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Editorial

The European Health Psychologist

To further the dialogue in Health Psychology: Multiple contexts and multiple matrices

Dear Readers,

This is a special issue of the European Health Psychology Society newsletter, published to mark several important dates and events for the Society. This year celebrations are in order, since we note the 20th volume of the EHPS journal, *Psychology and Health*, and we also launch the new review journal of EHPS, *The Health Psychology Review*. Events to mark these dates are planned during the 2005 Conference in Galway, Ireland.

To signal and reflect these developments, we are introducing the first issue of *The European Health Psychologist* and would like to draw your attention to its new and broader agenda. *The European Health Psychologist*, as the official newsletter and source of information for the European Health Psychology Society aims to move closer to its readers, reflecting the varied interests represented by the members of the EHPS. To fulfil these objectives the publication will include new contributions such as reflections on professional issues, dilemmas, research issues, current controversial topics in health psychology, and presentations of national events. We hope that the newsletter will continue to develop as a forum for interaction and dialogue between readers.

This first issue has some interesting features that will be maintained in the future. Key authors in Health Psychology have contributed to this number with position papers devoted to reflections on the challenges and important current issues in Health Psychology. The goal is to increase scientific excellence and to “set Psychology in motion”. A research letter has also been included. These new formats open the scope of the newsletter to a varied number of creative possibilities.

The European Health Psychologist will step on the traditions of the previous EHPS newsletters in offering timely and useful information about international developments in Health Psychology. The goal of *The European Health Psychologist* is to serve its readers, who are mainly psychologists working in the field of health, and therefore feedback, comments and contributions are greatly welcome.

A detailed mission statement of *The European Health Psychologist* can be found on www.ehps.net.

Irina Todorova, Vera Araújo-Soares & Falko Sniehotta



Susan Michie

President, EHPS

President's message

Who do we influence?

This first issue of *The European Health Psychologist*, developed from EHPS's newsletter, coincides with the launch of *Health Psychology Review*, EHPS's new review journal and the 20th anniversary of EHPS's internationally acclaimed *Psychology and Health*. These publications reflect the importance we attach to disseminating high quality research and fostering research activity and collaborations throughout the world. The publications report theoretical and methodological developments, synthesise evidence in particular areas and inform readers about opportunities for training, discussion and debate.

Health psychologists have a good record of conducting and disseminating good scientific research based on robust methods and informed by relevant theory. They also recognise the importance of translating the results of that research into policy and practice. This record is eloquently reflected in the position papers in this issue of *The European Health Psychologist*. Most health psychologists conduct their research in order to improve public and patient health, and we can involve ourselves even further with the process of working with those who can potentially use our evidence to change health policies and the delivery of health services. We need to find ways of making it easier for policy makers to access and engage with our work.

What are some of the issues?

- Scientists stress what they don't know; this is not helpful in influencing policy. We need to also stress what we do know!
- Scientists study problems; policy makers like solutions. We need to stress what we can do, and the problems we have solved, as well as outlining current challenges.
- Health psychologists draw on a plethora of theories and models, many with overlapping constructs with obscure names. We are in danger of confusing with unnecessary complexity and complications of both concepts and language.
- Effective science is cumulative; more could be done to build on existing work within and beyond health psychology, and to communicate fewer solid bodies of evidence rather than a multitude of approaches, study findings and theories. The more we "sing from the same hymn sheet", the more others may listen!
- We are not always clear about our "psychological currency"; economists have money - we have behaviour and well-being.

Michael Frese, the President of the International Association of Applied Psychologists, has made the point that other disciplines have more impact than us on policy e.g. economists, biomedical scientists, sociologists, theologians. Addressing a symposium of the European Congress of Psychology, he suggested four strategies to increase our influence:

1. Work to influence other influential disciplines such as economics (as Daniel Kahneman effectively did).
2. Have more psychologists in public office, although this requires political skills that are rare, and rarely taught to applied psychologists.
3. Engage in political activism e.g. via Non-Governmental Organisations (see Stout, *American Psychologist*, 2004).
4. Establish a Behaviour Expert Council (similar to the Economic Expert Council) to give advice, even when it is not asked for.

What are your views? How can we make progress in translating the evidence we produce from the pages of journals into health care, communities and society at all levels? *The European Health Psychologist* would welcome your contribution to this discussion. Please send your submissions to the Editor: ilgt1@comcast.net.

Susan Michie, President, EHPS

Position Papers

Health Psychology: Past, Present and Future

Howard Leventhal



Howard Leventhal

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Has health psychology come of age? In what direction is it moving? My response to these questions reflects 49 years of health research and the current focus of our NIA funded Center for the Study of Health Beliefs and Behavior. The center's goal is to develop interventions to improve quality of care for chronic illness. Framing our work around quality of care has raised the following questions:

- 1) Are we conducting applied research that translates existent behavioral theory and findings into the clinical setting?
- 2) Are intervention studies, or clinical trials, applied studies while descriptive modeling is basic, "causal" analysis?
- 3) Are we too focused on individual psychology when using concepts and findings from self management of chronic conditions in designing intervention trials?
- 4) Are psychologists equipped to assist patients in implementing behavioral changes for chronic illness management?

I believe that a qualified "No" is the answer to these questions.

A succinct overview of our prior research illustrates the source for these answers. Our health research began in two areas: 1) translation of utility theory, the Health Belief Model (HBM), to seeking inoculation during the 1957 influenza epidemic; and 2) communication studies that translated the learned fear model to the adoption of protective behaviors; e.g., tetanus inoculations, smoking cessation, etc. These were followed by studies on preparation for noxious medical examinations. Our approach in the fear and preparation studies was experimental; participants were randomly assigned to communications with specific and varied contents.

A look back clarifies what we learned and failed to learn from these studies. First, the HBM study showed that direct questions on illness perception, e.g., "How likely do you think it is that you will get the flu?" do not tap the perceptual beliefs that shape behavior. Instead these beliefs were exposed by questions that tapped the concrete cues that elicit risk perceptions. Second, we learned that fear and the cognitions involving perceptions of risk were processed as two parallel, largely independent, interacting systems. Third, we learned that protective action required both the perception of threat and an action plan to convert the perception to action. Action plans had participants specify when, where and how they would take the initial steps toward self protection. Once formed plans were executed automatically.

What didn't we learn? First, we knew nothing about the substance of the perception or representation of risk: our advantage was that we were aware of what we didn't know. Second, although we knew that many factors biased verbal reports of risk resulting in their lack of correlation with risk reducing behaviors, we did not fully appreciate the source for the dissociation. Our studies suggested that the pathway from the underlying cognitive/ affective mechanisms to verbal estimates of risk was different from the pathway to the perceptions of threat that stimulate action. Verbal responses did not predict action because the questions did not elicit the perceptual cues that activated the schemata underlying both perceived risk and risk reducing behaviors. Third, we did not appreciate the magnitude of the gap between our findings and clinical application. Only the findings on preparation were widely adopted in practice settings because their conceptualization and implementation were simple.

Howard Leventhal
Health Psychology, Past,
Present and Future

Howard Leventhal's Common Sense Self-Regulation Model has been amongst the most influential theoretical approaches in health psychology. He is member of the editorial board of the *Journal of Health Psychology* and he was associate editor of *Health Psychology* and co-editor of *Psychology & Health* and the *International Review of Health Psychology*. He gave a keynote address to the EHPS in 2001.

In the 1980s we began to address the most clearly recognized area of our ignorance by examining how patients interpreted symptoms and constructed the "Common-Sense Models" (CSM) that underlie both perceived risk and action for risk reduction. Information from practitioners, friends, family, and mass media feed into the interpretive processes that create the representations that are identified by their labels and symptoms, time-lines, perceived causes and consequences, and perceptions of control. Each facet of the representation is both concrete or perceptual and abstract or propositional. Moreover each level can influence the selection of procedures for threat control and provide targets for evaluating outcomes; e.g., hypertensive patients evaluated medication by observed symptom reduction although the symptoms were unrelated to blood pressure and stopped taking medication if it did not remove symptoms. Patients also develop representations of treatment; treatments have names, perceived causal routes of action, expectations regarding efficacy, time-frames for action, and consequences (side effects). Action plans, specific times and places for implementing treatment, link both the representations of illness and treatments to performance.

As the desire to create and disseminate procedures for enhancing quality of care was a primary objective for our center we asked whether we could create and test interventions to improve health outcomes by combining what we had learned about the self management process with what others have found in studies of self efficacy and cognitive behavioral therapy. Answering "Yes" would define our task as the translation of existent theory and method into the practice setting; a task of implementation. The medical members of our team argued against that approach, stating that many patients do not adhere to prescribed behaviors that are well within their competence. Although patients believe they are competent, they do not adhere as they fail to see a rationale for doing so. Second, the senior clinician of our team has used the CSM in her practice to address problems of treatment adherence, emotional distress and depression, and encouraging family members to assist chronically ill patients with their daily activities. She and clinicians like her listen to patients' complaints and observe their behaviors to fulfill two tasks: 1) to select tests for differential diagnosis of disease; and 2) to detect the clues useful for inferring the representations of disease and treatment that underlie patients self management. The clues they attend to are the heuristics or "rules of thumb" used for assigning meaning to aches and pains, rashes, tremors, falls, dizziness, memory lapses, moles, lumps, etc. When a patient presents with chest pain, the physician who is expert in the evaluation of common sense thinking knows that location has activated the patient's underlying schema and expectations of cardiovascular disease. The practitioner can anticipate other symptoms and fears of lack of control, and perceptions of cause, e.g., stress. The evaluation of the model is the first step toward intervention. The clinician has three tasks: diagnosis and prescribing treatment, identifying the underlying schema, and supportive listening. The three legs of clinical practice, followed by appropriate sharing of the diagnosis of the medical and common-sense model, provide the platform for behavioral interventions.

By assessing patients' common-sense representations the clinician brings psychological concepts from the laboratory to the clinical setting, and by identifying new rules of thumb for our dictionary of heuristics and showing us how to use this information when communicating with patients brings new concepts from the clinic to the laboratory. The act of inferring patients' representations, which are only partly conscious and not fully understood provides an opportunity for the study of social perception and theory of mind. Translation is now bi-directional.

The bi-directional paradigm revised our view of clinical trials. They are no longer applied tests of the efficacy of existent procedures but experimental tests of causal hypotheses. Experimental trials are the best way to understand how information processed in the dyadic setting can lead to agreement on illness, treatment, and

behavioral changes that improve medical outcomes. As patients may present varied physical complaints for the same disease at different points during the encounter, a flexible coding system is needed to validate the implementation of model components in response to these complaints. The clinician's response must mesh with the flow of the encounter rather than follow a rigid sequence defined by behavioral concepts imported from the laboratory.

The bi-directional paradigm concurs with the Bayesian statisticians who argue that clinicians, psychological and biological scientists must be full partners in the design and evaluation of trials. But what is the role of the psychologist in treatment? We suggested that the physician is at the heart of the intervention; she establishes the mutual understanding for self management, may expand the dyad to the triad of physician, patient, and family member. This mutual understanding is a platform for the acquisition of valid representations and skills for expert self and self and family management; for some patients it may be enough. Nurses and nutritionists will provide additional counseling when needed and psychologists will conduct cognitive behavioral therapy for the few patients who are severely depressed. These additions create a stepwise program that can improve disease management if patients understand the relationship among the components. For example, patients need to understand that the CBT for depression accompanying severe physical illness is an integral part of illness management as the two are linked, disease having a negative impact on function and mood and the latter two a negative impact on disease. In the absence of an integrated framework and an integrated treatment team, changing one side of the equation may have no effect on the other.

The bi-directional paradigm that we are developing for our quality care initiative differs from the view of many psychologists who suggest that translation is from the psychological laboratory to the clinic. They complain about lack of funding for social research (Markus, 2004) and the failure of NIH divisions to fund behavioral studies (Kraut, 2004). The results of the working group trial on diabetes prevention (2002) can support their belief in the need for behavioral research. It showed that changing life style was more effective than drugs in reducing the percentage of individuals who transitioned from pre diabetic to diabetic state in comparison to usual care controls (58% vs. 32%). Using evidence from the trial poses risk however, as the behavioral interventions it brought from laboratory to clinic were very complex, costly and not replicable in clinical settings. Physicians, fully aware of these findings and believing that less can be more, prefer to prescribe drugs. The resistance to funding and the prescribing of behavioral changes reflects a fundamental problem with current behavioral research and interventions; they are based on translation from the laboratory to the clinic, lack the conceptual content related to the dynamics of patient behavior, and are far too complicated and expensive to improve quality care. Effective translation requires a bi-directional model that introduces and integrates concepts from clinic and laboratory.

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Howard Leventhal
Health Psychology, Past,
Present and Future

Means and Meanings in Health Psychology

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Developments in European Health Psychology over the last 20 years can be characterised by changes in the theoretical frameworks and methods used. Two developments are noted. First, we are increasingly focussed on a smaller set of theories, which makes the discipline more cohesive and potentially more successful as a cumulative science. Second, our research is gaining a greater degree of emphasis on intervention rather than simply observation, with resulting changes to the research designs and methods we use.

Meanings: Theoretical frameworks

Change in the profile of theory can be characterised by increasing agreement over the key models involved. Twenty years ago, there was no pattern of theoretical focus nor even clarity about what kind of theories might be relevant. Now it is apparent, from both journal and conference papers, that the focus is on self-regulation models. While there are still a large number of these models in use (Abraham et al 1998), there are three dominant models, Leventhal's Common Sense Self-Regulation Model (CS-SRM), Bandura's Social Cognitive Theory (SCT) and Azjen's Theory of Planned Behaviour (TPB). These models have overtaken the Lazarus and Folkman model by focussing on specific parts of the process: the CS-SRM has clarified cognitions relevant to the illness situation, and how these appraisals interact with existing schema making the individual ready to act; the TPB has focussed on the behaviours appropriate to a particular situation, identifying the cognitions that develop the motivation and prepare the individual for these specific actions; and SCT has been most successful in identifying cognitions, especially self-efficacy, that make action more likely, independent of the specifics of the situation and the potential behaviour.

This theoretical focus is a sign of increasing maturity of the field. Successful academic disciplines typically show this narrowing range of theoretical perspectives, not necessarily because the theories are more accurate reflections of the 'truth'. Rather, the smaller range of perspectives makes it possible for the discipline to succeed. It facilitates the integration and comparison of findings, making a cumulative science possible. It allows people in other disciplines to recognise and have expectations of health psychology and health psychologists, an important issue given the close relationship of health psychology to other fields. At the simplest levels, it means that other disciplines, by recognising coherent theoretical frameworks, can see a need for the subject and encourage its development in an interdisciplinary context. In grant awarding situations, an applicant's proposal is less likely to be challenged theoretically if adopting a mainstream theory.

Nevertheless, we continue to have a large number of theoretical constructs, many of which overlap and duplicate each other. And improved methods of qualitative research are likely to generate even more constructs. While it is possible to reach agreement on reducing the constructs to a smaller number of construct domains (Michie et al., 2005), we need to develop methods of ascertaining when a construct is 'new' so that we can avoid meaningless proliferation.

The tendency to use one model while ignoring others increases the likelihood of duplication of constructs. Schwarzer (1992) has suggested that some models could be integrated into a single framework describing the process of self-regulation through motivational and action phases.

Alternatively, the relative merits of the models can be compared and redundant constructs eliminated by using competing models in parallel in the same investigation; for example, we have recently compared the above three models in explaining health professionals use of specific evidence-based practices in the management of specific clinical conditions (Walker et al., 2003).

Means: Methods of Investigation

The purpose and methods of investigation are increasingly to change behaviour rather than simply to understand. Health psychologists are attempting to change behaviour in all three domains identified in the definition of health psychology, 'the study of psychological and behavioural processes in health, illness and healthcare' (Johnston, 1994). There are many studies which aim to change health behaviours in healthy people, which try to change the behaviour of ill people with the aim of secondary or tertiary prevention, and which target the behaviour of healthcare professions with the aim of achieving delivery of care compatible with evidence of effectiveness. While other fields of psychology frequently investigate the effects of interventions on intrapsychic processes such as emotional states or cognitive changes, the dependent variable in health psychology is frequently behaviour per se. This emphasis on behaviour and behaviour change is appropriate in this, the American Psychological Association's 'Decade of behaviour', and it has affected the theory and methods we use.

Many behaviour change methods were developed in the context of clinical behavioural problems where it was likely that there was motivation for change. By contrast, methods arising in social psychology have focussed more on changing motivation, and investigated behaviours that are within the repertoire of the participants. Health psychology requires development of methods of enhancing both motivation in the unmotivated and action in the motivated. In order to achieve this, we will need to look to the evidence base for behaviour change, using evidence from other fields including clinical and educational psychology, as well as from basic, including animal, research.

The increasing emphasis on behaviour change is changing the research designs used, with more use of experimental rather than observational studies, and increasing use of longitudinal rather than cross-sectional designs. The randomised controlled trial not only gives evidence of effective interventions, it is also a means of testing theory. In order to advance effectively and securely, we may need to make increasing use of alternative experimental designs such as 'N of 1' trials (like those used effectively by Fordyce in the 1960s) or interrupted time-series designs, before progressing to full RCTs. The need to show some evidence of effectiveness before proceeding to RCTs of possible complex interventions has been recognised by the UK MRC (Campbell, 2000).

However, progress on behavioural interventions will depend on clear and specific descriptions of behaviour change techniques used. No definitive trial of effectiveness is justified until the components of the intervention can be specified clearly enough to be replicated. Otherwise, an intervention shown to be effective cannot be reproduced in practice and, perhaps more worryingly, it might be impossible to avoid using methods shown to be harmful. We urgently need a clear inventory or taxonomy of behaviour change techniques so that we can specify the hypothesised active components of an intervention. Beyond the simple inventory, it would be useful if techniques could be associated with particular theoretical constructs and/or particular types of behaviour, as well as likely modes of delivery.

Marie Johnston

*Means and Meanings in
Health Psychology*

Marie Johnston was president of the EHPS from 1992 to 1996. She is member of the editorial board of *Rehabilitation Psychology* and the *British Journal of Health Psychology* and she was co-editor of *Psychology & Health*. She gave keynote addresses to the EHPS in 1998 and 2005.

Marie Johnston

Means and Meanings in Health Psychology



Conclusions

Over the past 20 years, health psychology has achieved a consensus about the use of theoretical models but persists with overlapping and redundant theoretical constructs. Increasing emphasis on investigating methods of behaviour change are driving the field to use more experimental, longitudinal research designs but we need to improve our ability to specify replicable behaviour change interventions. The quality of our theoretical frameworks and methods of investigation will determine our success: in working with other disciplines, obtaining funding to conduct our research, answering our research and practice-based questions and in developing a cumulative science.

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Challenges and Prospects for a Socially Activist Health Psychology

Michael Murray



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In reflecting on the current state and future prospects for health psychology it is necessary to start with a broad canvas. The broad aim of health psychology is to promote the health of society and especially the health of the weak and the vulnerable. It means challenging the gross inequities in health and healthcare that exists in our societies. This challenge can take place at different levels although much of health psychology has focused at the individual and clinical level. In this short contribution I would like to argue that there is a need to expand our interest to the community and societal dimensions of health and illness.

Since its inception health psychology has had as its primary aim the development of theories and methods to contribute to a healthier society. Unfortunately this contribution has been limited by a very narrow definition of the social (Campbell & Murray, 2004). Health promotion has been defined and practiced in a proscriptive and controlling sense as being techniques to encourage more individuals to desist from unhealthy behavioural practices such as smoking, excessive eating and drinking and to encourage healthy practices such as healthy diet and exercise. The focus was on the individual whose behaviour was largely under the control of certain cognitive processes. Although this in turn might be influenced by various social norms its meaning within the broader social and cultural context has tended to be ignored. There is a need to expand our focus from cognitive processing to consider the social meaning of health and illness and the social, material and political world within which we live.

Health psychology has tended to regard communities and societies as collections of individuals with particular characteristics rather than as collectives with their own particular dynamics. I would argue that if health psychology is to achieve its full potential it will be necessary for it to develop an understanding of collective psychology as well as a greater awareness of social and political reality.

Humans are social beings - we are born, live and are enmeshed in a social world. We develop shared ways of thinking and interacting. We identify with certain social groups and not with others. Our health practices are part of our way of interacting with our social and material world. They cannot be extracted from that world. It is not a social world of equals but rather a social world driven by inequalities in power and wealth that ensure the maintenance of substantial inequalities in health. It is well-established that social groups and societies with the most power and wealth are also those with the best health. Evidence of this relationship between wealth and health is now well-established and is a major challenge to a health psychology designed to promote a healthier society.

There is also the massive gap in wealth and power between the developed and developing nations. The ongoing campaign to Make Poverty History reflects the growing awareness of this inequality. At the same time, as Nelson Mandela emphasized at the time of the G8 summit, developing countries do not want charity but social justice. Charity is an individual emotion expressed by one person to another who is in distress but it is premised upon a limited gap in wealth and power between them. It means little for a tyrant to proffer succour to a slave. In the same way, it means little for the capitalist developed world to offer aid to the developing world that it continues to plunder and to exploit. Or indeed in the developed world for the wealthy and powerful to give to charitable organizations when their proportion of wealth continues to increase and the numbers of people living below the poverty line continues to increase (Paxton & Dixon, 2004). Rather, in the developing world, as in the developed world, the campaign is about social justice - the reduction in these power inequalities and the creation of a healthier society for all.

Cutting across these different forms of intervention is the issue of social values. Health psychologists are part of an educated elite in society. As such we often identify with the interests of those with wealth and power despite having limited power ourselves - for example the impact of government control over our research activities constrains our opportunity to develop an independent research agenda. The challenge is for psychologists to reassess their connections in society. The Italian Marxist Antonio Gramsci discussed the important role of organic intellectuals - those with strong connections with their particular communities. Their task was to join "in active participation in practical life, as constructor, organizer, 'permanent persuader' and not just a simple orator'. In the same way, health psychology needs to carefully identify those communities it works with such that our contribution can have maximum impact on reducing these health inequalities.

But where does this locate health psychology. I would argue that it provides a starting point for developing a socially activist research and intervention strategy. Health psychology can research and intervene at different levels:

1. Science: Health psychology can reflect about the adequacy of our theories and methods. It can investigate the character and highlight the gross inequalities in health and the role of ideological, social, cultural and material factors in perpetuating those inequalities. This action can extend beyond the scientific domain to the community and political domain. Health psychologists can contribute to the broad debate about the social and political factors that contribute to ill-health. They can also challenge local beliefs when they accept established orthodoxy. Importantly, they can challenge those scientific models that individualize health complaints.

Michael Murray

*Challenges and Prospects
for a Socially Activist
Health Psychology*

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Michael Murray

*Challenges and Prospects
for a Socially Activist
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2. Community: Health psychology can participate in community organizing activities to strengthen the power of local communities. There has been ongoing debate about the meaning of communities and especially between those who define it in terms of geography or locality and those who prefer to define it in terms of interest. I would argue that it could be both. A community is not a community unless it has some awareness of itself and conversely this social and community awareness grows with social agency. Health psychologists can participate with community groups in organizing for a healthier society. This can range from assistance with self-help groups through to participation in community agitation for better living and working conditions.
3. Political: Health psychologists can contribute to those collective movements designed to reduce social and political inequalities and improve the health of those most deprived. They can investigate the factors that hinder and promote collective engagement.

In developing these interventions the work of health psychology can be strengthened by participatory and collaborative research. Through participation in the work and lives of communities health psychologists can begin to understand their problems and the opportunities for social change and the creation of healthier lives. At the same time through various forms of work with communities health psychologists can begin to recognize the importance of broader social struggles. Both overlap although sometimes there can be confusion. Community action is important for challenging community injustices but critical health psychologists recognize the limitations of this work. This is not to argue that such community health activities are worthless but that rather they must be placed within the wider socio-political and cultural context. In themselves they can provide substantial improvements in the health of deprived communities. But learning to live in deprived conditions is no substitute for transforming those conditions not only on a local but also national scale. As Black activists used to cry, it is necessary 'to keep our eyes on the prize'. Further discussion of these issues is developed elsewhere (Murray, 2004; Marks et al, 2005).

Health psychology has great potential for contributing to a healthier society but we must not be complacent or exclusive. We need to recognize the urgency of remedying health issues for those who are most afflicted and we need to connect with both those who are most affected as well as colleagues in other disciplines if we are to be effective.

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The Growing Centrality of Self-Regulation in Health Promotion and Disease Prevention

Albert Bandura

The recent years have witnessed a major change in the conception of health from a disease model to a health model. It emphasizes health promotion rather than mainly disease management. By managing their health habits, people can live longer, healthier, and retard the process of aging (Bandura, 2004; Fuchs, 1974). Self-management is good medicine. If the huge benefits of these few habits were put into a pill it would be declared a scientific milestone in the field of medicine. But health habits are neither commercially marketable nor offer an effortless quick fix, so health gatekeepers are disinclined to write behavioral prescriptions.

Current health practices focus heavily on the medical supply side. The escalating pressure on health systems is to reduce, ration, and delay health services to contain health costs. The days for the supply-side health system are limited, however. People are living longer. This creates more time for minor dysfunctions to develop into disabling chronic diseases requiring costly health services. In addition, the combined effect of growing public interest in health matters linked to expensive health care technologies, and the medicalization of problems of living with aggressive public marketing of drug remedies for them, is adding to the burdensome costs. Demand is overwhelming supply.

The social cognitive approach, which is rooted in an agentic model of health promotion, focuses on the demand side (Bandura, 1997, 2004). It promotes effective self-management of health habits that keep people healthy through their life course. Psychosocial factors influence whether the extended life is lived efficaciously or with debility, pain, and dependence (Fries & Crapo, 1981). Aging populations will force societies to redirect their efforts from supply-side practices to demand-side remedies. Otherwise, nations will be swamped with staggering health costs that consume valuable resources needed for national programs.

Health habits are not changed by an act of will. Self-management models, founded on social cognitive theory, develop the motivational and self-regulatory skills that enable individuals to adopt healthful lifestyles (Bandura, 1997; DeBusk, et al, 1994; Lorig & Holman, 2003). By adding personalized guidance through interactive media, the self-management system can provide individualized health-promotive services at low cost to large numbers of people simultaneously. Psychosocial programs should be evaluated not only by their effectiveness, but by their social utility. These self-management models are now being integrated into mainstream health care systems and disseminated internationally (Bandura, 2005).

People at risk for health problems typically ignore preventive or remedial health services. But they will use Internet-delivered guidance because it is readily accessible independent of time and place, highly convenient, and provides a feeling of anonymity. Randomized controlled studies attest to the promise of this mode of implementing self-management models (Munoz, et al., in press; Taylor, Winzelberg & Celio, 2001). Medical gatekeepers have a low sense of efficacy to get their clients to alter their health habits. So they often choose the easy option of substituting pills for behavior change. Health care systems need to institutionalize behavioral prescriptions to evidence-based self-management models. Societal efforts to get people to adopt healthful practices rely heavily on public health campaigns. These population-based approaches promote changes mainly in people with high efficacy for self-management and positive expectations that the changes will improve their health. However, there is only so much that large-scale health campaigns can do on their own, regardless of whether they are tailored or generic.



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Albert Bandura

The Growing Centrality of Self-Regulation in Health Promotion and Disease Prevention

Albert Bandura's Social Cognitive Theory has been amongst the most influential theoretical approaches in health psychology. Albert Bandura is member of the editorial boards of many journals relevant for health psychology, e.g., *Psychological Review*, *Psychological Inquiry* and *Applied Psychology: An International Review*.

The strength of population based approaches can be enhanced by linking viewers to effective Internet-based models that provide continued personalized guidance.

Vast populations worldwide have no access to services that promote health and early modification of habits that jeopardize health. For example, high smoking rates worldwide foreshadow a massive global cancer epidemic. We need to develop implementational models of global reach that are readily adaptable to diverse ethnic populations. Psychosocial health programs, implemented via interactive Internet-based systems, enable people worldwide to bring their influence to bear on their health wherever they may live, at a time of their own choosing, at little or no cost. Randomized controlled studies, in which participants are assigned to different versions of programs when they log in, are being conducted internationally to identify components that can further enhance the effectiveness of generic self-management models (Munoz, et al., in press).

The quality of health of a nation is a social matter, not just a personal one. It requires changing the practices of social systems that affect health rather than just changing the habits of individuals. The main focus of a social approach is on collective enablement for changing social, political, and environmental conditions that affect the quality of health of a nation. Socially-oriented approaches raise public awareness of practices that promote health and those that impair it, build community capacity to change health policies and practices, and mobilize the collective citizen action needed to override vested political and economic interests that benefit from existing unhealthy practices (Bandura, 1997). People's shared beliefs in their collective efficacy to accomplish social change play a key role in policy and public health approaches to health promotion and disease prevention.

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Research Letter

The HeartQoL study. An International Project to Develop a Core Heart Disease Health-Related Quality of Life Questionnaire

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for the HeartQoL Study Investigators.

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Introduction: Quality of life, or more precisely health-related quality of life (HRQL), is a concept cited increasingly often as an outcome measure in cardiovascular conditions. It has been measured in a myriad of ways with little consistency and thus an inability to build a cumulative comparative evidence base over time. Therefore, the European Society of Cardiology's Working Group in Cardiac Rehabilitation and Exercise Physiology (since 2004 changed to the newly created European Association for Cardiovascular Prevention and Rehabilitation) have developed a project called EuroCardioQoL to establish a single reliable and valid core coronary heart disease specific HRQL questionnaire, to be called the HeartQL, and to be eventually available in 13 European languages. This can allow comparison of outcomes with the same, or different, treatments among pure or mixed populations of patients with myocardial infarction, angina pectoris, and/or heart failure. The project is led by a multi-disciplinary team including an exercise physiologist (NO), a cardiologist (HS) and a health psychologist (HM). The EHPS is a named partner in this project through input of a number of its members on the Steering Group: David Hevey (Ireland), Derek Johnston (Scotland), Juhani Julkunen (Finland), Maria Kopp (Hungary) and Therese van Elderen (Netherlands).

Methods: The study protocol involves collecting data in a total of 15 European countries with 40 sites. The questionnaires to be used are each available in Dutch, English, Finnish, Flemish, French, German, Italian, Lithuanian, Norwegian, Portuguese, Russian, Spanish, and Swedish. Each of the 40 sites will continue to collect data until 35 patients with each diagnosis are accrued, resulting in a total of 4,200 patients across 13 languages. Patients with myocardial infarction (MI), angina, or heart failure are being recruited. They complete self-report questionnaires once with 25% of patients completing further information for test-retest purposes. The selected questionnaires are previously validated specific HRQL questionnaires and other patient-centered measures:

Heart Disease Specific HRQL questionnaires

The primary outcome of the study will be the development of a core heart disease HRQL instrument for use in research and hopefully also suitable for use in clinical practice. The core heart disease HRQL instrument [and modules if necessary] will be developed from the responses to reliable, valid and responsive specific HRQL instruments previously used as outcome measures in randomized controlled trials of intervention in patients with MI, angina, and heart failure. Instruments were chosen on the basis of these criteria and also that they were available in each of the proposed languages groups:

Research letters in The European Health Psychologist

Research letters reporting original research can be submitted to The European Health Psychologist. Letters should not exceed 1000 words of text and up to 6 references and may include a table or figure. Letters must not duplicate other material published or submitted for publication.



Neil Oldridge et al.
The HeartQoL study.

- The MacNew Heart Disease HRQL questionnaire (27 items in three domains: physical [8 items], emotional [11 items], and social function [8 items]).
- The Seattle Angina Questionnaire [SAQ] (19 items in three domains: physical and symptoms [12 items], treatment satisfaction [4 items], and disease perception [3 items]).
- The Minnesota Living With Heart Failure Questionnaire [LHF] (21 items in three domains: physical and symptoms [11 items], psychological [seven items], and socioeconomic [3 items]).
- Other patient-centered psychosocial questionnaires to be used for psychometric validation: Hospital Anxiety and Depression Scale; Global Mood Scale; Type D Scale; and Medical Outcome Study Health Survey [SF-36].

Further details on the protocol are available (Oldridge, Saner & McGee, et al., 2005).

Discussion: This study will use three existing reliable and valid heart disease specific HRQL questionnaires, each designed for use in one of the three primary CHD diagnoses, i.e., MI, angina, and heart failure, as the basis from which to develop a single heart disease core HRQL instrument that can be used in each of the three CHD diagnoses. Many patients will experience more than one of these conditions either in parallel or consecutively and many treatments cover more than one category of these patients. Thus a single measure can give a more meaningful evaluation of patient status and of treatment efficacy (McGee, Oldridge & Hellemans, 2005). Strengths of the study include the large number of patients and the range of languages involved. The potential of this project is evidenced by the interest among investigators from the 40 different sites in 15 different countries who have essentially volunteered their time and effort to conduct this study. The project is currently underway in all sites. It is hoped that data collection will be completed in 2006 with first reports on a core instrument expected in 2007. It is hoped this instrument will facilitate cross-national and cross-language studies in Europe and elsewhere.

Acknowledgements

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From the EHPS Journals

Psychology & Health: Current Trends

Paul Norman

Department of Psychology, University of Sheffield, UK

Interest in the study and application of psychological approaches to health and illness continues to grow. The last twenty years have witnessed the development of health psychology as a major area of scientific enquiry and this has been reflected in the increasing number of journals devoted to publishing research and theory on the role of psychological factors in health and illness. *Psychology & Health* has established itself as one of the leading journals in the area, with a reputation for publishing high quality theoretical and empirical work as well providing a forum for new/critical approaches to psychology and health. The year sees the publication of the 20th volume of *Psychology & Health*. Since its inception in 1987, the journal has grown in terms of the number of issues, pages, submissions and impact factor. Over this time, the journal has also seen three Editors (John Weinman, Ad Kaptain and Paul Norman) and a new Editor is due to be appointed from 2007. *Psychology & Health* is the official journal of the *European Health Psychology Society*.

Psychology & Health publishes work on the full range of issues pertaining to the role of psychological factors in health and illness, including psychological aspects of the aetiology, experience and treatment of physical illness, health attitudes and behaviour, the interface between individuals and health care systems, and psychologically-based interventions. However, its main areas of strength currently reside in two areas - illness perceptions and social cognition models of health behaviour - as evidenced by citation counts and the number of papers downloaded from the *Psychology & Health* website.

Considering work in the first area, the journal has been at the forefront of work on illness representations. In particular, Weinman et al.'s (1996) paper which reported the development of the Illness Perception Questionnaire (IPQ) is widely regarded as a "citation-classic" ($n = 163$) and has had a major impact on the field. The development of the IPQ provided the catalyst for numerous studies on illness representations and adaptation to illness, many of which have been published in the journal. This work has been expertly summarised in a recent meta-analysis of the common-sense model of illness representations conducted by Hagger and Orbell (2003) (which was the second most frequently downloaded *Psychology & Health* paper in 2004). A revised version of the IPQ has been published in the journal (Moss-Morris et al., 2002) - it is the most highly cited paper of recent years and was the fourth most frequently downloaded paper in 2004. In addition, ongoing work is being conducted on a brief version of the IPQ. Such developments in the measurement of illness representations are likely to stimulate further research in this area.

Considering work in the second area, the journal has a strong reputation for publishing both empirical research and theoretical papers on social cognition models and health behaviour. This work was consolidated by the publication of two special issues in 1998 on *Social Cognition Models in Health Psychology* (edited by Mark Conner & Paul Norman) and *Self-Regulation and Health* (edited by Charles Abraham & Marie Johnston) that have had a major influence on subsequent research in the field. The journal continues to publish work on the application of social cognition models, such as the theory of planned behaviour, to the prediction of health behaviour. However, recent attention has been directed to the use of these models to inform the development of theory-based interventions to change health behaviour. An influential paper in this respect

Paul Norman

Psychology & Health:

Current Trends



Past and current Editors of *Psychology & Health*

surrounding the use of social cognition models in intervention design have been discussed in more detail by Michie and Abraham (2004) (which was the most frequently downloaded paper in 2004). It is likely that this work will stimulate further tests of theory-based interventions to change health behaviour.

Two other areas of work published in the journal should be highlighted. First, the journal has a long tradition of publishing work on coping and illness. For example, a special issue of the journal on *Coping and Physical Health* (edited by Carolyn Aldwin and Crystal Park) was published in 2004, and a couple of the most frequently downloaded papers in 2004 focused on coping and adaptation to illness. Second, a growing number of papers have been published in the journal that have used qualitative methods to investigate psychological aspects of health and illness. Much of this work has been influenced by Smith's (1996) seminal paper on Interpretative Phenomenological Analysis (IPA), which has been highly cited ($n = 76$). The use of IPA in health psychology has been critically evaluated in a systematic review conducted by Brocki and Wearden (2006) which will appear in the journal next year.

It is likely that the journal will continue to publish work in its main areas of strength, although the journal welcomes submissions from all areas of health psychology (the primary criterion for publication in *Psychology & Health* being the quality of the work submitted, as assessed by peer review). Encouragingly, the journal's main areas of strength are well represented by European authors who have been at the forefront of many recent developments. Nonetheless, the journal is international in nature and, in particular, has attracted increasing interest over recent years from researchers based in North America. The current editorial team will seek to further strengthen the journal's position in the field, providing an outlet for work that reflects the strength and vitality of contemporary health psychology in Europe and beyond.

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is the systematic review conducted by Hardeman et al. (2002) on the use of the theory of planned behaviour in behaviour change interventions - one of the most frequently cited papers of recent years ($n = 35$) and the third most frequently downloaded paper in 2004. Various issues

Health Psychology Review

Teresa McIntyre

On behalf of the EHPS Publications Subcommittee

Joop Van der Pligt

Health Psychology Review Editor

The development of the Health Psychology Review was spearheaded by the EHPS Publications Subcommittee, which was created by the EHPS Executive Committee in early 2004 in order to examine the possibility of expanding publication initiatives under the auspices of EHPS. The idea of a review journal came from consulting with recognized publishers as well as from a reflection on the range of current publication outlets in Health Psychology in Europe and beyond. It became apparent that the field of Health Psychology has achieved a degree of considerable maturity that entails a need for more reflective and critical publications, which are able to examine state of the art thinking in a given domain or across domains, and thus contribute to further conceptual development.

Despite the field's development, there are a limited number of publication outlets for theoretical and conceptual pieces in the area of Health Psychology and there are no review journals in this field. Occasionally, good theoretical papers in our field are published in review journals in the more general field of Psychology, but too often good, theoretical papers do not get published, or are published as chapters in edited volumes that have a relatively limited readership.

Therefore, it seemed that the time is right to launch a journal that features theoretical, conceptual and review articles in Health Psychology. We are convinced that the field would benefit from a journal featuring such articles. A journal of this type is also likely to encourage new conceptual work. The latter is crucial to the advancement of the discipline of Health Psychology, and is also likely to strengthen the relationship between Health Psychology and related disciplines.

The Publications Subcommittee, the Health Psychology Review Editor and Associate Editors are working together to insure that the editorship of the journal and its supporting editorial board will be well balanced in terms of representing diverse theoretical orientations and topics, as well as providing a wide geographical representation of the European continent and other continents.

This year marks the 20th Anniversary of *Psychology and Health* the official journal of EHPS, a journal that features predominantly empirical research, and has successfully contributed to the advancement of scientific enquiry in Health Psychology both within Europe and internationally. EHPS has formed a partnership with Taylor and Francis to launch the *Health Psychology Review* in 2007. We hope that these two journals will join in contributing to fulfil the main purpose of the European Health Psychology Society: To promote the development of Health Psychology as a science and profession worldwide.

Aims and scope

Health Psychology Review (HPR) is a landmark publication - the first review journal in the important and growing discipline of health psychology. This new international forum, directed by a highly respected editorial team, will provide a leading environment for review, theory, and conceptual development. HPR will contribute to the advancement of the discipline of health psychology and will strengthen its relationship to the field of psychology as a whole, as well as to other related academic and professional arenas. It is essential reading for those engaged in the study, teaching, and practice of health psychology, behavioral medicine, and associated areas.



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Conference Reports

Reproductive Disruptions Conference

University of Michigan

The members of the Adoption, Infertility, and Gender Study Group of University of Michigan's Institute for Research on Women and Gender organized an international conference devoted to the theme of "Reproductive Disruptions: Childlessness, Adoption, and Other Reproductive Complexities." The conference took place from May 19-22, 2005. More than 225 scholars from 31 countries attended the conference, with travel funding provided to approximately 25 scholars from resource-poor societies around the globe.

This conference represented the third international effort to bring together social and behavioral scientists and humanities scholars from around the world who study childlessness, adoption, and other forms of reproductive disruption/complexity. The first conference was held at the University of Amsterdam, Netherlands, in November 1999, and the second in Goa, India, in September 2002. This third international conference at the University of Michigan, Ann Arbor, was devoted to a broad range of reproductive topics including (but not limited to): local practices detrimental to safe pregnancy and birth; conflicting reproductive goals between women and men; the contested meanings of abortion; intentional reproductive loss through sex-selective feticide and female infanticide; miscommunications between pregnant women and genetic counselors; cultural anxieties over infertility, adoption, donor parenthood, and childhood disability; the globalization of new reproductive technologies; and feminist critiques of the "new eugenics".

The breadth of this conference—with its explicit move from the local to the global, from the realm of everyday reproductive practice to international programs and policy-making—demonstrates that the notion of reproductive disruption is productive for examining the meanings of difference, the workings of power, and the tensions between women's (and men's) reproductive agency and various structural and cultural constraints. By expanding the arena of reproduction disruption to include topics like nurturing of biological and adopted children, medical communication, male-female reproductive negotiation, and the (mis)uses of reproductive technologies, the conference has moved the social science and humanities fields of human reproduction into new and important spaces.

Ten keynote speakers participated in three plenary sessions. The invited speakers included: Caroline Bledsoe (Northwestern; Africa, Pregnancy Loss/Child Death), Carole Browner (UCLA; Latin America/US, Prenatal Diagnosis/Abortion), Hal Grotevant (U Minnesota; US, Adoption), Linda Layne (Rensselaer Polytechnic; US, Pregnancy Loss), Margaret Lock (McGill; Japan, Menopause/HRT), Rayna Rapp (NYU; US, Prenatal Testing/Disability), Dorothy Roberts (Northwestern; US, Race/Reproductive Rights), Carolyn Sargent (SMU; Africa/Europe, Birth/Family Planning), Gamal Serour (Al Azhar; Middle East, Gender Selection) and Nada Stotland (Rush Medical; US, Abortion/Mental Health). Additionally, 24 sessions of papers (with 4-7 panelists each) took place at the conference, followed by "open for all" where major themes and future plans were discussed. Conference entertainment included a reproductive disruptions "film festival" and a museum tour and banquet in "Arab Detroit."

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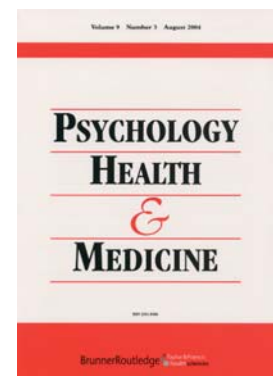
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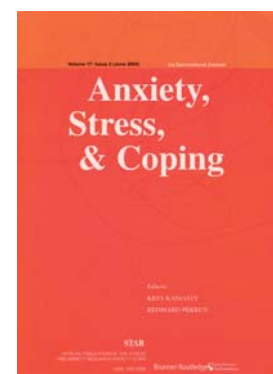
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