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EHPS 2013 Conference Evaluation

Delegate Feedback on the 2013 EHPS Conference, Bordeaux, France

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EC Conference Officer

The 2013 EHPS Conference took place in Bordeaux (16-20 July 2013) and was attended by 771 delegates. An online conference evaluation survey was sent to all delegates, of whom 225 (29%) completed the survey.

Of the delegates who completed the survey, the highest numbers were from the UK (n=38), The Netherlands (n=24) and Germany (n=21), which broadly reflects the profile of EHPS members and conference delegates. For 35% of respondents, this was their first conference, although a similar number of respondents had attended at least 3 EHPS conference in the past 5 years (44%).

Scientific Programme

As shown in Table 1, respondents' overall ratings of the scientific programme were broadly positive, with all aspects of the conference programmes receiving mean ratings above the scale mid-point. These ratings were reflected in delegates' comments on the conference.

> *"The programme was one of the best I have ever seen at a conference. I was reluctant to miss anything!"*

In terms of the balance of sessions in the scientific programme, the vast majority of respondents (>80%) were happy with the numbers of symposia, workshops, keynotes and oral presentations. However, 16% thought that there were too many oral presentations. This may have been due to the decision to include 9 parallel sessions on some days of the conference to accommodate a greater number of oral presentations. The large number of parallel sessions was commented on by some delegates.

> *"Too many interesting presentations at the same moment – difficult to choose!"*
> *"Similar topics should not be at the same time slot"*

In addition, 34% of respondents felt that there were too many poster presentations. Many delegates commented that they liked the interactive poster sessions, but that they could be improved. In particular, having fewer posters, ensuring that presenters and chairs attend, and moving the poster sessions to a different time of day would help to increase engagement.

> *"I like this [poster presentations] idea and I have seen it work well at the DHP BPS conference. However, it seemed slightly disorganised at EHPS (i.e., was at the wrong time of day to maximise audience and often chairs and presenters did not*

Table 1. *Scientific Programme – Overall Ratings (1=Poor to 5=Excellent)*

	M	SD
Overall quality	3.69	0.87
Keynotes	3.66	0.93
Symposia	3.96	0.87
Oral presentations	3.85	0.77
Roundtables/debates	3.75	0.85
Chairing	3.95	0.88
Conference workshops	4.08	0.95
Poster presentations	3.73	0.85

turn up to their sessions)."

"I would like the poster session to be at another time. After keynote many participants are too exhausted to actually participate in the poster presentation."

Delegates were asked whether they would prefer to have poster sessions with short presentations, without short presentations, or with a mixture of posters with and without presentations. Almost half of respondents (45%) indicated that they would prefer poster sessions with short presentations. A further 28% indicated that they would prefer a mixture of posters with and without presentations. Only 15% indicated that they would prefer not to have any presentations, with 12% undecided.

"I think that chaired poster sessions with short presentation facilitate discussion and exchange between the presenter and audience and add to their value as a conference contribution."

Respondents' ratings of specific aspects of the scientific programme were generally positive (Table 3), although respondents felt that the programme was slightly less successful as regards to including papers that were relevant to clinical practice and addressed issues relevant to a health psychologist's work.

The majority of respondents (54%) reported that they had accessed the online abstracts before the conference, although only 18% reporting accessing the online abstracts during the conference. Most of the comments on the abstract book were positive although a minority of delegates indicated that they would prefer to have a paper version at the conference. In addition, some delegates commented that they were unaware how to access the abstracts in advance and that the lack of internet access at the conference venue prevented them form accessing the online abstracts during the conference.

"I preferred having hard copy given at the conference but understand why not"

"Much better than a printed abstract book. Easy to access in advance of the conference."

"It was unclear how to access abstracts in advance. Helpful to have a reminder email before the conference about this."

"Because of internet availability (or lack thereof) it would've been nice to have a hardcopy of the abstracts."

Table 2. *Balance of Sessions in the Scientific Programme*

	Too Few	Fine	Too Many
Symposia	7%	90%	3%
Workshops	10%	90%	0%
Keynotes	10%	82%	8%
Oral presentations	3%	81%	16%
Poster presentations	2%	64%	34%
Poster presentations	2%	64%	34%

Other Aspects of the Conference

Respondents' ratings of various aspects of the conference were broadly positive (Table 4).

Table 3. *Aspects of the Scientific Programme (1=Poor to 5=Excellent)*

	M	SD
Good quality research	3.97	0.81
Range of theoretical approaches	3.99	0.80
Theory-based interventions	4.00	0.77
New/yet to be published research	4.00	0.81
Range of methods	3.98	0.79
Relevant to clinical practice	3.77	0.85
Relevant a health psychologist's work	3.82	0.84

Respondents gave high ratings for the overall time schedule of the conference as well opportunities to meet and talk with colleagues. Other aspects of the conference such as the venue and the social programme received lower, but still positive, ratings. These ratings were also reflected in delegates' comments. In particular, respondents were very critical of the suitability of the conference venue, particularly in relation to the lack of air-conditioning in the lecture rooms, which detracted from their engagement with, and enjoyment of, the conference.

"If the conference is going to take place in a hot country then I think it is very important to choose a venue that has air conditioning, otherwise it becomes very difficult for people to remain focussed and you notice that people are less inclined to attend all sessions."

"After the first keynote, in which I nearly fainted, I didn't attend any others. I also ended up picking talks to see partly based on how hot the room was likely to be. If future conferences are held in locations with similarly high average temperatures, the venue needs to have climate control."

"Venue - there was no air conditioning, which made it impossible to attend many of the talks (including the keynote sessions)."

This year the conference dinner took place on the Thursday evening (rather than the normal Friday slot). Delegates were asked for their preference. There was an even split between preferring Thursday (23%) and Friday (23%) with a further 34% indicating no preference. The conference dinner attracted many positive comments, but some delegates also commented on the lack of a vegetarian option.

"Fantastic conference dinner."

"The venue was brilliant."

"Conference dinner was good (unless you were a vegetarian)."

"Vegetarian meals were not provided for the dinner even for people who had registered as vegetarian."

Table 4. *Aspects of the Conference (1=Poor to 5=Excellent)*

	M	SD
Overall time schedule	3.85	0.92
Venue	3.07	1.26
Social programme	3.27	1.16
Opportunities to meet colleagues	4.17	0.84
Value for money	3.30	1.05

Planning for Future Conferences

Looking forward, there are four key issues that the EC will need to consider when planning future conferences.

1. When organising conferences for mid-summer, the suitability of the conference venue will need special attention, especially in relation to the provision of air-conditioning.
2. Future Scientific Committees will need to look at ways to limit the number of posters, to make the sessions more manageable. In addition, the timing of the poster sessions may need to be reconsidered to increase participation.
3. Accessibility to the online abstracts needs to be improved by (i) making the link to the online abstracts more explicit before the conference and (ii) ensuring that the conference venue has adequate wi-fi to delegates to access the online abstracts during the conference.
4. The provision of appropriate vegetarian food at the conference dinner (and throughout the conference) needs to be ensured.

Final Comment

Overall, respondents' ratings of, and comments on, the conference were less positive than for recent conferences. This was mainly due to the high temperatures in Bordeaux at the time of the conference and the lack of air conditioning in the conference venue. Nonetheless, many delegates commented that the quality of the scientific conference was very high and that the social events were enjoyable. We are indebted to the hard work of the Conference President, Bruno Quintard, and the Chair of the Scientific Committee, Holger Schmid, for ensuring the success of the conference.

> *"Well done to the organizing team, very enjoyable conference! However, air conditioning and working wi-fi were sorely needed."*

Thank you to all delegates who completed the conference evaluation survey – your comments and suggestions are very helpful and will help to shape the structure of future EHPS conferences.

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original article

Health Psychology in the UK and Ireland

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With an ageing population, limited resources for care, and people living longer with chronic illnesses, it seems that Health Psychology is perfectly placed to offer a solution to the difficulties that lie ahead. However, the field has often struggled to have its voice heard in health services and policy making.

The EHPS is currently working on devising a model that will recognise the equivalence of competencies across Europe in the hope of establishing a clearly defined and coherent field of Health Psychology (Marks, Skyes & McKinley, 2004). This article aims to provide a detailed snapshot of Health Psychology within the UK and Ireland. I interviewed individuals from the Republic of Ireland, Northern Ireland, Scotland, and Wales, and asked them what successes have been achieved and what challenges lie ahead in order to explore the current state of Health Psychology. Details about the contributors are provided in Table 1. This article will give a brief overview of the structure of Health Psychology in each area, followed by a discussion of the interview findings. Interviewees were asked to provide a SWOT analysis of Health Psychology in their region, focusing on strengths, weaknesses, opportunities and threats to the field.

Since 1994, the National University of Ireland in Galway has offered a MSc. in Health Psychology, accredited by the Psychological Society of Ireland (PSI). NUI, Galway also offers a structured PhD in Psychology and Health. There is a strong Division of Health Psychology (DHP), with active representation on the PSI council and other relevant committees. The DHP in the Republic in Ireland has a good collaborative relationship with their peers in Northern Ireland (NI). One example of this coordination can be seen in the annual Psychology, Health and Medicine Conference, running now for 10 years. The Republic of Ireland has 25 EHPS members and has hosted the annual EHPS conference twice to date (2005 at NUI Galway; 1998 in Dublin). Byrne (See Table 1.) believes that as the model currently stands, Ireland is ripe for the development of professional training in Health Psychology.

The UK offers a clear training route through the BPS accredited MSc. (Stage 1 – currently 29 courses in the UK) and two years Independent practice (Stage 2). The BPS works with the Health and Care Professions Council (HCPC) in terms of training standards of proficiency to ensure core competencies are met. There are currently 124 members of the EHPS in the UK. There is also an active DHP that helps to guide and promote the division and create benefits for membership. There are currently 162 members in this group. The annual meeting of the DHP is well-attended, with both national and international delegates attending and giving keynotes. The UK hosted three EHPS Conferences, in Oxford (1990), St. Andrews (2001) and Bath (2008). The BPS also offers the well-established Health Psychology Update to disseminate good practice and research.

The BPS Division of Health Psychology – Northern Ireland (DHP-NI) was established in 2008. The MSc. in Health Psychology at the University of Ulster is accredited with the BPS

Table 1. Contributors and Affiliations.

Name	Region discussed	Affiliations and qualifications
Dr. Molly Byrne	Republic of Ireland	Lecturer (above the bar) & Co-Director of the MSc in Health Psychology & Structured PhD in Psychology and Health at NUI, Galway Ireland. She is also Chair of PSI Division of Health Psychology Sub-Group on Professional Development for Health Psychologists and is the Irish National Delegate for the European Health Psychology Society.
Lisa Hynes	Republic of Ireland	PhD student Psychology and Health research cluster at NUI, Galway.
Dr. Angel Chater	UK	Health Psychologist and Sport & Exercise Psychologist at UCL School of Pharmacy. She is the UK National Delegate for EHPS, committee member of DHP.
Dr. Neil Coulson	UK	Associate Professor of Health Psychology within the School of Medicine at the University of Nottingham. He is both a Chartered Psychologist (British Psychological Society) and Registered Health Psychologist (Health and Care Professions Council).
Dr. Triece Turnbull	UK	Consultant Health Psychologist and MD of www.safecoolsex.com. She is also a Chartered Psychologist, a Chartered Scientist, a Fellow of The British Psychological Society, and a Fellow of the Royal Society of Public Health.
Dr. Noleen McCorry	Northern Ireland	Research Facilitator, Marie Curie Cancer Care, Marie Curie Hospice Belfast
Dr. Vivien Swanson	Scotland	Senior lecturer at the University of Stirling and a founder member of BPS Division of Health Psychology Scottish Committee
Dr. Paul Bennett	Wales	Professor at Swansea University.
Dr. Val Morrison	Wales	Chartered Psychologist at Bangor University School of Psychology.
Dr. Bev John	Wales	Reader & Head of Research in the School of Psychology at the University of Glamorgan
Dr. Caroline Limbert	Wales	Caroline Limbert is Senior Lecturer and Joint Programme Director MSc Health Psychology at Cardiff Metropolitan University

and is the only postgraduate course in Health Psychology in Northern Ireland. It is also the only distance learning MSc. in Health Psychology in the UK. Four of the programme team members are Registered Health Psychologists and several are actively involved in the development of

Health Psychology nationally and internationally. The University of Ulster also offers a two year taught Professional Doctorate in Health Psychology covering the BPS stage 2 competencies in Health Psychology leading to Chartership and Statutory Registration as a Health Psychologist. DHP-NI also has excellent links with their colleagues in the BPS DHP nationally and the Chair of DHP-NI is invited to sit on the national DHP Committee of BPS. Through these links the DHP-NI hosted the national BPS DHP annual conference in Belfast in 2010. DHP-NI is currently focusing on the development of Health Psychology in primary care and has planned to run a joint workshop with the Royal College of General Practitioners in the near future.

In Scotland, there are currently 2 MSc. courses offered at the Universities of Stirling and St Andrews which train over 30 people per annum to Stage 1 level. A unique NHS funded Stage 2 training programme has been running since 2007. Fifteen Health Psychologists have participated in the training to date with a further 6 about to start in the next few weeks. It is funded jointly by the Scottish Government (NHS Education for Scotland) and the local NHS Health Boards. Trainees work in the areas of health improvement, public health, and long-term conditions. They work full-time and are salaried for 2 years to complete their training at the same grade banding as clinical Psychology trainees. Trainees follow the BPS independent training route, and are supervised in the workplace, and by Stage 2 'academic' supervisors. The programme therefore links the NHS with university-based Health Psychology expertise, and has regular network meetings of all stakeholders. The professional body, the Division of Health Psychology in Scotland (established in 2002) includes academics, practitioner psychologists and postgraduates. The committee has representation from across Scotland, and hosts annual CPD and training events, as well as an annual scientific conference. The Postgraduate section of the Committee is very active in networking to offer social and professional support to postgraduates and Health Psychologists in training, and holds two professional events each year.

There are two thriving MSc. Health Psychology programmes in South Wales. PhD students have been funded by the Welsh Assembly Government social and health research streams across a number of institutions. From a low baseline in the mid-2010s, the number of recognised Health Psychologists in Wales has increased significantly. There are now 77 members of the DHP in Wales, and many are working across a range of positions and organisations. The Division of Health Psychology is now developing a Welsh Branch, and has just appointed a representative to sit on the national DHP committee

It seems that although Health Psychology research possesses the same aim across these areas, we are all on different trajectories. Similar obstacles are often described in relation to the development of the field of professional Health Psychology, and many common themes emerged during the consultations. These are addressed below.

Public Awareness of Health Psychology

There was a consensus that those seeking out a career in Psychology are unlikely to be attracted to a field that does not offer a clear career trajectory and focus. Courses that focus on Health Psychology may struggle to maintain numbers of applicants. There appears to be little awareness both from the public and other health professionals in relation to what Health

Psychology can offer.

Despite success in securing funding for training, there are still only a small number of NHS posts for Health Psychologists across Scotland. In the five years since the formation of the Division of Health Psychology- Northern Ireland (DHP-NI) the focus has been on raising the awareness of Health Psychology within Northern Ireland, with a longer term goal of developing funded training pathways for Health Psychologists and increasing the employment opportunities. Currently there are no Health Psychologists working under that title in the health and social care services in Northern Ireland. Byrne pointed out that, in Ireland, Health Professional registration does not currently list Health Psychology as a recognized professional discipline of Psychologists. The Irish Health Service Executive (HSE) does not currently recruit Health Psychologists for registered Psychologist posts. The Division of Health Psychology is working with others in the PSI to have Health Psychologists recognised as eligible for such posts.

Across the UK, there are few roles that are specifically advertised for a Health Psychologist. Many find themselves in roles without a clear definition that they are in Health Psychology (i.e. health promotion, smoking cessation, weight management). There is also a lack of a clear system in place for supervision of those in practice.

Funding Health Psychology in the UK and Ireland

Many areas are still in the process of recovering from a recession. Faced with the threat of austerity and economic stringency, it is unlikely that more posts will be created within the current economic climate or that training positions will be funded. These uncertainties will continue if funding bodies and employers do not see a direct benefit to the workforce. Furthermore, many of the funding streams in the NHS and elsewhere are short-term or temporary.

Scotland has led the way in the UK in terms of securing funding for trainees. Swanson highlighted the unique NHS funded Stage 2 training programme as a key strength of the system. This programme has made a significant contribution to raising the profile of Health Psychology across the NHS in Scotland, and the bidding for places – both from NHS Health Boards and trainees, is very competitive. There is a strong sense of enthusiasm for the profession of Health Psychology in DHP members in Scotland – from postgraduate level upwards. The current health priorities and targets focus on patient-centred care and promoting better self-management, which provides an ideal environment for the development of Health Psychology. In contrast, there is no provision of funded stage 2 training at any institution within Wales. Bennett, Morrison, John and Limber argue that there is a need to obtain more funding for training and development of Health Psychologists– particularly stage 2 funding: both for students and courses.

Developing Health Psychology as a career pathway

Throughout the consultations, the strengths of evidenced-based research in the field of Health Psychology were highlighted, with practice drawing on a scientist-practitioner model in the multidisciplinary model. There is a strong focus on the promotion of a theoretically driven understanding of health behaviour decision making, treatment approaches and behaviour change interventions (such as the

current work on the Behaviour Change Wheel and BCT Taxonomy v1). In diverse settings across the UK a strong selection of both academics and practitioners represent Health Psychology.

However, in general there appears to be a need to promote careers in Heath Psychology to students. It was suggested that Health Psychology will need to be promoted to the right people such as commissioning groups and Public Health England. This may be achieved by integrating Health Psychology training into other allied health professionals training programmes.

It is believed that many good students use the courses such as an MSc. in Health Psychology as a means of increasing their chances of entering a Clinical Psychology training programme. As for those interested in health, potentially good students are being drawn to other Masters level programmes. These courses allow them to qualify as practitioners on graduation without the necessity for further training. Swanson reiterates the concern that if career paths do not emerge in the near future it is likely that the expertise and enthusiasm which have been captured will not be sustained.

The group also highlighted the perceived 'competition' with Clinical Psychology for funding and positions as a challenge to Health Psychology. For example funding is provided for Doctorates in Clinical Psychology in the UK but there is currently no funding for Stage 1 or Stage 2 outside of Scotland. Perhaps unsurprisingly, given such challenges, there is also a shortage of training opportunities for those seeking to pursue Stage 2. There is a fear that there will be a reduction in the number of trainees if the options for graduates are limited.

One of the main problems highlighted in Scotland is a lack of a professional career path for Health Psychologists in the NHS. Senior Health Psychologists in NHS posts could provide role models and supervision models for trainees and employees in junior level posts. However, the current DHP training for Stage 2 Health Psychology does not always lead trainees to acquire the relevant competencies for working in an NHS context, which makes it difficult for them to apply for some NHS posts. The training is currently under revision, and it is hoped that revisions will focus on a broader approach to psychosocial interventions in the NHS context.

Health Psychology and Interdisciplinary Collaborations

There are opportunities to work with other professional groups. McCorry addressed good relationships with other psychologists, particularly Clinical Psychologists working in Northern Ireland. Health Psychologists in Wales have strong links with local health providers, including services for palliative medicine, cystic fibrosis, eating disorders, cardiac disorders, orthopaedic surgery and arthroplasty as well as regional groups including North Wales Brain Injury Service and Welsh Medicines Resource Centre.

Health Psychology graduates are now working for public health organisations in Wales, such as the Welsh Assembly Government (NIHSCR) and Action on Smoking & Health (ASH). Health Psychology in Wales has the potential to develop more meaningful links with health-related departments as graduates move towards more senior positions. Currently, there are some links with quality implementation scientists and trials units who can support high quality research. Health Psychologists have also developed strong associations with health economists whose expertise is needed to support bids for health service related funding.

Health Psychology at a local level

The field of Health Psychology does not exist within a vacuum and this was clear from the interviewees who referred to the contexts in which they were working. Although the BPS has a Division of Health Psychology that represents the interests of its members across the UK, the formation of DHP-NI was considered important, particularly because Northern Ireland has a devolved government, with its own Department for Health, Social Services and Public Safety. Northern Ireland has an integrated health and social care system, unlike other parts of the UK. Consequently, it is important that the promotion of Health Psychology in Northern Ireland takes account of legislation and services in Northern Ireland. McCorry highlighted that this is the challenge for DHP-NI, but it is also a strength–Northern Ireland is a small place and it is easier to access policy-makers than it is in other larger geographical areas. This may be compared to Health Psychology in Scotland where a similar model of devolved Government exists.

Scotland has many health challenges – and comes close to the top in league tables for health problems such as coronary heart disease, obesity, drug and alcohol problems, low breastfeeding rates and teenage pregnancy (http://www.audit-scotland.gov.uk/docs/health/2012/nr_121213_health_inequalities.pdf). Yet, the Scottish government has a forward thinking and enlightened approach to promoting public health, and supporting patient empowerment. The current health priorities and targets focus on patient-centred care and promoting better self-management. This provides an ideal environment for the development of Health Psychology approaches to health improvement.

A unique challenge lies in the geographic topography of Wales. This makes unity of purpose and cohesive activity difficult and tends to result in 'local' research collaborations in the north and south rather than across the Principality. There is no training programme for Health Psychologists in the north of Wales (Bangor University), The Welsh branch of the BPD Division of Health Psychology is still in its development and meetings are hindered by the wide geographical dispersion of members.

Health Psychologists and Health Policy

Health Psychologists are increasingly becoming more involved in government and health consultations. Health Psychology in Scotland has flourished in its aim to be heard at government and policy level. In 2009-10 the UK Division of Health Psychology and the Scottish Government jointly funded a secondment for two senior Health Psychologists (Dr Diane Dixon, University of Strathclyde and Professor Marie Johnston, University of Aberdeen) to work with the Government to develop guidance around health behaviour change. The aim of the posts is to promote the use of Health Psychology theory, application and practice in relation to the physical health improvement agenda. These posts have great potential to showcase the work of Health Psychology and to demonstrate how it can contribute to the health improvement agenda at a high level, and to the training of health professionals. A second secondment is planned for 2014. This will be a joint secondment including senior health and clinical psychologists, so it presents a unique opportunity for applied Psychologists to work together to achieve health-related targets.

In Wales, there are opportunities for the field to develop in line with the growth of The Mental Health Measure. The Mental Health (Wales)

Measure 2010 is a piece of law made by the National Assembly for Wales that aimed to ensure appropriate care is in place across Wales which focuses on people's mental health needs. The next phase refers to Health Psychology and chronic physical conditions. Across the UK and Ireland there is a need to engage systematically and effectively with the government to promote Health Psychology and issues of relevance to health psychologists.

Concluding thoughts

Health Psychology in the UK and Ireland has grown considerably in just a few decades. The central position of health has emerged in Government Policy in the UK and Ireland. This is a climate whereby a Health Psychology approach has the potential to make a significant contribution.

Employers challenged by the need to improve health need to have clear information about the skills and competencies of health psychologists. A good example of this can be seen in leaflets designed by the BPS that clarify the role of Health Psychologists for the public and for employees in the NHS. Health Psychologists need to engage in a structured system of continued professional development throughout their career, with adequate supervision available for both trainees and practitioners. Health Psychology has some way to go to establish itself as a strong and clear professional discipline. Perceived (or actual) competition with other groups (such as clinical psychologists and those in the field health promotion) is closely linked to problems relating to a lack of awareness among the general public about what the field has to offer. It may be a problem relating to definition and specificity. Faced with austerity measures, Health Psychologists will have to sell themselves and what they can do in order to attain funding. Consistency in terms of training and a clearly defined function would help aid the promotion of the field to government and funding agencies, as well as the general public.

In the UK and Ireland Health Psychologists are working hard to continue to develop the discipline in terms of training. The stage 2 curriculum in the UK is currently under consultation to include more skills in the areas of assessment, formulation, and communication in practical settings. In Ireland, a task force for the development of Health Psychology has been established within the DHP. This group aims to devise the criteria for accrediting a professional training qualification in Health Psychology. These guidelines will then form the basis for development of professional training in Health Psychology in Ireland. Members of this subgroup work alongside PhD students in the Psychology and Health research cluster from NUI, Galway who have formed an informal group named "Health Psychologist Trainees in Ireland".

All groups will need to liaise more with other countries. It is hoped that the EHPS will move towards a statement of equivalence between countries where competencies and training are recognized as equivalent. These developments will allow for a cohesive, well-defined model of Health Psychology to emerge that may serve to solve many of the difficulties identified by those working in the UK and Ireland, while building on the successes already achieved to date.

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original article

Exposure to adverse experiences in childhood

A research topic for health psychologists

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> "*No violence against children is justifiable; all violence against children is preventable*".
> (UN Global Study on Violence against Children, 2006)

Introduction

Violent manifestations are part of our everyday reality and have been present among people from the beginning of humanity. Despite these overwhelming facts, it is only in the last decades that the research community has directed their efforts in studying violence against children. Recent research findings indicate that violence can take several forms (physical, psychological, electronic), it can take place at different levels of human interaction and its effects can be long lasting throughout the lifespan (Pinheiro, 2006; Butchart, Phinney Harvey, Kahane, Mian, Furniss, 2006). The World Health Organization (WHO) defines child maltreatment as "*all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power*" (p. 16) (Krug, Dahlberg, Mercy, Zwi, Lozano, 2002). Children are considered to be one of the social categories who are the most vulnerable to abuse and maltreatment. They can be exposed to abuse at home, in schools, on the playground or in other public or private institutions. Also, the abuser can vary, from a parent or other family members, to people who live in the same community, teachers, people who work in different childcare institutions, or even peers. The 2006 United Nations report on violence against children stresses that "*no country is immune to this phenomenon, the violent manifestations cut across boundaries of geography, race, class, religion and culture*" (p.XI) (Pinheiro, 2006), thus emphasizing the wide spread nature and intensity of this phenomenon.

The prevention of child abuse and maltreatment is a priority worldwide (Krug et al., 2002; Pinheiro, 2006; Butchart et al., 2006; Sethi et al., 2013). The WHO Regional Office for Europe has recently released a new report which outlines the high burden of child maltreatment, its causes and consequences, and the cost-effectiveness of prevention programs. In order to estimate the prevalence of child maltreatment in Europe, a combined analysis of all the community surveys available for the prevalence of child abuse and maltreatment have been aggregated. According to this data, the prevalence of child physical abuse in Europe is 22.9% and child emotional abuse is 29.1%. The estimated prevalence of childhood sexual abuse in Europe is 9.6% (13.4% girls and 5.7% boys), and the prevalence of physical neglect is 16.3% and emotional neglect is 18.4%. Thus, at least 10% of European children experience some form of maltreatment. It is probable that the real prevalence of child abuse and maltreatment is higher due to problems associated with underreporting (Norman, Byambaa, De, Butchart,

Scott, Vos, 2012).

Immediate and long term consequences of maltreatment and neglect in childhood

The exposure to abuse and neglect throughout childhood and adolescence causes immediate and long term negative effects (Felitti VJ et al., 1998, Krug et al. 2002, Gilbert, 2009). Krug et al. (2002) emphasized that the amplitude of these negative effects could be influenced by the child's age when the abuse happened, the severity of the abuse, the type of the abuse, the child's relationship with the abuser, the time interval in which abuse occurred, and some other factors related with the social environment of the child.

The main source of information about the scale and impact of child maltreatment can be inferred from the official statistics on child deaths. Other important sources of data for child maltreatment represent the information offered by the child protection agencies, social institutions (hospitals, schools, police, primary care, social care services), and community surveys. The next section will focus on presenting the results from a wide scale retrospective survey which investigated the prevalence of adverse childhood experiences (ACE studies) and its relationship with mental and physical health. Previous studies based on ACE methodology showed that several abuse categories (physical abuse and neglect, psychological abuse and neglect, sexual abuse) co-occur with several household dysfunctions (domestic violence, substance abuse by a family member, mental illness, suicide attempts or criminal behavior of a family member). Moreover, using the same methodology, several studies indicated that there is a relationship between exposure to multiple ACEs categories and health risk behaviors (smoking, substance abuse, risk sexual health behaviors, suicide attempts), and also between ACEs and several health complaints or health problems (chronic liver or heart dysfunctions, headaches, depression etc.) (Felitti et al., 1998; Ramiro, Madrid, Brown, 2010). The conclusions of these studies emphasized the fact that as the child is exposed to a higher number of ACE categories, it increases also the risk for developing health problems such as: chronic obstructive pulmonary disease (COPD), ischemic heart disease (IHD), liver disease, and fetal death (Felitti et al., 1998). Also, the exposure to more than one ACE category has been connected with higher chances for engagement in health risk behaviors such as: alcoholism and alcohol abuse (Dube, Miller, Brown, Giles, Felitti, et al., 2006), illicit drug use (Dube, Felitti, Dong, Chapman, Giles, et al. 2003), risk for intimate partner violence, multiple sexual partners, sexually transmitted diseases (STDs) (Hillis, Anda, Felitti, Nordenberg, Marchbanks, 2000), smoking, early initiation of smoking (Anda, Croft, Felitti, Nordenberg, Giles, et al. 1999), unintended pregnancies, early initiation of sexual activity, and adolescent pregnancy. Another important aspect is the fact the children who have experienced adverse experiences during childhood have a higher risk for developing mental health conditions such as: depression (as young adults, but also in late adulthood) (Chapman, Whitfield, Felitti, Dube, Edwards, et al., 2004) and/or to have suicide attempts/suicidal ideation (Dube, Anda, Felitti, Chapman, Williamson, et al. 2001). Nevertheless, the exposure to adverse childhood experiences was also associated with low health-related quality of life (Edwards, Holden, Felitti, & Anda, 2003; Dong et al., 2004).

The conclusions from a recent meta-analysis come in line with the previous presented ACE studies results and suggests the existence of a

casual relationship between non-sexual child maltreatment (physical abuse and emotional abuse, physical and emotional neglect) and mental health disorders (depression, anxiety), drug use, suicide attempts, sexually transmitted infections and risky sexual behaviors (Norman et al., 2012).

One possible mechanism that could explain the relationship between child maltreatment and later health problems has been revealed by recent neuroscience research emphasizing the effect of child abuse and maltreatment on brain development. Repeated exposure to stress alters the function of hypothalamus-pituitary-adrenergic system. Even if short term exposure to stress facilitates the development of new functional coping strategies, prolonged exposure to stress over-activates the body's response to stress. This over-activation alters the normal brain metabolic functioning, and its coping with normal daily stress. For example, children who have been abused tend to have higher cortisol levels (Twardosz & Lutzker, 2010).

It becomes critical to understand which factors predispose an individual to use abuse or neglect against children in order to develop better intervention strategies. The best theoretical framework for understanding these factors is offered by Bronfenbrenner's ecological model (Bronfenbrenner, 1974), as the interplay between the individual characteristics of the child, parents, caregivers or other adults, together with the relationships within the families and communities and the society is accountable for child maltreatment (Pinheiro, 2006; Butchart et al., 2006; Sethi et al., 2013). According to Sethi et al. (2013), the main individual risk factors towards child maltreatment are, at child level: child's age and gender (males have a higher risk for physical abuse, Akmatov, 2011, and girls are more likely to report sexual abuse, Laaksonen et al., 2011), child disability and externalizing problems. At the perpetrator level, individual risk factors are: past childhood maltreatment, mental health problems, substance abuse, low educational achievement, poor parenting skills, reduced social support, parental stress and unemployment, and being a young or a single parent. At the relationship level, the main risk factors indentified are: family conflict, domestic violence, poor parenting behaviors, parental approval of corporal punishment, large family size, low socioeconomic status, non-biological parent in the home. At community level, socioeconomic disadvantage, poor social capital/social disorder, availability of alcohol and presence of drugs are considered to be the main risk factors. Cultural norms that are supportive towards violence, weak legislation for preventing child abuse, economic stress and societal conflict are considered to be the main risk factors at the societal level. On the other hand, factors such as: parental nurturing and attachment, knowledge of parenting and child development, parental resilience, strong social network for parents, social and emotional competence of children are considered to be the main protective factors against child abuse and maltreatment.

Main findings from ACE study in a Romanian university sample

In the last decade, violence against children has become an important topic for Romanian authorities, NGOs and civil society. There has been close collaborative work between the Ministry of Health and the WHO Regional Office for Europe on highlighting the problem of violence against children at the country level. This collaborative work culminated with the collaboration between the WHO Regional Office for Europe (coordinated by Dr. Dinesh Sethi), the

WHO Romanian Office (coordinated by Dr. Victor Olsavszky) and Babes Bolyai University (coordinated by Prof. Adriana Baban) which aimed to investigate the prevalence of adverse childhood experiences and health problems among Romanian university students and their association with engagement in health risk behaviors and health problems in adulthood (Baban, Cosma, Balazsi, Dinesh, Olsavszky, 2013). The study was based on the methodology developed by CDC-WHO. The sample consisted of 2088 young adults (1343 females and 745 males) from 17 public universities in Romania. A stratified sampling strategy was employed according to two variables: the development region (there are eight development regions in Romania) and the type of the city (according to the number of inhabitants). The number of participants in each stratum (24 stratums) was estimated by taking into account the number of recorded students from higher education institutions from a specific city in a specific region. The final sample (N=2008) was a representative sample for Romanian young adults' student population with an error of +/- 2.5 %.

The study findings show that exposure to violence and maltreatment during childhood has a high prevalence among Romanian university students. Specifically, 26.9% of participants reported that they have experienced physical abuse; emotional abuse was reported by 23.6% of participants, sexual abuse was reported by 12.7% by participants, physical neglect was reported by 16.5% of participants, and 26.3% reported emotional neglect. Female participants reported significantly more often being exposed to sexual and emotional abuse. Exposure to household dysfunctions was also common: 21.9% lived with an alcoholic parent, 17.4% witnessed violent treatment of their mother, 15.6% had experienced parental separation, and 12.9% reported that a household member had a mental illness. An ACE score was computed by summing all the categories of abuse and household dysfunction that each participant was exposed too in the first 18 years of life. Overall, 18% of students reported that were exposed to four or more types of ACE. Exposure to adverse experiences during childhood were positively associated with engagement in health-risk behaviors in late adolescence and young adulthood, such as smoking, alcohol abuse, illicit drug usage, attempting suicide, running away from home, or multiple sexual partners. Moreover, the exposure to a higher number of ACEs increased the probability of having somatic complaints and mental health problems in adulthood (e.g. feeling depressed and suicide attempts).

Conclusions

Child maltreatment remains a widespread phenomenon and its devastating consequences impact on the life and development of young people. It is important to be aware that these situations can be prevented. There is a lot of research literature which presents which measures are valid and effective in combating child maltreatment and violence. Also, while many countries have implemented structured measures for prevention and intervention at different levels (universal approaches, selective and indicated programs), data on their effectiveness is lacking. In this context, it becomes critical that each intervention or prevention program must focus on developing evidence on their effectiveness, focusing on what measures work with which group in which context (Sethi et al., 2013).

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spotlight

A spotlight on a National Delegate

Jasminka Despot Lucanin doing humanitarian work

Efrat Neter

EHPS National Delegate Officer

Dr. Jasminka Despot Lucanin is a National Delegate for Croatia. She completed her master's degree and PhD in Psychology at the University of Zagreb. Jasminka has advanced in her academic career at the University of Zagreb, where she is now a full professor at the Department of Psychology, Centre for Croatian Studies, serving currently as Head of the Department. Throughout her teaching career she has taught undergraduate and graduate courses in: Lifespan Developmental Psychology, Health Psychology, Psychology of Communication, Psychology of Aging, and Counselling Older Persons.

Jasminka's main research interest is the psychology of ageing - biological, psychological and social factors and correlates of health and survival in old age. She has published 30 scientific and 30 professional articles, co-authored and co-edited 4 textbooks and 11 book chapters, and has presented at 23 international and national conferences. She was the principal investigator of two research projects and a co-investigator in 3 other research projects. She is a member of the Editorial Board of the The Journal of Gerontopsychology and Geriatric Psychiatry, Hogrefe.

Jasminka was drawn into humanitarian work during the ex-Yugoslavia dissolution wars in 1991-95. Events were engulfing, even for someone not directly involved in hostile activities. There were massive movements of populations from war-afflicted areas to Zagreb and to other countries in Europe. Once shelter and medical assistance were provided, the need to address the stress and trauma that people experienced emerged as a significant issue. Jasminka was 35 years old at the time, with two young children, a spouse stationed outside of Zagreb, hosting her refugee mother-in-law, and working as a professor in a nursing school. She and other professionals were first approached to advise government agencies on the appropriate psycho-social assistance for refugees, but they quickly realized it would be more effective to work directly with the afflicted people. Jasminka was part of a team who set up an NGO named "Dobrobit" ("Well-Being") that operated as: a counselling centre for individuals, a training centre for professionals, a knowledge-generating hub and an advisory body to government agencies. Jasminka worked shifts counselling women, separated families, and older adults.

'Dobrobit' received foreign assistance in funding, training, and program development. For example, it published clinical guidelines adapted to Croatian circumstances, and structured workshops on grieving, on burn-out among professionals (soldiers, police personnel, nurses) and on returning home. Even returning home needed preparation for adults, as the home they were coming back to had changed, or they were not necessarily returning to their own previous home.

'Dobrobit' was a place of hectic professional activity, warm and supporting relationships among its staff, and a laboratory for translating scientific knowledge into services for people in need. Jasminka's knowledge and skills in the domains of health psychology - stress, coping,

communication skills, and ageing - helped forge up-to-date, flexible and responsive services.

Jasminka's relentless commitment to helping older adults continued after the war had ended – through 'Dobrobit' – in providing free services to the poor senior citizens in Zagreb, with the purpose of preserving or improving their independence in the activities of daily living, their dignity, control and self-fulfilment. The program relies on a network of student volunteers, supervised by psychologists and other health professionals; the students gain much-needed skills and experience, and at the same time they are exposed and trained on the needs and challenges facing older people.

Jasminka currently lives in Zagreb, with her husband (a psychologist), and her daughter (also – a psychology student). Her son (the only non-psychologist in the family) is a computer sciences PhD student who lives and works in Vienna.

Health psychology in Croatia is well represented in the higher education system, in research activities and to a somewhat lesser extent in practice. Courses in health psychology are taught to students of psychology at the graduate, postgraduate and doctoral levels, though there are still no separate postgraduate programs in health psychology. The pressing challenge for health psychology in Croatia is to create employment for young professionals. Although the role of health psychologists is well recognized, there are constant issues of differentiation from clinical psychologists, in terms of positions and acknowledgment as a separate field of expertise. Another challenge is plainly jobs, particularly for young colleagues just starting their careers.

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visiting scholar grant report

Examining the effects of multiple implementation intentions

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I am a final year PhD student from Utrecht University. In my research, I focus on using implementation intentions in interventions aiming to change unhealthy snacking habits. My PhD has been significantly influenced by the research of Professor Paschal Sheeran. Naturally, when I attended one of his presentations at the EHPS conference 2012 in Prague, I took the opportunity to introduce myself and to talk to him about his research. Fortunately, he showed a lot of interest in my research. In the few minutes that we discussed my studies, I became even more enthusiastic about my PhD project and I left with a lot of new research ideas.

Back in Utrecht, after discussing my experiences with my supervisors, we thought it might be valuable for me to spend some time at another university. Visiting another university would provide me with the opportunity to expand my knowledge and develop myself as a researcher even further. So, I sent Prof. Sheeran an email requesting to collaborate and spend some time at the University of Sheffield. He responded positively. Moreover, he proposed that Dr. Thomas Webb could co-host my visit as well. As the research I was working on built greatly on Dr. Webb's theoretical framework and research, I was very pleased to be given this opportunity. We agreed that I would visit the University of Sheffield for a two month period. Shortly after, I applied for an EHPS Visiting Scholar Grant and I was very happy when our application was accepted.

Our research

I visited the University of Sheffield between April and May 2013. The main purpose of the visit was to closely collaborate on studies and expand the line of research I am currently working on. To elaborate a little more on this: the project concerned the use of multiple implementation intentions to change undesired existing habitual behaviours, such as unhealthy snacking behaviour. Implementation intentions (specific 'if-then' plans) are found to effectively change unhealthy snacking habits by replacing the unwanted behaviour (like eating chocolate when feeling bored) with a healthier response (eating an apple, for example). In this way, a plan can be formulated linking the critical situation that was formerly inducing the unwanted response to a favourable alternative (e.g., 'If I am feeling bored, then I will eat an apple!'). So far, research has mostly been concerned with the effectiveness of a single plan. Yet, unhealthy behaviours such as snacking are often induced in various situations; not only does someone eat unhealthy snacks when feeling bored, for example, but perhaps also when watching television, or when being at a party. Indeed, many behaviour change interventions use multiple plan paradigms to target behaviour in different situations. For example, participants are asked to identify three situations that trigger their habit of eating unhealthy snacks and are asked to formulate three different if-then plans, targeting each of these situations. However, in my research I found that implementation intentions are less

effective when multiple plans are formed at once compared to making a single plan. Therefore, one of my research projects is aimed at gaining more insight into the processes underlying these findings.

In that previous study, we found that making multiple implementation intentions targeting the same behaviour (like unhealthy snacking) is less effective for successful goal pursuit than making a single plan, but that making additional yet unrelated implementation intentions (targeting academic achievement) did not affect the effectiveness of the one relevant plan. Our results suggested that the 'dilution effect' of multiple implementation intentions does not occur as a result of merely formulating multiple plans, but arises when acting upon those plans. We hypothesised that making multiple plans for the same goal (unhealthy snacking) might activate similar, competing mental pathways. Consequently, this could result in weaker associations between the critical cue and the alternative response compared to when multiple plans are formulated for unrelated goals (snacking and academic achievement). The study conducted in Sheffield was designed to examine this hypothesis and to address possible mechanisms underlying this effect. In addition, we aimed to identify the circumstances under which these dilution effects remain absent and to examine how the effectiveness of multiple plans could be enhanced.

Visiting the University of Sheffield

During my visit, Prof. Sheeran, Dr. Webb, and I engaged in weekly meetings. Prof. Sheeran and Dr. Webb were enthusiastic and motivating, and I enjoyed these meetings a lot. Yet, it was quite a challenge for me to keep up with them as both were talking and thinking incredibly fast. We set up a study which I conducted at the university during my stay. In addition, I had the possibility to join their research group meetings, in which research and/or methodological issues and solutions were discussed. I also got the chance to attend several presentations and to visit the PhD conference which was held at that time. Apart from collaborating with Prof. Sheeran and Dr. Webb, it was also a great experience to be part of another research group and to connect with PhD students and staff from another university. My visit to Sheffield involved quite some hard work but also a lot of fun, including the occasional trip to the beautiful Peak District and the typical English afternoon tea breaks with the other students and staff.

Spending time at another university and working together with Prof. Sheeran and Dr. Webb provided me with a unique opportunity and a great learning experience. It was an honour to collaborate with such influential scholars. Moreover, it was valuable to be able to visit a research group outside my own university and to gain international experience in conducting research at another university. This visit, which could not have been realized without the EHPS visiting scholar grant, provided the opportunity to develop myself as a researcher, contributed positively to my PhD research, and laid the foundations for future collaboration.

I would like to take this opportunity to thank Paschal and Tom again for being so welcome and such great supervisors during my stay. In addition, I would like to extend special thanks to my supervisors Dr. Marieke Adriaanse, Prof. Denise de Ridder, Dr. Emely de Vet, and Prof. Bob Fennis, for supporting and facilitating this visit.

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original article

What is the subject matter of health psychology?

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Introduction

The subject matter of health psychology is a serious issue. It can be problematic. Significant numbers of people who attend EHPS conferences or similar conferences do not label themselves as health psychologists (for a multitude of reasons). Health psychology is seeking to spread its sphere of influence, as is highlighted by a recent paper at the 2013 APA annual convention in Hawaii, where Alan Christensen argued that the subject matter of health psychology/ behavioural medicine should include gun violence. Diversity is healthy and health psychology should be a voice in the current debates concerning a myriad of health related subjects. However, there is a distinction to be drawn between the actual subject matter of health psychology and the processes that guide the journey towards the subject matter. The subtle yet important difference between the two is highlighted by Mark Burton (Joint winner of the BPS 2013 Award for Promoting Equality). Burton (2013) elucidates how one particular focus on equality can have the undesired effect of ensuring that other types are ignored. One of the examples that he cites is preventable deaths of learning disabled people (Heslop, Blair, Fleming et al, 2013).

They are no neat answers to the question of what is the subject matter of health psychology. I certainly don't have one. However, we have invited some of the 'wise owls' from health psychology to tackle it. In the following article, we have contributions from David French, Alison Wearden, Christina Lee, Kerry Chamberlain, Michael Murray, Mark Conner and Daryl O'Connor.

Academic institutions and accrediting organisations encourage academics to identify early with a narrow (sub) discipline – I'm a health psychologist, she's a political economist, we have nothing interesting to say to each other. Can I re-frame this question – how can health psychology connect with related fields of research, in ways that enhance our capacity to do both applied and theoretical work that reflects the world in which people live? It doesn't matter what the subject matter of health psychology is, what matters is that health psychologists adopt a question-first approach and use whatever methods and collaborations will address that question.

For example, it is fairly clear that one of the best ways to improve physical and emotional wellbeing (at least in developed countries) is to reduce the gap between rich and poor. How do psychologists contribute to that? What alliances do we need to build, whose behaviours and attitudes do we need to understand and affect, what cultural discourses do we need to understand and undermine?Questions such as these should define the field, not arbitrary

definitions of what's in and what's out.

To what degree does the content of our health psychology journals cover your answer to question one?

Academic authors assume that the content of academic journals is dictated by editors, but as an editor I am afraid that it is actually dictated by the work that people choose to submit. If you'd like to see our journals publishing work that takes a more human approach to the broad field of physical and emotional health, wellbeing, and human capacity in complex material and discursive contexts, you know what to do. Pay attention to the meaning of what you do, pay attention to effect sizes and real-world significance, pay attention to your own and others' biases and assumptions about the world and about research, place your research in context.

We know that a one-shot cross-sectional survey can't tell us anything about causation or prediction. We know that a statistically significant effect doesn't mean anything at all without an indication of effect size and human meaning.We know that reliability isn't the same as validity. We know that under-powered studies have a high rate of Type 1 errors, as well as Type 2 errors. We know that measures of cognitive variables aren't veridical indicators of some universal truth, but are what happens when research participants make up responses on the spot in reaction to researchers' questions.

More importantly, we know that if a theory purports to explain human behaviour, but doesn't situate the individual, both materially and discursively, in the world, then it will be partial at best. Research must pay explicit attention to broad social categories – gender, age, ethnicity, social class, sexuality, (dis)ability, and their intersectionality – and to the social, political and economic context – employment rates, finance systems, job security, social safety nets. This approach makes our theories less certain and our findings less universal, but it may enable us better to engage with the human condition.

Alison Wearden & David P. French

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The British Journal of Health Psychology (BJHP) explicitly specifies in its instructions to authors that it has the following scope:

> *"The aim of the British Journal of Health Psychology is to provide a forum for high quality research relating to health and illness. The scope of the journal includes all areas of health psychology across the life span, ranging from experimental and clinical research on aetiology and the management of acute and chronic illness, responses to ill-health, screening and medical procedures, to research on health behaviour and psychological aspects of prevention. Research carried out at the individual, group and community levels is welcome, and submissions concerning clinical applications and interventions are particularly encouraged. The types of paper invited are:*
>
> - *papers reporting original empirical investigations, using either quantitative or qualitative methods;*
> - *theoretical papers which may be analyses or commentaries on established theories in health psychology, or presentations of theoretical innovations;*

- *review papers, which should aim to provide systematic overviews, evaluations and interpretations of research in a given field of health psychology; and*
- *papers dealing with methodological issues of particular relevance to health psychology."*

This is consistent with many standard definitions of health psychology (see French, Vedhara, Kaptein and Weinman, 2010a). Implicitly, we would tend to define health psychology as material that falls within the curriculum for professional recognition, as defined by the British Psychological Society's Division of Health Psychology. There are many textbooks that are organized around this definition, e.g. French, Vedhara, Kaptein and Weinman (2010b).

To what degree does the content of the BJHP cover your answer to question one?

BJHP is open to papers which reflect all of health psychology. The editorial we wrote when at the beginning of our editorship stated (Wearden & French, 2013):

> *"We will welcome excellent contributions relating to all aspects of the theory and practice of health psychology, using a range of quantitative and qualitative methods, as long as those contributions make a substantial and worthwhile contribution to knowledge and understanding"*

We believe that the published content of the journal generally reflects this broad church approach. Our panel of Associate Editors has a range of expertise covering e.g. qualitative methods and psycho-neuro-immunology. It has members based in Germany, the Netherlands, Republic of Ireland, the USA, Australia and New Zealand, as well as the UK.

Our main concern is to publish high quality material that falls within health psychology, especially on topics that are"cutting edge" and which have the potential to move the field forward. As examples, we have recently published editorials on topics such as: whether self-efficacy can be considered a cause of health-related behaviour (French, 2013), advocating more use of N-of-1 studies to more appropriately test theory (Johnston & Johnston, 2013), and development of a unified theory for adjustment to chronic illness (Moss-Morris, 2013). Other editorials by experts in the field will be published in 2014, and we currently have a call out for a special section on mixed methods, edited by Lucy Yardley and Felicity Bishop.We are trying to move away from cross-sectional studies using questionnaires, unless they are exceptional in some way, as they are unlikely to move the field forward.

There are probably some aspects of health psychology which are underrepresented in our journal, most likely due to authors submitting papers to higher impact medical journals rather than to lower impact psychology journals. Papers reporting studies with biological outcomes (such as psychoneuroimmunology studies) tend to be few and far between. Similarly, randomized controlled trials in clinical settings (for example psychological treatments for particular patient groups) tend to be sent either to specialist journals relating to the patient group in question or to prestigious general medical journals. Interventions with healthy populations or at risk populations are more likely to appear in BJHP.

Some papers that get sent to BJHP are not sent out to review because we think they are not health psychology – often we think they would be more appropriate for a clinical psychology journal. Typically, these are papers which deal with mental health issues without any reference to physical health. For example, a paper on a mental health condition (e.g. post-

traumatic stress disorder or depression) in young people following family breakdown would normally be rejected. However a paper on PTSD after an illness or injury might be considered as within the remit of the journal, although it would be right at the boundary (or point of overlap) between clinical and health psychology. Other papers which might not get sent out for review are ones which deal with the design, management or provision of health care services but either with no reference to psychological principles, or they are not about the provision of health psychology services.

Michael Murray

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The subject matter psychology is often defined in terms of mental activity and social relations. For health psychology the field can be defined in terms of the role of psychological processes in understanding and enhancing individual and social health and wellbeing. Rather than being restricted by medical definitions, health psychology often starts with the WHO definition of health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Health is not a finished project but a work in progress both personally and socially. It is not something that resides within the individual but rather in our relationships with each other and with broader social structures which are pervaded by power differentials both material and psychological. As the philosopher Gadamer says: *"Health is not a condition that one introspectively feels. Rather, it is a condition of being involved, of being in the world, of being together with one's fellow human beings, of active and rewarding engagement in one's everyday tasks."* However, we need to go further and consider health and illness within their social, cultural, political and historical context. Health psychology is concerned with developing theories, methods and practices to further enhance our ability to both grasp the changing and varied nature of health and illness and to develop strategies for health improvement by and for individuals, communities and society.

Current journals

In the 1990s I edited the Canadian Health Psychologist/le Psychologue Canadien de la Santé (CHP/PCS). In the first issue I set out the aim of the CHP/PCS 'to promote the interests of health psychologists throughout Canada by providing a forum for ideas and information about research, teaching and practice'. It was a cross between a journal and a newsletter including research articles, shorter reports on particular topics, summaries of conference symposia, book reviews and some business items from the Canadian Health Psychology Section. I adopted an inclusive policy including articles on psychological aspects of such clinical health issues as irritable bowel syndrome, diabetes, and asthma as well as supplements on such themes as Psycho-oncology, Child Health Psychology, and HIV/AIDS. Most importantly, I was keen to provoke discussion with articles on qualitative research, health cognitions, and narrative health psychology as well as articles about complementary medicine, working in community settings and the prostate cancer 'epidemic'. Finally, I aimed to increase awareness of cultural and political issues with articles on health psychology in countries such as Australia, Cuba, Ethiopia, and Britain.

Although the CHP/PCS was a small venture it attracted substantial interest. A measure of its

success was that over the 10 issues almost 100 people contributed to its pages, membership of the Canadian Psychological Society Health Psychology Section increased by at least 25% at a time when CPA membership was declining, and I received requests from many health psychologists outside Canada for copies.

In comparison with contemporary journals the CHP/PCS aimed to promote dialogue and debate rather than being simply a place for publishing reports of research. Contemporary publications often seem somewhat complacent and divorced from broader debates about the nature of health and illness, the political challenges to healthcare and the continuing social inequalities in health. Instead they seem to be dominated by discussion about the adequacy of a limited range of so-called social cognition models to predict health practices. Paulo Freire, the literacy educator, used to criticise what he described as the banking model of education in which supposedly uncontested facts were deposited in the heads of the student. He contrasted that approach with a dynamic and critical process which actively engages with the student to provoke discussion about ideas and to increase critical awareness about the potential for change. In the same way there is a need for health psychology journals to deliberately move beyond ever more reports of predictors of health practices and to reach out to question our ways of researching health and illness, to consider the varied meanings of these phenomena and the social, cultural, political and historical context within which they are nested, and to be self-critical and open to new ways of research and practice. The aim should be to help us to better understand the everyday experiences of health and illness, how we can contribute to reducing pain and suffering, and how we can challenge health inequalities.

Mark Conner and Daryl O'Connor

Editors Psychology & Health

As Co-Editors-in-Chief of Psychology & Health we like to take a broad definition of what is health psychology and encourage submissions of articles across this broad field. Health psychology is an academic discipline focused on a series of research questions concerning health and wellbeing. Central to health psychology is the biopsychosocial model. This model proposes that health and illness are influenced by psychological factors and social factors as well as biological processes. It is also a profession comprising trained practitioners who have a set of core competencies enabling them to initiate change at individual and social levels (Abraham, Conner, Jones, & O'Connor, 2011). Health psychologists seek to identify and understand the determinants of "physical, mental and social well being", focusing on physical health, rather than mental illness. The broad definition of health psychology provided by Matarazzo (1980, p. 118) still seems relevant nearly 35 years after it was written:

"Health psychology is an aggregate of the educational, scientific and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, the identification of etiologic and diagnostic correlates of health, illness and related dysfunction and the improvement of the health care system and health policy formation."

This much-cited definition highlights: (1) the overarching aims of health psychology, that is, to promote health and prevent illness; (2) the scientific focus of research in health psychology, that is, understanding etiologic and diagnostic

correlates of health; and (3) key priorities of professional practice in health psychology, that is, improving health care by focusing on delivery systems and policy (Abraham, Conner, Jones, & O'Connor, 2008).

Health psychologists seek to understand the processes which link individual perceptions, beliefs and behaviours to biological processes which, in turn, result in physical health problems. For example, how a person perceives work demands and copes with them will determine his/her stress levels which, in turn, may affect the functioning of the cardiovascular and immune systems. Health psychologists also study social processes including the effect of wider social structure (such as socio economic status) and face-to-face interactions with others (e.g., work colleagues) because these social processes shape perceptions, beliefs and behaviour. In addition, health psychologists explore individual processes that shape health outcomes and health behaviours and social processes which influence the effectiveness of health care delivery. For example, the way health care professionals communicate with their patients influences patient behaviour, including patients' willingness to take medication and adopt health-enhancing behaviours. Since, most health and medical interventions depend both on the behaviour of health care professionals and, critically, on the behaviour of patients, behaviour change processes limit the potential of health service delivery.

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The subject matter of health psychology is, and should be, very broad. As health psychologists we should be interested in anything that connects psychology to health, although the boundaries of each can be difficult to determine. At the beginnings of the discipline health psychology, (ignoring its roots in psychosomatics and behavioral medicine) a definition of health psychology was proposed for the new field. This was presented to the new APA Division of Health Psychology at their annual meeting in 1979, and essentially defined health psychology as the contribution of all the educational, scientific and professional aspects of psychology to any and all areas of physical health. The initial definition included health promotion and maintenance, illness treatment and prevention, and the role of psychological factors in health and illness (Matarazzo, 1980). Later, the definition was extended to identify a role for health psychology in improving health care services and policies (Matarazzo, 1982). And that definition has remained in general use today, at least in textbook discussions and overviews. Kaptein and Weinman (2004) refer to the components in this definition as the four "core elements of health psychology" (p. 6) and Sarafino (2005) identifies them as the four "goals of health psychology" (p. 14). However, there are some interesting constraints on these disciplinary boundaries. For instance, the extent to which health psychologists attempt the additional tasks of policy development and improving health care seems quite limited

(hence the limitation to 'four' in the comments above). Another obvious boundary on subject matter is the separation between physical health (the province of health psychologists) and mental health (the province of clinical psychologists), although this separation became more difficult to delineate once health psychology began constructing forms of specialisation, such as clinical health psychology (Christensen & Nezu, 2013; Llewelyn & Kennedy, 2005). Marks (2002) argues that four different approaches to health psychology may be identified – clinical health psychology, public health psychology, community health psychology, and critical health psychology – each tending to operate in different settings, with different values, assumptions, objectives, and research practices. Hence it can be hard to specify the subject matter of health psychology in any detailed or specific way, with people who would define themselves as health psychologists doing quite different things. This should not be regarded as a limitation, but as a strength of the discipline.

To what degree does the content of our health psychology journals cover this?

Given the breadth and scope of health psychology, the answer to this question obviously depends on where you stand in relation to the field. As a critical health psychologist, my answer would be, "not that much". If we overview the content of health psychology journals, then we quickly see that this covers 'mainstream' health psychology research for the most part. Journal content is focused very strongly on providing research evidence, where 'evidence' is defined in specific ways, focused largely around the 'big four' objectives noted above. There is nothing inherently wrong with this, but it does limit both the content of, and the discussion about, the discipline in a range of ways. One noticeable limitation is the strong focus on 'scientific' and 'objective" evidence, which takes on very specific epistemological meanings, and the consequent rather limited presence of research using qualitative approaches. Qualitative content is increasing, but qualitative research is still the 'poor relation' in health psychology research, perhaps because we lack traditions of training for quality research in that arena, and researchers are often deficient at conducting and presenting high quality research from social constructionist positions. Qualitative research can reveal the complex and situated ways that people address, respond to, engage with health issues in their everyday lives – this is where health gets done. We need to see more of this, rigorously conducted, in our journal content. The scientific, evidence-based focus for health psychology journal content produces other important ramifications. It contributes to an ideology of practice, for both research and application, although this goes largely unexamined (Rose, 2013). Health psychologists largely presume the power of psychology, assume expertise and impose their ideas on people in need; they develop knowledge and interventions for people rather than with them (Chamberlain & Murray, 2009). Health psychology also function as a servant of biomedicine (Chamberlain, 2009), taking a biomedical rather than a critical position on many health issues; obesity provides a good example of this. The individualizing approach of psychology, adopted uncritically into health psychology, also leads the discipline to overlook or ignore important social processes affecting health, such as medicalization (Bell & Figert, 2012). Critical health psychologists are concerned with the fundamentally important question: who benefits from our activities? Critical health psychology seeks to challenge the assumptions of psychology (and its own) and to

identify how forms of knowledge and practice can empower or enfranchise people, or the reverse, disempower and disenfranchise. However, these concerns are invisible in our journal content, with the ideology of psychology taken for granted and assumed to be wholly beneficial (cf., Rose & Miller, 2013). The point of raising these issues here is not to argue for an immediate transformation of health psychology, but to note that debate on these matters is not contained within our journal content; the emphasis on evidence, and the preference for particular forms of evidence, tends to silence such debate by default. We need to recognise the value of such debates and we need more space for debate, about the nature, focus and directions of health psychology, within our journals.

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