectancies, risk awareness, intention to stop smoking, planning and smoking behaviour as well as the smoking-specific CHBs were assessed. In line with previous research mentioned above, we found that smoking-specific CHBs were significantly negatively associated with the intention to stop smoking over and above HAPA-specific predictors. However, no direct association between smoking-specific CHBs and smoking behaviour was found. Overall, CHBs provide a very promising construct to explain why individuals often fail to generate and/or to follow their intentions. Yet, as always in the case of a rather new construct, quite a number of unanswered questions remain.

Future research challenges

Overall, more studies are needed to investigate the impact of CHBs on intention or behaviour. First of all, we need more research on everyday and on longer-term effects of CHBs for health behaviour change. Focusing on the everyday perspective, the question would be in which situations and how often CHBs are used during a day and how this relates to (antecedents of) behaviour. Moreover, it should be explored whether CHBs are activated before (as a result of anticipated guilt) or after the performance of unhealthy behaviour. Another key question that deserves future attention is the investigation whether there is a difference between beliefs of compensatory health behaviour and the execution of them, because CHBs are first and foremost a cognitive strategy ('belief') and need to be differentiated from compensatory behaviour. First results of Kaklamanou, Armitage, and Jones (2012) yielded evidence for the assumption that individuals distinguish between the belief and the behaviour. This means that individuals on the one hand behave in a way that is consistent

with the CHBs, but on the other hand do not really believe in the compensational effect. Moreover, research focusing on CHBs in interventions is strongly needed. How can CHBs be overcome or how can their impact be effectively reduced?

Conclusion

As the research summarized above demonstrated, CHBs are a potential barrier of behaviour change in different health domains (e.g., dieting or smoking), because the justification of eating a delicious cake by compensating for it later undermines people's intentions and goal achievement to behave healthily. Therefore, CHBs offer the potential to enhance the effectiveness of behaviour change interventions in the future. ■

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original article

Fun in the workplace: a matter for Health Psychologists?

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Anecdotally, we all seem to agree that some fun at our workplace is desirable and even necessary for letting go of the problems and worries of everyday working life. During the last decades, there has been a considerable interest about the promotion of fun in the workplace. Popular business thinkers have published guides and lists of activities that contribute to promoting a fun workplace. However, such guides lack an evidence-based background and the conclusions that they reach stem from their everyday practice. The study of positivity in Psychology and its importance in the management of our health is increasing exponentially (Luthans, 2002; Seligman & Csikszentmihalyi, 2000). However, fun, as an explicit concept is understudied, especially in the context of workplace where the demands are high.

The concept

Conceptualizing and measuring fun in the workplace is complex. Fun in general is perceived as a positive subjective experience (Baldry & Hallier 2010); consequently it is difficult to categorize what is and is not fun from an external point of view. Workplace fun specifically is defined as a work environment that intentionally encourages, initiates, and supports a variety of enjoyable and pleasurable activities, such as participating in parties, giving awards, playing competitions, and gathering to have fun activities (Ford, McLaughlin, & Newstrom, 2003). Lamm and Meeks (2009) defined workplace fun as playful, social, interpersonal, recreational, or

task activities intended to provide amusement, enjoyment, or pleasure. Several lists of activities that contribute to fun are found in the literature (Chan, 2010; Ford, McLaughlin, & Newstrom, 2003; Karl, Peluchette, Hall-Indiana, & Harland, 2005). Most expressions of these activities have to do with personal events, professional milestones, social events, humor, games and competitions, or community involvement. But, the most highly appreciated are food related activities and outings (Karl, Peluchette & Hall, 2008).

However, the formal initiation that is implied in the above definitions of fun needs to be contrasted with organic fun (Strömberg & Karlsson, 2009), a concept that describes fun that is created spontaneously by individuals in the workplace. Strömberg and Karlsson (2009) in an observational study described how workers used humor in the form of joke telling, physical joking practices (e.g., nudges, pokes, tickles, jostles, grapples, dances, tactics of scaring people) clowning, nicknaming and satire to create by themselves a fun workplace. This is what they called organic fun, to differentiate it from organized fun, the type of fun that is formally initiated and pre-organized. Also, Fleming and Sturdy (2009) conceptualized fun as an expression of the authentic self and associated it with diversity. Plester (2009), after examining interpretations of fun in organizations, proposed that genuine (organic) workplace fun is spontaneous, contextual and has an unmanaged, liberated element that defies control. Fineman (2006) also notes that fun typically gains its “funness” from its

spontaneity, surprise, and often subversion of the extant order.

Health

Fun is not a topic that is covered often in the Health Psychology literature. In terms of health, fun is most commonly associated with humor (Martin, 2001; Overholser, 1992). Humor has been seen as a coping mechanism and researchers have used variables like sense of humor and humor style in order to predict well-being or stress, or to help tolerate the pain (Åstedt-Kurki & Liukkonen, 1994; Bizi, Keinan, & Beit-Hallahmi, 1988; Hulse, 1994; Porterfield, 1987). But, humor is mostly perceived as a stable personality trait and the research about it focuses on the individual, while fun seems to be a state that is context related and stems from social factors. Specifically fun may include humor, laughter or playfulness, but these don't seem necessary in order to experience a situation as fun.

When thinking about the outcomes of fun in health and work related issues, it may become more explicit, if we fit the concept into a model. The job demands-resources model (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001) provides an interesting platform on which we can conceptualize fun. Individuals use job resources to buffer against the problems they face (Bakker, Demerouti, & Euwema, 2005; de Jonge, Le Blanc, Peeters, & Noordam, 2008). Fun could be one type of job resource that moderates the physiological and psychological costs. Specifically, we can conceptualize fun in the workplace as a job resource that stems from the social aspects of work (the daily experience of work for most people is socially constructed). The interactions and interpretations that will occur will label a situation as fun or not. The fun related stimuli (internal or external to the self) can be an array of activities, ranging from time and energy consuming, extreme actions to

simple, instant and relaxing. These actions may have physical, emotional and cognitive effects on the actor or on other people. For example, the use of fun can function as a factor that provides a sense of belonging, feelings of sharing something common between co-workers and even trust. It is important to consider the social-organizational resources in the workplace, for example a supportive climate, which has been consistently related to psychological well-being (Boudrias, et al., 2011) and is negatively associated with the risk of long-term sickness absence (Clausen, Nielsen, Carneiro, & Borg, 2012). Moreover, negative aspects of interpersonal relationships, especially with supervisors, are strongly related to job stress, negative job feelings, depression and physical health (Israel, House, Schurman, Heany, & Mero, 1989). Thus, fun most probably plays an important role in the way that employer-employee-colleague relationships are experienced. For example, fun may be a moderator between social support and well-being. Indeed, fun may be a coping mechanism or an outcome of coping (or both)?

Research has yet to demonstrate the effects of fun explicitly on health in general. In spite of this, research on fun in the specific context of the workplace has some encouraging evidence to offer. Karl and Peluchette (2006a) found that when employees experience workplace fun, they enjoy performing their job duties and are satisfied with their job. Adding to the above, Karl and Peluchette (2006b) found that people who experienced fun at work reported less emotional exhaustion and less emotional dissonance. In 2008, Karl, Peluchette, and Hall found that employees who experienced higher levels of fun in their workplace also had lower turnover intentions.

Fun as a relatively new idea cannot be easily conceptualized and its measurement is in its

infancy. In most studies to date, fun is measured using questionnaires and the most common way to perceive it is as an array of activities or as an experience. The problem is that the perception of fun as an experience is represented in these questionnaires in a non-comprehensive way and might not depict all the aspects of fun. As far as the lists of activities are concerned, given the conceptualization of fun as a subjective and contextual factor it is not easy to accept that the activities or behaviors in the lists represent all the possible manifestations of fun. There are also studies that measure the attitudes towards fun in the workplace. Studies that try to understand the concept of fun in the workplace using individual interviews, focus groups, documentation analyses and observations are also found in the literature, but although they provide thorough and deep understandings of the concept, they do not supply us with information about relational aspects of fun with other concepts.

Can fun be created?

There is a critical issue in the discussion about fun; can fun be created in order to balance the demands and resources in the workplace? Given the fact that what differentiates fun from other concepts, like joy or happiness, is the element of spontaneity and freedom, how can we intervene and promote a fun working environment? Fleming and Sturdy (2009) mentioned that in organizations where positive non-work experiences are imitated, the results are not always the expected and desired ones. In case studies, they found that although some employees internalized the philosophy of a culture of fun, some others perceived these programs as patronizing and degrading. They see through this a form of cynicism and note that it is a result of the blend of boundaries between work and non-work time.

The main question here is if workers need

specific fun oriented activities to actually have fun at work. Are celebrations of birthdays, extra time off, wellness programs, informal gatherings, happy hours, annual dinners, organization of provided food, and casual dress days what employees need in order to perceive their workplace as fun? As noted above, lists of activities that contribute to fun in the workplace, recommendations, expert opinions and guides thrive in popular press articles. So far, many well known companies have used fun as a label for their work places and a formal strategy, incorporating "play & fun" culture programs in their human resources or even marketing/recruitment strategies. The benefits of these strategies in health are yet to be studied. Although most of them were initiated as a method of identification with the organization and not as a way to manage stress and promote well-being, the positive outcomes for health cannot be neglected, even from the scope that people desire fun in their workplace and they should have it.

In the issues of stress management and coping, simply infusing activities that people think are fun should not be enough. Organizations that suffer from stress and need this kind of actions should do it collectively and try to spread a culture of fun in their premises. The first step should be to make clear that fun (whatever its source) is an accepted behavior. Leaders and other change agents can play an important role in this plan, by trying to change their own behavior in the first place, and then influence people's attitudes and help them learn new behaviors.

Conclusions

Considering the above, fun in the workplace is not an issue to take lightheartedly. In the workplace context where demands are increasing and the need for coping strategies to reduce stress is great, fun could play the role of an

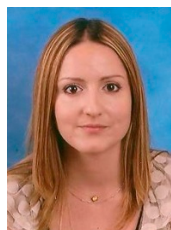
important coping mechanism that ameliorates the stressors or demands and contributes to well-being.

But one cannot simply incorporate fun activities during work time and expect to have a result. Also, having in mind that fun is a perceived and subjective factor and also that there are regional and contextual differences in humor use and generational differences in attitudes towards fun at work, how can we promote a fun working environment? Further research needs to be done in order to study the concept, so that we can understand the mechanism in the individual as well as in the organizational level, how it is stimulated, how it feels and what the benefits in the workplace are. We need more well-structured models to describe and test the processes and dynamics involved. Researchers should initially approach fun with a qualitative approach. I believe that this is very important in order to clarify conceptual issues and define fun in psychological terms. So, fun should be a matter for occupational health psychology. ■

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EC report

A template for a European masters programme in Health Psychology



Efrat Neter

National Delegates Officer

The need for a European-wide Masters programme in health psychology has been a recurring theme in discussions among National Delegates of the

EHPS in recent years. The need has been more pressing in countries with few or new Masters degree programs. The Executive Committee has acknowledged the need and last year (at the Crete conference) it was decided set up a committee whose role was to write such a programme. Members of the committee are Winnie Gebhardt (NL), Christel Salewski (Germany) and Mark Forshaw (UK). Members have been involved in either setting up, reviewing, or evaluating Masters programmes in Health Psychology. The facilitator is National Delegates Officer, Efrat Neter.

The committee started its work by assembling materials—the programme objectives and programme content from various universities. Following several exchanges, the committee decided about the **scope** and **general principles** of its mission.

Scope

The committee decided to divide the goal into two stages. The *first* stage encompassed writing up of programme objectives and structure, and was to be realized within the current year. The *second* stage will involve applying for an EU grant for curriculum revitalization that will attempt to build a detailed programme including

course syllabi and objectives. The EU funding scheme is called TEMPUS, and it promotes partnerships between higher education institutions in the EU and the Partner Countries surrounding the EU. The average grant is 700,000 euro. The *second* stage depends on interest of potential applicants.

General principles

(1) Use the ECTS (=Education Credit Transfer System, following the Bologna Process) as the credit system; (2) Work on a 1-year programme and a 2-year programme so that countries with different Masters structures could benefit from the template.

The facilitator suggested a template to which members responded and made remarks. Corrections were made and several iterations took place. The committee is still engaged in this ongoing process. Originally, the committee had hoped to have a face-to-face meeting this year, but this is now unlikely. The committee expects to finish up its work by July, to send the materials to National Delegates and discuss responses in the Prague conference in August. EHPS-members who are or have been involved in developing a Master Program in their country are also invited to share their experience with us at the Prague conference. ■

EHPS 2012

"Meet the Expert" 2012 at the 26th Annual Conference of the EHPS in Prague

Angela Rodrigues & Pamela Rackow

MTE organising team

We are excited to announce this year's "Meet the Expert" sessions at the Health Psychology Conference in Prague.

These pre-conference sessions provide a great opportunity to promote research facilitation and interaction. We are hoping to approach especially young researchers and early career scientists to grab this unique chance to discuss and get advice on their research ideas from experts in the field in a friendly and relaxed environment.

This year's group of experts are established research leaders with numerous scientific publications and an outstanding record as academic teachers in health psychology. The following four experts have kindly agreed to facilitate this event: Profs., **Carol D. Ryff** (USA), **Kavita Vedhara** (UK), **Charles Abraham** (UK), and **Johan K. L. Denollet** (Netherlands). Their specific areas of interest are the following:

Professor Carol D. Ryff (University Wisconsin-Madison, USA)

- psychological well-being and its multidimensional assessment
- mechanisms and pathways through which well-being may confer against illness and disease
- variation of psychological well-being by age, gender, socioeconomic status, ethnic/minority status, and cultural context as well as by the experiences, challenges, and transitions individuals confront as they age

Professor Kavita Vedhara (University of Nottingham, UK)

- experimental and applied research into the

- diverse ways psychological factors influence health and disease outcomes
- development of psychological interventions
- psychoneuroimmunology and chronic disease

Professor Charles Abraham (Peninsula College of Medicine & Dentistry, UK)

- development and evaluation of behaviour change interventions
- modelling motivational and volitional processes that regulate action
- health-related behaviours, for example preventive actions, patient help-seeking, or patient assessment

Professor Johan K. L. Denollet (Tilburg University, the Netherlands)

- psychological factors and the development and progression of cardiovascular diseases
- observational studies in medical settings, intervention research in cardiology, psychoneuroimmunological research
- validation of patient reported outcome measures

The above key scientists are willing to pass on their knowledge and experience and will try to:

- assist young researchers plan a research project.
- provide young scientists with information and resources relevant to the needs of their current research work. Participants may be provided with useful materials and tools, as well as advice concerning the overcoming of specific obstacles they may be facing.

- provide young researchers with ideas about collaborations and networking opportunities.
- provide guidance for publishing in scientific journals.

The consultation sessions will be 30-minutes long and either one-on-one or in small groups. They take place in the afternoon of the first conference day, **Tuesday, 21st August, 2012** at Diplomat Hotel (Conference venue) Prague, Czech Republic. Participants are asked to send in some information about themselves and their study and prepare some questions in advance. This would help the experts prepare for and make best use of the sessions.

Feedback from last years showed that these sessions substantially exceed participants' expectations. They found the sessions to be extremely useful, of high quality and ideal length.

Feedback from previous meet the expert sessions:

"Absolutely great talk with an amazing atmosphere ..."

"...extremely valuable opportunity for young researchers... hope it goes on with more and more experts continuing to donate their valuable time to such a worthwhile course ..."

"My expert was very generous and helped me plan my research"

"Although it was a group session, I had the time to answer all the questions I had, and it was nice to meet others with common interests."

Registration deadline: 29th June 2012

For the application form see:

www.ehps2012prague.com/meet-the-expert-2012.htm

For more information contact: Angela Rodrigues
a.rodrigues@newcastle.ac.uk

We invite applicants from a wide range of countries and research backgrounds. Priority will be given to EHPS members and student members. We will inform you of the outcome by 20th July.

*On behalf of the EHPS Executive Committee,
Angela Rodrigues and Pamela Rackow, MTE 2012
Organizing Team* ■

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