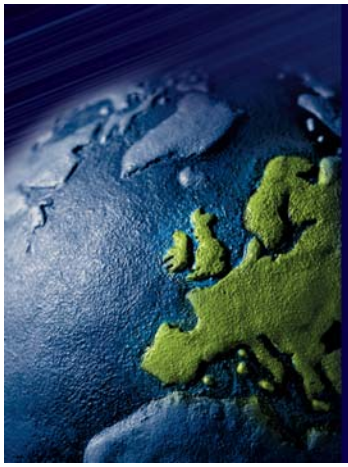

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The European Health Psychologist Editorial

Dear Readers,

This is a truly special issue of the *European Health Psychologist*. Not only does it mark the 1st anniversary of the EHP and appears, like all September issues, in print, it is also the last issue that will appear under the editorship of Irina Todorova, who will become President Elect of the European Health Psychology Society. Irina has been the Editor of the EHPS newsletter since 2002. During the four years in office she has established the newsletter as a key source of timely information on health psychology within and beyond the EHPS.

In 2004, the EHPS Executive Committee and the Editor involved us as co-editors with the aim to expand the potential of the newsletter, to develop a new format for the newsletter guided by the principle of involvement and a strong focus on science. As a result, the *European Health Psychologist* was launched to address the growing need for communication in a rapidly developing dynamic society. It retains the role of official source of information of the EHPS, but it adds scientific contributions using formats which are not available in other health psychology publications, including short and provocative position papers and concise research letters.

The development of the newsletter has been guided by a clear philosophy of a publication that involves its readers in the generation of content, provides a platform for communication about health psychology and represents the diversity of scientific approaches within the EHPS. This strategy was facilitated by the development of new formats such as 'Hot Topics', country and workgroup profiles, but also by involving individuals and attracting high quality contributions. Some of the leading health psychologists contributed to the previous and current issues and we have received vivid and enthusiastic feedback. We would like to thank all the contributors for their work, as well as the readers for their feedback.

We would like to thank Irina Todorova for the outstanding work as Editor and for giving us the chance to be involved. We wish her all the best for her future role as President of the EHPS.

We hope you will continue to submit interesting work as well as relevant information for publication in the EHP. All previous issues, as well as information for authors can be found on the web (**www.ehps.net**). Most important, the EHP is open to communicate any issues relevant for the scientific progress within the EHPS and welcomes ideas, input and involvement that helps to *further the dialogue in Health Psychology.*

Falko Sniehotta & Vera Araújo-Soares, EHP Co-Editors

Inside this Issue

Susan Michie

President, EHPS

President's Message

Dear EHPS Members,

In Warsaw, I end my term as President; for the next two years I will serve as Past President. When I became President, the Society had been put onto a firm financial and procedural basis. As President, I set myself the goal of increasing membership and member involvement. This is necessary, in order to increase the activities and effectiveness of the Society, both in terms of providing services for members but also in terms of having an impact on the wider scientific and social community.

During the last two years, we have developed a recruitment strategy and developed four sub-committees of the EC, involving many new members in important developmental work. These are Education and Training, Publications, Research collaboration and the *European Health Psychologist* collective. As a result, the Society has become much more active, as illustrated by an increased membership of 27% in 2005, the launch of Health Psychology Review and the European Health Psychologist, new Special Interest Groups (e.g. Occupational Health Psychology, Qualitative Methods) and the initiation of satellite Conference workshops. We have increased our presence at other international conferences and strengthened our interdisciplinary links e.g with the International Society of Behavioral Medicine with which we have had joint symposia at each other's conferences for the last three years.

As ever, there is much more to do. My view is that the next phase should include a "looking outwards" to disseminate the evidence we build and use our expertise to influence a wide variety of health and social policy. In the UK, the Department of Health pays the Division of Health Psychology for one day a week of Health Psychology time. As a result, we have a direct input into strategies such as the current anti-obesity strategy, and public health policies e.g. the development of a new type of health service worker, trained in behaviour change techniques. It would be wonderful if we could become similarly involved at a European, and a global level.

Five years ago, 189 member states of the United Nations agreed eight goals for the New Millenium. All are related to behaviour, and most are related to health behaviour. To mention just four of them:

- Combat AIDS/HIV, malaria and other diseases
- Eradicate extreme poverty and hunger
- Improve maternal health
- Reduce by 2/3 child mortality.

The International Association of Applied Psychology has achieved, within four years, non-governmental organisation status at the United Nations, and has begun to contribute to the work of the UN. They have accreditation on two UN committees, the Department of Public Information and the Economic and Social Council and four representatives in New York, Geneva and Vienna. The American Psychological Association also has representation. They are part of a newly formed Coordinating Council of 35 psychology representatives to strengthen the voice of psychology within the UN. It would be a great step forward for the EHPS to be part of that voice.

I have enjoyed these two years as President of EHPS immensely, and would encourage others to become involved in the Society. EHPS is your organisation, and it is vital for its success that members are involved in all the important decisions and activities of the Society. Your participation increases the quality of decisions and the quantity of activities. I extend warm thanks to my fellow EC members, past Presidents and countless others for wonderful support in the many and varied tasks of President,

Susan Michie, President, EHPS

Posttraumatic Growth Actions Work, Posttraumatic Growth Cognitions Fail: Results from the Intifada and Gaza Disengagement

Overview Paper

Brian J. Hall & Stevan E. Hobfoll

Studies have begun to address the psychological consequences following exposure to terrorist activities (Galea, Ahern, Resnick, Kilpatrick, Bucuvalas, & Gold, et al., 2002; Schlenger, Caddell, Ebert, Jordan, Rourke, Wilson, et al., 2002; Schuster, Stein, Jaycox, Collins, Marshall, Elliot, et al., 2001; Silver, Holman, McIntosh, Poulin, & Gil-Rivas, 2002) and during ongoing terrorism exposure and threat (Bleich, Gelkopf & Solomon, 2003; de Jong, Komproe, Van Ommeren, El Masri, Araya, & Khaled, 2001; Hobfoll, Johnson, & Canetti-Nisim, 2006). These studies have demonstrated the relationship between the trauma of terrorism exposure, posttraumatic stress disorder (PTSD), and symptoms of depression.

In addition to recognizing the negative impact of trauma, the recent work of Tedeschi and Calhoun (1995) promoted an interest in the potential for a positive reaction to trauma, a construct they termed posttraumatic growth. Much of the ensuing work focused solely on the positive legacy of trauma including closer relationships, positive changes in self-perception and experiencing greater meaning. However, in taking this approach, studies often neglected to examine the link between posttraumatic growth and symptoms of psychological distress. In studies addressing this connection, an inconsistent pattern of results emerged as few studies pointed to the salutogenic role of posttraumatic growth (Ai, Cascio, Santangelo, & Evans-Campbell, 2005; Frazier, Conlon & Glaser, 2001) whereas others implicated posttraumatic growth in greater symptom levels (Lehman, Davis, DeLongis, Wortman et al., 1993; Park, Cohen & Murch, 1996; Tomich & Helgeson, 2004).

With the rise of global terrorism and the need for understanding its multifarious effects, several studies arose that address the possibility of positive reactions following exposure to terrorism and community disasters (Ai, et al., 2005, Hobfoll, et al., 2006). Results from these investigations have paralleled the mixture of positive and negative findings that appear in the literature. This article will briefly outline recent findings from two studies conducted in Israel during tumultuous periods of heightened terrorist activity within an evolving research program aimed at examining the role of posttraumatic growth as a risk or protective factor in the development of posttraumatic symptomatology.

We conducted a longitudinal study of terrorism during the Al Aqsa Intifada, a four year period (2000 – 2004) of increasing violence and terrorism in Israel. A nationally representative sample of Israelis (N = 1,136) was obtained using random digit dialing. Structured interviews were used to ascertain the level of posttraumatic symptomatology, terrorism exposure, the perception of growth related to the Intifada, and several constructs related to outgroup biases: threat perception and exclusionism of Arabs, and the endorsement of political violence.

Bivariate analysis indicated that posttraumatic growth was positively correlated to symptoms of PTSD. This illustrates the negative role that the growth construct can perpetrate in posttrauma adaptation. Multivariate exploration of the growth construct as a predictor of probable PTSD and PTSD-related functional impairment in logistic regression analyses, controlling for theoretically relevant demographic variables, demonstrated the same deleterious effect. The more growth Israeli's experienced, the greater their likelihood of experiencing symptoms of PTSD, probable PTSD, and functional impairment.

Brian Hall

is currently a doctoral student in clinical psychology at Kent State University. Mr. Hall has presented research on the topic of posttraumatic stress disorder at numerous national and international conferences. His research and clinical interests are related to coping following trauma and the psychological sequelae of terrorism.

Growth Actions Work, Growth Cognitions Fail

Stevan Hobfoll receiving the Lifetime Achievement Award at ICAP 2006, Athens, Greece

Stevan E. Hobfoll
Key Note Speaker
EHPS 2006, Warsaw

Distinguished Professor and Director, Applied Psychology Center
Kent State University
&
Director, Summa-Kent State University Center for the Treatment and Study of Traumatic Stress, Ohio

Given the potential for profound existential activation following trauma, terror management theory was used as an organizing model to test the relationship between posttraumatic growth and outgroup bias. Terror management theory posits that the awareness of the inevitability of our death creates the potential for great anxiety and terror. This anxiety is lessened through cultural worldviews that provide a sense of self-esteem, that one is a person of value in a world of meaning (Becker, 1973; Greenberg, Solomon & Pyszczynski, 1986; Solomon, Greenberg & Pyszczynski, 2004). Being reminded of one's mortality (i.e., mortality salience) has been linked to the derogation of threatening outgroup members, the process of worldview defense, as individuals will strive to bolster and protect their cultural worldviews (Rosenblatt, Greenberg, Solomon, Pyszczynski, & Lyon, 1989). We posited that posttraumatic growth would function as a vehicle for worldview defense, as one dimension of posttraumatic growth measures the sinews of greater social connectedness following trauma. Given that exposure to terrorism has the potential to produce mortality saliency (Pyszczynski, Solomon, & Greenberg, 2003), we further hypothesized that Israeli Jews, who were exposed to terrorism and who consequently perceived posttraumatic growth, would likely evidence an increase in the endorsement of exclusionism and threat perception of Israeli-born Palestinian Arabs, and to further support the use of extreme political violence. The results of multiple hierarchical regressions supported the hypothesized relationship between posttraumatic growth and outgroup bias, further demonstrating its pathogenic rather than salutogenic consequences.

Taken together, these findings suggest that posttraumatic growth is not related to a positive and adaptive response in reducing posttraumatic symptomatology, but may rather function as a risk factor for developing symptoms of PTSD and impairment to one's functioning. Furthermore, whereas defensive processes of identification with ingroup members against threatening outsiders may portend the belief in greater social connectedness, this process does not appear to link to psychological wellness.

Upon reviewing the social psychological literature, we began to conceptualize posttraumatic growth not as a veridical phenomenon expected to ameliorate posttraumatic symptomatology, but rather a cognitive illusion that was employed as a method of coping (Taylor, 1983). We find support for this assertion in a recent study conducted on self-enhancement in individuals who were at or near the World Trade Center during the September 11, 2001 terror attacks (Bonanno, Rennicke, & Dekel, 2005). Self-enhancement bias was a significant predictor of self-reported adjustment, an initial resilient outcome, ratings of better adjustment prior to the attacks, and positive affectivity. However, 18 months after initial interviews, friends and family rated self-enhancers as being less socially adjusted. So in this way, posttraumatic growth may serve the role of a cognitive coping strategy following extreme stress, but not a reified change in positive posttraumatic functioning.

In line with Victor Frankl's (1959) existential discourse and the weighty evidence of behavioral activation in the behavioral and cognitive behavioral tradition (Jacobson, Martell, & Dimidjian, 2001; Martell, Addis, & Dimidjian, 2004), we began to conceptualize true posttraumatic growth not simply as cognitive process, or intellectual exercise in reframing, but salutogenesis through *action focused growth* whereby an individual actualizes their benefit finding cognitions – or reifies their illusions through action. This leads us to hypothesize that within a group of individuals who are already living their lives in the pursuit of an ideological purpose, and who thereby take positive actions in the face of ongoing trauma exposure, the experience of posttraumatic growth would not only be beneficial, but demonstrable behaviorally. We turn now to a study conducted in the throws of the recent Israeli disengagement.

As evidence of Israel's commitment to peace and in line with the two state solution (i.e., one state for the Jewish people and one for the Palestinians), the Israeli government decided to remove the settlers in the Gaza Strip through the process of "disengagement."

For the settlers, this heralded a change in governmental policies that specifically undermined the ideological focus of the settlement movement in Israel, a movement in place for more than half a century. For them, this policy change was a betrayal and threatened the security of Israel.

We hypothesized that a representative group of settlers (N=190) who have been the target of repeated terrorist attacks and were a part of the forced evacuations from Gaza would have higher levels of PTSD and depression compared to settlers before the disengagement. Those who reported posttraumatic growth in the process of a lifestyle that demands *daily actions* to face their traumatic circumstances would be less likely to develop PTSD and depression than those who did not derive growth from their experience.

Comparisons of probable PTSD and major depression between settlers before and during the Gaza Disengagement offered clear evidence of the significance of this event to exacerbate already high levels of symptomatology. Rates of probable PTSD jumped from 6.5% to 26.3% and probable major depression rose from 3.2% to 27.4%. Consistent with our predictions, results from logistic regression analyses demonstrated that posttraumatic growth served as a protective factor against probable PTSD diagnosis. Individuals who took positive social actions during the disengagement and construed this action as growth, enjoyed a significant reduction in the odds of developing probable PTSD (but not probable depression).

Conclusion

The role of posttraumatic growth as a beneficial process of adaptation and wellness has been challenged by our recent work in Israel. During the Intifada, Jews who experienced greater posttraumatic growth also had higher levels of PTSD symptoms, probable PTSD diagnosis, impairment of their functioning, and demonstrated greater outgroup bias. However, in Gaza, we see a different pattern of results emerging, suggesting that posttraumatic growth may be a marker of positive adaptation when accompanied by actions, not solely cognitive maneuvers. It is our position that posttraumatic growth should be considered a positive phenomenon when its link to psychopathology is more clearly defined. Until such time, facilitating growth within the context of treating trauma survivors may be ill advised (Calhoun & Tedeshi, 1999). In our opinion, true growth and transcendence in the aftermath of trauma will be evidenced by a concomitant reduction in symptomatology.

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The Significance of a Health Psychology Approach in Transforming Societies

Maria S. Kopp, MD, PhD., Árpád Skrabski, PhD.

Overview Paper

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Up to the end of the 1970s mortality rates in Hungary had been actually lower than in Britain or Austria. Subsequently, mortality rates continued to decline in Western Europe, whereas in Hungary and in other Central East European (CEE) countries this tendency reversed, especially among middle-aged men (Black et al., 1992; Bobak & Marmot, 1996; Cornia & Panixcia, 2000; Marmot & Wilkinson, 1999). In the late 1980s, the mortality rates among 45-64 year old men in Hungary rose to higher levels than they were in the 1930s, while the mortality rates in the older age groups were comparable to the worst in Western-Europe. Cardiovascular mortality accounts for the majority of this excess mortality in these countries (Weidner, 2000).

What is the explanation for the vulnerability of middle aged men during this period of rapid economic change? This deterioration cannot be ascribed to deficiencies in health care, because during these years there was a significant decrease in infant and old age mortality and improvements in other dimensions of health care. Furthermore, between 1960 and 1989 there was a constant increase in the gross domestic product (GDP) in Hungary. Thus the worsening health status of the Hungarian male population cannot be explained by a worsening material situation.

A growing polarisation of the socioeconomic situation occurred in the CEE countries, especially in Hungary between 1960 and 1990. The vast majority of the population lived at a similarly low level in 1960, with practically no income inequality, and there were no mortality differences between socioeconomic strata. Since that time increasing disparities in socio-economic conditions have been accompanied by a widening socio-economic gradient in mortality, especially among men (Black et al., 1992; Mackenbach et al., 1999).

The theory of relative deprivation hypothesises that chronic stress can arise out of situations in which there is rapid improvement in living standards for some but not for others. Relative deprivation may be deleterious to both psychological and physical health, mediated through stress-related coping responses (e.g., more smoking, heavier drinking) as well as invidious social comparisons. Conversely, social cohesion and meaning in life may help to counterbalance the widening gap in material circumstances (Skrabski et al., 2003, 2004, 2005).

One of the most interesting features of the so-called "Central-Eastern-European health paradox" is the gender difference in worsening mortality, in spite of the fact that men and women share the same socio-economic and political circumstances. In Hungary the male/female differences in life expectancy in 2004 was 8.3 years, which is considerably higher than the average difference found in countries of Western Europe, for example 5,7 years in the neighboring Austria, 4.6 years in Denmark and Great Britain (Demographic Yearbook, 2004). The mortality ratio comparing the lowest to highest educational stratum is 1.8 for Hungarian males, while 1.2 for females (Mackenbach et al., 1999). There are also marked morbidity and mortality differences according to the Hungarian counties and sub-regions.

Based on the data of our national representative surveys conducted in the Hungarian population (Hungarostudy 1983,1988, 1995, 2002; Kopp et al., 1995, 1998, 2000, 2002, 2005; Kopp & Skrabski, 1996; Skrabski et al., 2003, 2004, 2005) we found that a worse socioeconomic situation is linked to higher morbidity and mortality rates in Hungary as well. According to multivariate analyses, however, a relatively poor socioeconomic situation in itself does not cause higher morbidity rates, only through the mediation of depressive symptoms. In 1988, according to our national representative study in the Hungarian population, depression mediated between low income and self-rated morbidity among men, while among women low income was not significantly connected neither with depression, nor with self reported morbidity. In 1995 this pic-

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ture had changed, low income became connected directly to morbidity both in men and women, but the mediating effect of depression between low income and morbidity remained more important among men than among women. Consequently, not only the difficult social situation in itself, but the subjective experience of relative disadvantage, the prolonged negative emotional state, that is chronic stress proves to be the most important health risk factor (Kopp & Réthelyi, 2005).

Presumably a self-destructive circle develops from the enduring relatively disadvantageous socioeconomic situation and depressive symptoms. This circle resulting in chronic stress, plays a significant role in the increase of morbidity and mortality rates in the lower socioeconomic groups of the population. Until the 1970's with the uniformly low living standards, Hungarian health statistics showed more favourable data, than in several Western countries, such as in Great Britain or Austria. During rapid socioeconomic changes the disadvantaged continuously blame themselves or their environment, consider their future hopeless, experience permanent loss of control and helplessness, because they cannot afford a car, better living conditions, higher income, while others around them are able to achieve these. They constantly rate their own situation negatively, feel helplessness, and a loss of control. This experience becomes widespread when society becomes rapidly polarized and social cohesion, trust, reciprocity and social support decrease dramatically.

Though the relationship is true in general, the significance of the different factors varies according to periods and to environmental processes. In relatively stable societies, existing without great social shocks, the social factors and the psychological coping with these factors have less significance. In a region like Hungary and the other Central and Eastern European countries, dramatic changes have occurred in the last decades. During this time period depression and premature cardiovascular and overall mortality increased in parallel, primarily among men.

Men were found to be more susceptible to the effects of relative income inequality and GDP deprivation, but the pathway of this relationship is yet to be explained. Two possible explanations can be hypothesized. One is that the income inequality is much higher among men. In Hungary, in 1988 the main income of working women was 31% lower than that of working men, with a standard deviation 26% lower, while in 1995 the average personal income of women was 24% lower with 37% lower standard deviation, that is the income inequalities among men were and remained more substantial (Kopp & Réthelyi, 2005).

The other possible explanation might be that men are more susceptible to loss of status than women. Animal experiments have shown males to be more sensitive than females to loss of dominance position, that is loss of position in hierarchy (Réthelyi & Kopp, 2005). Most animal studies on social rank examine males, where social rank is the best predictor of quality of life and health. The relationship between social inequality and health applies to women as well as to men in several respects according to several studies, although the income and occupation of women are not as powerful predictors of mortality as they are for men (Marmot & Wilkinson, 1999). Especially in a suddenly changing society, such as Hungary, the social inequalities in mortality rates are much more pronounced among men. In such a situation, in a more traditional society, the relative income deprivation might be a more important risk factor for men than for women. There are significant gender differences in ways of coping during the sudden changes of the political-economic system, male morbidity seems to be more affected by the socio-economic changes (Kopp, 2000).

Middle aged men are more vulnerable to the socio-economic risks of their society, but this is closely connected with different male-female roles in the society. Men are affected not only by their own social situation but by the subjective evaluation of social status of women as well (Kopp et al, 2005). The subjective social status and education of women were strongly and inversely correlated with male mid-aged mortality, which means that in sub-regions where women hold more negative appraisal of the social standing and have lower education, there is greater male health deterioration.

In preventing the high male premature mortality in Central-Eastern Europe women might play an important role.

It can be hypothesised that the socio-political changes may have different consequences for men and women. The improvement of higher education of women seems to be beneficial both for male and female longevity. Educated women accept more the responsibility for the socio-economic situation of their family. The feeling of relative socioeconomic deprivation among women in the relatively deprived regions, on the contrary, might result in a vicious cycle of relative deprivation among men (Kopp et al., 2005).

During the modernisation process of society the female patterns of inequity, risk factors and health might approach male patterns as it has been experienced in several Western countries.

In the comparison of women to men socio-economic factors are nearly four times more important predictors of middle-aged mortality differences among regions. Social distrust and the rival attitude are important predictors of middle aged mortality differences among men (Skrabski et al., 2003, 2004). This indicates that in a suddenly changing socio-economic situation relative economic deprivation, rival attitude and social distrust are all more important risk factors for men while the strong collective efficacy could be a protective factor, even in the case of men. Rival attitude has a highly significant negative association with participation in civic organizations, consequently the protective effect of participation in civic associations might influence health through a lower rival, competitive attitude in members of civic networks among men.

The existing and broad socio-economic differences among the Hungarian regions are less important regarding the middle aged female mortality differences. Neighbourhood cohesion, religious involvement, trust and reciprocity were not as much influenced by sudden socio-economic changes in the last decades, therefore the protective network of women remained relatively unchanged.

The above results show that health psychology approach might play a central role in preventing the middle aged morbidity and mortality crisis in transforming societies.

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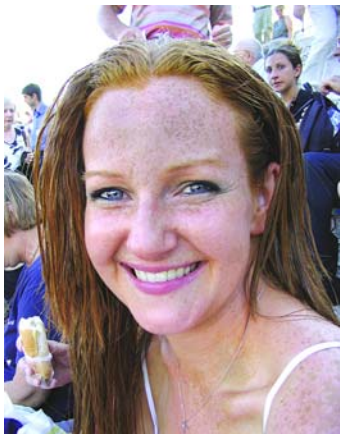


Intervention Checklist
Developing a comprehensive checklist to guide the design of interventions

The initial idea for the Intervention Checklist (ICL) was devised during the CREATE 2005 workshop "*Designing and evaluating theory based interventions*", facilitated by Charles Abraham, Susan Ayers, and Susan Michie at EHPS Conference in Galway, Ireland. The participants within this innovative workshop identified a need for an integrated perspective framework, that would allow for both theory testing and provide concrete strategies on "How To" design, plan, implement and evaluate theory based interventions.

A focus group was formed comprising members of the original workshop, whose goal was to bring the initial idea to fruition. A key initial area of consideration was the dissemination of the final "product". It was decided very early on that a web-based forum would be needed to aid access for those people that would consider using the ICL. With this in mind the focus group split into two teams. The first of which would design the website and the second would develop the content of each section, both being overseen by an editor-in-chief. Within the content team, a brain storming exercise ensued. While still in Galway, we decided the outline of the points that we would need to incorporate in the website. Each person was then in charge of doing a comprehensive literature review on their specific sub-section. Over the proceeding months, this was compiled by the editor-in-chief into a coherent order. Slowly the Intervention Checklist began to emerge. However, being in separate countries proved to be a consistent stumbling block. We kindly received funding from the EHPS for four of us to meet in a central location to facilitate the final phase of the project. This proved to be integral to advancing the ICL nearer to its completion and we are very grateful to EHPS for this opportunity.

It is envisaged that the ICL will have a three layered approach, representing different levels of specificity depending on the users' needs. Level 1 will form the "Checklist at a glance", Level 2 will be the "Procedures" and Level 3 will be "In-depth information". Broadly, Level 1 will display a global iterative approach to the designing, planning, implementation and evaluation of an intervention. This will incorporate steps such as "specify research aims and conditions"; analyse problem and define clear objectives for behaviour and/ or environmental change. An iterative next step within this level would be to "select theory and review evidence". With this, a formulation "of testable hypotheses and research questions" will be employed. The "designing the study" section within Level 1 has a number of subsections such as, "translate strategies and research questions into material and measures"; "anticipate effects" and "sampling" , any constraints that may need to be considered and finally to "anticipate the implementation" of the intervention. Another point to consider when taking the global Level 1 view within the ICL would be "preparation for and piloting of the interventions itself". Data analyses is also contemplated and finally how best to communicate the findings of the intervention plus any long-term follow up would need to be given due thought. Level 2 of the Intervention Checklist will comprise of specific content on each of the topics mentioned within Level 1. This will allow those users that require more detail, to have that available to them. Level 3 of the ICL will encompass relevant references to the literature and also relevant links to websites of similar topics.

Catherine Darker (University of Birmingham)

On Behalf of the ICL Focus Group, including Anna Davies (University College London) Andries Oeberst (International University of Bremen) Martina Panzer (International University of Bremen)

The strengths of the ICL are that it is an integrated framework for interventions. It allows for both theory testing and theory application. It will provide concrete strategies and "How To's" for specific stages of an intervention design and implementation. The web-based format will also allow for flexibility in application and for further development of the checklist.

The Intervention Checklist will be available within the EHPS website and members of the focus group will be presenting it at EHPS Conference 2006. It is hoped that the ICL will also have a link to Wikipedia, whereby using these features, visitors will be allowed to comment on the ICL and offer suggestions on how best to improve the website. The CREATE 2005 participants hope that the Intervention Checklist will become a tool for all researchers to utilise when designing, planning, evaluating and implementing their interventions. It is hoped that the ICL will be available very soon - so keep checking! We encourage you to visit the EHPS website, use it and please make any suggestions that could improve the design and content of the Intervention Checklist.

CEU Summer School "Gender, health and inequality"

July, 18–26, 2006, Budapest

From July 18th to 26th, the Central European University (CEU) sponsored an intensive summer course on ***"Gender, health and inequality"***. Located in Budapest, the CEU is an international university, accredited both in the USA and in Hungary. It offers a wide range of courses, targeting issues of social change and the policy implications of transitions to open societies. The CEU ***summer university program (SUN)*** was established in 1996 in order to host interdisciplinary, research-oriented, academic courses and workshops for professional development in the humanities and social sciences. These courses are designed to attract both young scholars (i.e. Ph.D. students, junior researchers) and professionals (e.g. representatives of NGO's) from all over the world, but especially from the emerging democracies of the former Soviet and East and Central European countries. The courses cover a wide spectrum of disciplines, from legal studies and international relations to public policy, anthropology and cultural studies.

The ***"Gender, health and inequality"*** course examined the complex interrelations between health, gender and inequality. The program included a variety of topics such as: reproduction and public policy, sex trafficking, private violence and complicity, the anthropology of health policy, reproductive disruptions and reproductive technologies,

CEU Summer School

Adriana Baban and Gail Kligman, Course Directors

Roma health issues, labor market inequalities and health, political economy and the health of nations, immigrant's health, stress and health, masculinities and men's health.

The lectures offered students multidisciplinary perspectives on gender, health and inequality issues. These were followed by critical debates, small group assignments and discussions that provided ample opportunities to compare gender constructs, health experiences and health care delivery across countries and cultures. Participants were also encouraged to discuss their research and interests during individual or group meetings with faculty. The learning process continued throughout the nine intensive course days, including ongoing debates during lunch, dinner or even the Sunday boat trip to the small town of Szentendre.

The course was co-organized by directors Adriana Baban, Professor of Psychology, Babes-Bolyai University (Romania) and Gail Kligman, Professor of Sociology and Director of the Center for European and Eurasian Studies, UCLA (USA). In addition, participating faculty included: Nicolette Hart, Professor of Sociology, UCLA, Eva Fodor, Professor of Sociology, CEU (Hungary), Michele Rivkin-Fish, Professor of Anthropology, University of North Caroline (USA), Irina Todorova, Director of the Health Psychology Research Center (Bulgaria), Larrisa Remennick, Professor of Sociology, Bar-Ilan University (Israel) and Andor Urmos, Director of the Department of Roma Integration inside the Ministry of Youth, Family, Social Affairs and Equal Opportunities (Hungary).

Twenty young scholars and professionals participated in the course. Their academic and professional backgrounds ranged from cultural and medical anthropology and sociology, to health psychology and human rights law. The course participants came from different geographical regions: Central Asia (Uzbekistan, Kyrgyzstan, Armenia, Georgia and Turkey), East and Central Europe (Romania, Bulgaria, Hungary, Poland and Czech Republic), USA, Mexico and Spain. On the whole, participants found the course to be stimulating and instructive, noting that the lectures and reading materials (available before the course) offered a very useful and well-structured background for discussion. We quote some of the students' impressions:

"The course was very helpful for my research and career development. I appreciate the suggestions I received from the professors that are working in my field and I also enjoyed the multicultural experience, the time spent with the wonderful people I met at this course" (Eva, Czech Republic).

"For me it was very useful to see how researchers have studied gender and health related phenomena that I have experienced subjectively in my country. The course provided me with the opportunity to exchange ideas and come up with topics for future collaborative studies. I also enjoyed very much meeting the teachers and the colleagues from different countries and talk to them about gender and health issues." (Almagul, Kyrgyzstan).

This kind of summer course enables young scholars and professionals from different geographical areas to meet, engage in academic and social exchanges, and discover their similar interests, making "the globalization of friendship" possible. Importantly, such a course also serves as a productive starting point for future collaborative and comparative research projects which address issues associated with gender, health and inequalities in an increasingly globalized world, and promote appropriate policy interventions.

As a course participant I hope that in the future, other young researchers and professionals will apply and benefit from the opportunity to participate in this course and contribute to the study of the complex issues associated with and interrelations between gender, health and inequality.

Catrinel Craciun, Babes-Bolyai University, Cluj-Napoca

International Congress of Applied Psychology Division 8 – Health Psychology

Conference Impressions

The International Congress of Applied Psychology took place in Athens, Greece, from July 16th – 21st, 2006. The Health Psychology Division of the IAAP, Division 8, was represented with an outstanding scientific program, with Program chair Esther Greenglass. There were a total of 201 oral papers, 179 posters, 46 sessions of which 19 were Invited Symposia. Topics included coping and social support, health behavior change, women's health, terrorism as well as sessions on psychological effects of disasters. Several international leaders in health psychology were invited key note speakers or symposium conveners.

Presidental Address: Ralf Schwarzer (Germany) *Social Cognition Models in Health Behavior Change*

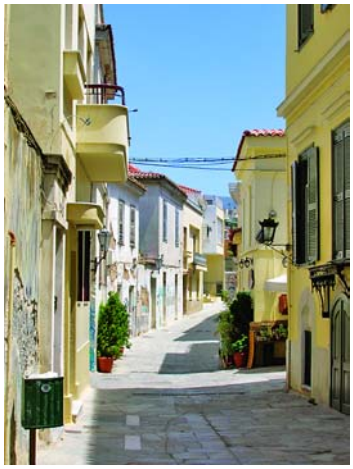
State of the Art Lecture: Susan Michie (UK) *Genetic Testing: Psychological Consequences and Intervention*

Keynote Lectures:

Adrian A. Kaptein (The Netherlands) *Illness Cognitions in Chronic Somatic Illness*

Stevan E. Hobfoll (USA) *Terrorism's Impact on the Self and Society: Even our Gains May be Losses.*

The program at ICAP 2006 included a **Joint Invited Symposium of IAAP and EHPS** on Women's Reproductive Health, chaired by Irina Todorova. This was the first such joint symposium presented at ICAP. However, the collaboration between EHPS and IAAP Div. 8 has been on-going for several years, for example, there were IAAP sponsored symposia at the EHPS Conference in Kos, Greece, 2003. At the EHPS Conference in 2004, in Helsinki, Finland, Division 8 of IAAP co-sponsored a symposium with EHPS entitled, "Coping as a Synergistic Concept: Implications for Health" chaired by E. Greenglass in which health psychologists from German, Poland, Canada, and Finland presented research on coping and its relationship to health.



At the Division 8 Business Meeting, it was announced that Aleksandra Luszczynska has been elected and will serve as President-Elect for the period of 2006-2010. Thus the new board of Division 8, effective July 18, 2006, is:

President: Esther Greenglass, Canada
President-Elect: Aleksandra Luszczynska, UK and Poland.
Past-President: Ralf Schwarzer, Germany
Secretary: Urte Scholz, Switzerland

At the meeting, **The Lifetime Achievement Award** was presented to Stevan Hobfoll, and the Early Career Award to Benjamin Schüz. Ralf Schwarzer, President, Division 8 IAAP 2002-2006, was given a silver cup in gratitude for his work during this period.

Division 8 will be working with the editor of *Applied Psychology: An International Review*, the IAAP journal, to increase the visibility of health psychology on the international scene. For example, several special issues are being planned for this journal, including on the topic of women's health internationally, using the Symposium on Women's Health in Athens as a start.

For the first time in Athens, Division 8 hosted a **Social Hour**, at the top of the Divani Caravel Hotel. This very successful social hour brought together over 100 guests over the background of the breathtaking view of Athens from the roof Terrace.

Esther Greenglass, Aleksandra Luszczynska

www.healthpsych.de/iaap

Health Psychology Review

Health Psychology Review: A new EHPS journal

There is a limited number of publication outlets for theoretical and conceptual pieces in the area of health psychology. Occasionally good theoretical papers in our field get published in review journals in the more general field of psychology, but too often good theoretical papers do not get published at all, or are published as chapters in edited volumes that have a relatively limited readership. A journal featuring theoretical and review articles could help to initiate new lines of research or provide a coherent framework for past and existing programs of research. This is what *Health Psychology Review* hopes to achieve.

Twenty years ago *Psychology and Health* was launched, and the growth and success of Psychology and Health as a journal of empirical research has led to the conviction that the time is right to launch a companion journal that features theoretical, conceptual and review articles. *Health Psychology Review* does not specify appropriate topics, but rather seeks to publish significant work reflecting the entire breadth of the field of health psychology.

We are convinced that the field would benefit from a journal featuring theoretical and review 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 as well as the general field of psychology.

The general focus of *Health Psychology Review* will be on papers presenting theoretical and conceptual work, as well as evaluative and integrative reviews and interpretations of substantive issues in the general domain of health psychology. Generally the articles will have some empirical base. The latter can be based on a review of past research including one or more meta-analyses and/or initial empirical tests of the proposed theory or framework. Original research is thus reported in summary form and only for illustrative purposes. Systematic evaluations of alternative theories in a specific domain will also be considered for publication. Reviews that develop connections between areas of research are particularly appreciated. Manuscripts devoted to more descriptive surveys of the literature, problems of method, design and measurement, or reports of empirical findings are not appropriate. Commentary that contributes to progress in a specific subfield of health psychology such as discussions about previously published articles, comments that apply to existing theoretical models, critiques and discussions of theoretical approaches can also be published as Theoretical Notes. Occasionally the editors might decide to invite commentaries to be published alongside a target article.

Presently we are working on the first issue of the journal which should be published in 2007. We hope that EHPS members will play an active role in the journal both as authors and as reviewers. More information about the journal can be found at:

http://www.tandf.co.uk/journals/titles/17437199.asp

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Conference Announcements

"Organ Transplantation: Ethical, Legal and Psychological Aspects"

This European conference is aimed at psychologists, ethicists, clinicians, lawyers and policy makers in the field of organ transplantation.

Transplantation medicine is a rapidly evolving science. New technologies and transplantation programs raise questions about the ethical, legal and psychological implications of these developments. In various (new) countries within the European Union, these psychological, legal and ethical aspects are evolving in different ways. Because of this there are opportunities for better cooperation between countries. On the other hand, important pitfalls emerge, like unequal access to care.

The purpose of the conference is to encourage the exchange of information, ideas and experiences, at an international level. In addition the aim is to establish a permanent international platform to formulate guidelines and stimulate joint research efforts. To achieve this we have chosen a format of workshops on various topics with the goal of formulating recommendations for the plenary closing session.

Workshops are centered on the following 6 topics:

1. Commercialization and trafficking.
2. Legal systems for organ donation and allocation.
3. Altruism, counseling and psychological aspects of living donation
4. Minorities, religion, and gender aspects.
5. Expanded post mortem donor criteria, including Non Heart Beating donation.
6. Role of patients, media and pharmaceutical industry.

The Conference will be held in Rotterdam, the Netherlands from 1–4 April 2007. Deadline for abstract submission is November 1, 2006. For more information, see: www.elpat.eu.

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