

The New European Health Psychologist 2007-2008

Dear readers,

Since the introduction of the *European Health Psychologist* in 2005 we have been publishing a diversity of thought provoking think-pieces (e.g., Bandura, 2005; M Johnston, 2005; Leventhal, 2005; Maes, 2005; James, 2006), excellent overview papers (e.g., Hall & Hobfoll, 2006; DW Johnston, 2007 – this issue), research letters (e.g., Oldridge, Saner & McGee, 2005) and interviews with key researchers such as Alexander Rothman (2007 – this issue) and Sir Michael Marmot (2007 – this issue).

The EHP has been shifting its focus from a newsletter towards a true bulletin of the European Health Psychology Society reflecting the scientific developments in European health psychology. In doing so, the *EHP* will continue to publish relevant information from the EHPS and provide an unorthodox vehicle for the dissemination of health psychology science beyond traditional means. Hence, the *EHP* emerges as a medium which provides health psychologists with the opportunity to formulate positions and communicate reflections, to initiate discussions or comment on particular scientific controversies, and to develop new ideas and innovative approaches. Thus, while we strive to maintain the high level of quality of past issues, you will notice that

the tone of the *EHP* has been changed to reflect an increasing focus on science, multidisciplinary and interactivity.

We hope that our readers will continue to be involved in the process of planning and creating the *EHP* by actively and frequently submitting think-pieces, research letters, debates, or interviews. The *EHP* is a fast, interactive and flexible means of communication, providing a platform for discussions, controversies and debates relevant to health psychology, as well as to responses to pieces that appeared in *EHP* past issues. The *EHP* team has been assembling an informal peer-review process to ensure top quality. Please do not hesitate to contact us if you have any queries or proposals.

With a new international editorial team consisting of Nihal Elamin Mohamed, (New York) Gerard Molloy (London), Benjamin Schütz (Berlin), Emely de Vet (Amsterdam), and Dawn Wilkinson (London) as co-editors and Justin Presseau (Aberdeen) as editorial assistant, the *European Health Psychologist* will continue its transformation into a platform for the exchange of your scientific findings, reflections and ideas.

(Continued on page 2)

inside this issue

page

- 1** The New European Health Psychologist 2007-2008
- 2** The European Health Psychologist: Always Something New
- 3** An Interview with: Professor Sir Michael Marmot
- 6** An Interview with: Alexander Rothman
- 9** Keynote Report by Professor Derek Johnston
- 12** EHPS 2006: Conference Report
- 14** EHPS 2007: Conference Announcement
- 14** EHPS 2007: Conference Funding
- 15** EHPS 2007: Conference Workshops
- 17** Other Conference Announcements
- 18** New EHPS Members

editorial message (cont'd)

We present this issue in the hope that it will challenge your ideas and inspire scientific debate, and look forward to being the forum for European health psychology.

Hope you will find this issue challenging to discover!

Sincerely yours on behalf of the entire EHP team,



Vera Araújo-Soares & Falko Sniehotta
Editors – *The European Health Psychologist*

past editor's message

The European Health Psychologist: Always Something New

Dear EHPS members and friends,

For many years, the Newsletter of the EHPS has been offering information about important current topics in health psychology, EHPS organizational activities, and announcements about international events in the field. Several Editors have contributed to its existence and have left their mark on its design, goals and philosophy, always aiming to offer something new and engaging to the readers. In the past two years, the newsletter expanded its Editorial team and thus its creative reservoir of original ideas for both format and content. In 2005, it became *The European Health Psychologist*, with a redesigned format and expanded goals and content, to include even more substantive materials about theory, research and practice in health psychology.

I have tremendously enjoyed my two terms as Editor of *The European Health Psychologist*. During this time, my work on the quarterly issues has connected me to many people who contributed to its pages with original texts, ideas, feedback and support. I will remember each contribution and will be grateful to everyone who dedicated their time to

References

- Bandura, A. (2005). The Growing Centrality of Self-Regulation in Health Promotion and Disease Prevention. *The European Health Psychologist*, 1, 11-12.
- Hall, B.J. & Hobfoll, S.E. (2006). Posttraumatic Growth Actions Work, Posttraumatic Growth Cognitions Fail: Results from the Intifada and Gaza Disengagement. *The European Health Psychologist*, 3, 3-6.
- James, J.E. (2006). Health, Commerce, and the Future of Health Psychology. *The European Health Psychologist*, 1, 5-8.
- Johnston, M. (2005). Means and Meanings in Health Psychology. *The European Health Psychologist*, 1, 6-8.
- Leventhal, H. (2005). Health Psychology: Past, Present and Future. *The European Health Psychologist*, 1, 3-5.
- Maes, S. (2005). Health Psychology: Past, Present and Future. *The European Health Psychologist*, 2, 4-5.
- Oldridge, N., Saner, H., & McGee, H. (2005). The HeartQoL study. An International Project to Develop a Core Heart Disease Health-Related Quality of Life Questionnaire. *The European Health Psychologist*, 1, 13-14.

enriching its contents. Since I was joined by the two EHP co-editors, Falko Sniehotta & Vera Araújo-Soares two years ago, the work became even more rewarding. With the current issue they are taking on as the new Editors of *The European Health Psychologist*. The new editorial team will also include the co-editors Gerry Molloy, Benjamin Schulz, Emely de Vet, Dawn Wilkinson and Nihal Elamin Mohamed. I would like to wish all of them smooth writing and as much fulfillment in their work as I found during my terms.



Irina Todorova
Past Editor – *The European Health Psychologist*
ilqt1@comcast.net

an interview with

Professor Sir Michael Marmot

by Gerry Molloy, Co-Editor

Status Syndrome and Health Psychology

Michael Marmot has been at the forefront of research into health inequalities for the past 30 years. He is Principal Investigator of the Whitehall Studies of British civil servants, investigating explanations for the striking inverse social gradient in morbidity and mortality. He leads the English Longitudinal Study of Ageing (ELSA) and is engaged in several international research efforts on the social determinants of health. He chairs the Department of Health Scientific Reference Group on tackling health inequalities and the British Heart Foundation Primary Prevention Committee. He was a member of the Royal Commission on Environmental Pollution for six years. In 2000 he was knighted by Her Majesty The Queen for 'services to Epidemiology and understanding health inequalities'. Internationally acclaimed, Professor Marmot is a Vice President of the Academia Europaea, a member of the RAND Health Advisory Board, a Foreign Associate Member of the Institute of Medicine, and the Chair of the Commission on Social Determinants of Health set up by the World Health Organization in 2005. He won the Balzan Prize for Epidemiology in 2004 and gave the Harveian Oration in 2006.

I had the opportunity to sit with Professor Sir Marmot to discuss his work investigating the status syndrome.

GM: *What is the status syndrome?*

MM: The status syndrome is a term that I coined to describe the close relationship between an individual's position in the social hierarchy and their health. The higher the position in the hierarchy, that is their social status, the better their health. It runs from the top to the bottom of society. I coined that term precisely to make clear that inequalities in health follow a social gradient. It is not simply bad health for the poor and good health for the non-poor. The gradient in health runs from the very top to the very bottom of society and hence the term status syndrome.



Professor Sir Michael Marmot
Director
International Institute for Society and Health

MRC Research Professor of Epidemiology and Public Health
University College London, England, UK

GM: *Health psychology focuses on the psychological and behavioural processes in health, illness and healthcare. What does the evidence from your work say about the role of psychological and behavioural process in explaining the status syndrome?*

MM: There are a number of possible responses to the social gradient in health. The first is that it is inevitable. This line of reasoning runs: hierarchies are inevitable in society and if health is a consequence of where you are in the hierarchy, then it must be inevitable, so there is no point in looking for explanations. It is somehow built into living as a social animal. I don't take that view. I do take the view that hierarchies are inevitable but evidence shows that the health consequences of hierarchies vary within a society over time and across societies. There is not a constant relation between hierarchies and health. The influence of where you are in the hierarchy on your health is contingent on what hierarchy means in a given society at a given time. The fact that we find very strong evidence of the gradient in health now doesn't mean that there is an inevitable link between status and health. That's quite encouraging. It means that we have to understand what is responsible for the link between status and health.

(Continued on page 4)

an interview with

Professor Sir Michael Marmot*(Continued from page 3)*

A second reaction is that the gradient in health must be due to medical care. That is commonly argued in the US for example, where those without health insurance don't have the same access to health care as those with insurance. The assumption is that the worse health of the disadvantaged must be due to lack of health care. My response is that high quality health care ought to be available to all equally, regardless of the ability to pay. However lack of health care is not the major explanation of the status syndrome.

A third response to the status syndrome is that it must be due to behaviours and somehow people are to be blamed for their bad behaviours. The fact is that people lower in the hierarchy are more likely to smoke, eat fewer fruit and vegetables and to be more sedentary in their leisure time. The evidence suggests that these behaviours do play a role in explaining the gradient in health, particularly smoking. To the extent that they do play a role, the question is then, why do we find a social gradient in these behaviours? I don't blame people for their behaviour, I seek to understand it. Why do these behaviours follow a gradient? The second part of this is that in the Whitehall studies, the standard coronary risk factors, including health behaviours, explain about a third of the social gradient in mortality with smoking being the most important contributor. It may be with better measurement some of the other behaviours may have been more important, diet in particular, but still it suggests that some large part of the gradient is unexplained. We have evidence from the Whitehall studies that another important contributor to the gradient is a variety of psychosocial factors, in particular, to use a term familiar to psychologists, chronic stress. So psychological processes are therefore very important both in asking why we have a social gradient in health behaviours and how we understand the relationship between status, chronic stress and disease.

GM: *There has been a great deal of interest in health related behaviour change in health psychology. More specifically much of this work has used various self-regulation theories such as Bandura's social cognitive theory. This theory emphasises individual beliefs about capabilities to exercise control over*

functioning and over events that affect one's life. In your work you argue that the notion that inequalities can lead to inequalities in capabilities and you explain how this is informed by the economist Amartya Sen's work, and that this is a key processes in explaining the status syndrome. Do you think that Sen and Bandura's notion about capabilities are related?

MM: I would imagine that Sen would take a much broader approach to capabilities and that capabilities in his sense leads to functioning across a whole array of domains, so that beliefs about capabilities might be part of that. If you can't control your micro environment, then your capabilities to function must be hampered. So I would say there is some connection between the two concepts. I had been thinking about control over work in the job strain sense, without knowing about Sen's capability theory, but with a passing knowledge of concepts of control and self-efficacy that psychologists discuss. I was quite surprised when I came across Sen's work on capabilities fairly late on in my own thinking and to realise that this is what I had been thinking. Control is a part of capabilities. Giving people control over their work or their home life is enhancing their capabilities. So I think that there are similarities in the two concepts, but that capabilities in Sen's terms is a more expansive notion.

GM: *Do you think that behaviour change can reduce social inequalities in health?*

MM: There is not a great deal of data. At least 10 years ago, a group in York conducted a review of the effect of successful behaviour change interventions in reducing the social inequalities in health. They found that there really wasn't much evidence available. My own view of that is not that behaviour change is ineffective; it is just that there isn't much evidence and there may be a number of reasons for that. First of all it's hard to do randomised controlled trials in this area, which is what that review focused on, so partly it's that the work hasn't been done, because it's too difficult to do and arguably it reflects a particular view of what constitutes evidence. I would say that the observational evidence that we have suggests that behaviours do make an important

(Continued on page 5)

an interview with

Professor Sir Michael Marmot

(Continued from page 4)

contribution to the social gradient in health. You then get this dilemma about evidence. Take smoking for example. The evidence is that if you raise the price consumption goes down. However the evidence also shows that consumption does not go down among the very poorest when the price is raised. So that those most affected by both the price and the smoking are those that are the least price sensitive. We need to understand this behaviour. Hillary Graham has done some interesting work in this area where she shows that among single mothers on benefits, the majority of whom smoke, giving up smoking is not a priority. They have too many other things to worry about. So clearly smoking is an unhealthy behaviour and one needs to understand the determinants of it and any help that we can give people in unfortunate disadvantaged circumstances to give up smoking we need to do. But we also need to understand the social situation, it's not simply a matter of saying to individuals change your behaviour. Such behaviours have a social context.

GM: *What other areas of health psychology do you see as most important in your body of work?*

MM: There are two other important roles for psychologists that we haven't discussed. One is helping to understand the processes, not just in behaviour change, but other psychological processes that might help explain the social gradient in health. Secondly the work making the psychological-biological links is also crucial. For example my collaboration with Professor Andrew Steptoe has been very important. His work very much informs my own. Therefore I couldn't do what I do without the input of psychology and psychology has played a very important role in my thinking.

References

- Arblaster, L., Lambert, M., Entwistle, V., Forster, M., Fullerton, D., Sheldon, T.A., et al. (1996). A systematic review of the effectiveness of health service interventions aimed at reducing inequalities in health. *Journal of Health Services Research and Policy*, 1, 93-103.
- Graham, H. (1993). *When Life's A Drag: Women, Smoking and Disadvantage*. HMSO: London.
- Marmot, M.G. (2004). *Status Syndrome*. Bloomsbury Publishing: London.
- Marmot, M.G. (2006). Status syndrome: a challenge to medicine. *JAMA*, 295,1304-1307
- Sen, A. (1999). *Development as freedom*. Oxford University Press: Oxford.

an interview with

Alex J. Rothman

by Dawn Wilkinson, Co-Editor

Initiating and maintaining the link between theory and practice

Alexander J Rothman is Associate Professor in the Department of Psychology in Minnesota. He received his PhD from Yale in 1993 and by 2002 he had been awarded the American Psychological Association's (APA) Distinguished Scientific Award for Early Career Contributions to Psychology; only the 5th person to receive the award for work in the area of Health Psychology. Much of Alex's work centres around the way people process and react to health information and the influence of message framing on behaviour. His publications cover numerous theory-based interventions targeting, for instance, weight loss, sunscreen use, mammography screening, smoking, and flu shots. Increasingly his work has emphasised processes associated with long-term behavioural maintenance, as well as methodological and conceptual issues around theory development, theory testing and interventions.

These themes were reflected in his key note speech at the recent British Psychological Society's Division of Health Psychology (DHP) conference "*Is there nothing more practical than a good theory? Linking theory and practice in the study of behavioural initiation and maintenance*". The speech outlined the importance of advancing theories through experimental interventions using examples from Alex's own work testing a theoretical model delineating initiation and maintenance processes. I managed to catch up with Alex during the DHP conference in the glamorous setting of University of Essex Sports Centre car park. I asked him what, in particular, were the main themes that he wanted people to take away from his key note:

AR: What we are trying to demonstrate is the idea that you can use interventions to test theoretical ideas. I am really interested in the decision processes that may differentiate between initiation and maintenance and you need to be in the intervention world [to do that]. Maintenance to me is not what you do in the last 10 minutes of an hour long experiment or one week into an intervention but what happens over the next 18 months and I'm not even sure that 18 months is where you want to stop.

DW: Alex's keynote emphasised that we need to prevent theories from stagnating. This would involve being more comfortable with contradictory and disconfirming findings. I asked Alex whether he thought an emphasis on significant confirmatory research was in part due to the constraints and

**Alexander J Rothman**

Associate Professor
Department of Psychology, University of
Minnesota, Minneapolis, MN, USA
rothm001@umn.edu

expectations of the academic system, for example journals' reluctance to publishing null findings.

AR: OK, null findings can be ridiculously difficult to interpret. But I think we need to be more comfortable with being wrong and to be more supportive of people making precise predictions and thus running the risk of being wrong. When a prediction is or is not supported, it speaks to whether the prediction was correct or incorrect and not how good a scientist someone is. As regards to publishing and researchers' practices, it's hard to know what's the chicken and what's the egg. If researchers pursued tight focussed predictions I think the field would feel more comfortable with null findings.

DW: Alex believes that applied theory-testing can and should lead to a "second generation" of research in which you take the principles of an effective intervention and work out the most optimal way to deliver that intervention in applied settings. However, there is a tendency toward what he calls "horizontal growth" in research and uses the metaphor of a "waistline getting bigger", for example amassing supportive evidence by repeatedly testing the same aspects of a theory, perhaps across different behaviours. Whilst Alex sees this is as valuable in its own right, he highlights the need for more "vertical growth" in which theories are refined and translated into deliverable intervention programmes:

AR: I probably shouldn't stop just because I've just developed a good [theoretical intervention] technique that worked, because there is probably a lot of room to develop and refine that technique. Just because something works doesn't mean it is necessarily the best

(Continued on page 7)

an interview with

Alex J. Rothman*(Continued from page 6)*

or optimal thing to do. Even well designed intervention techniques aren't disseminated as well as one would like. That [intervention] technique might be effective but you need a team of five PhD health psychologists to implement it. In a clinical centre you might have that type of staff support, but in most parts of the country you don't; so consideration must be given to whether there is a way of delivering that [intervention] by people with different kinds of training.

DW: *Alex notes that vertical progress and theory development can only happen where there is collaboration and cross-working:*

AR: You can think about your own personal research programme – how do the studies you are conducting build on each other – but there is another level of research program that's important - the larger programme around a health issue, for example, risk communication. From this perspective, one asks how the studies conducted by different teams of investigators build on each other. And the idea is that if everything is working perfectly I would report a finding and advance the field a little bit, but then I am comfortable with your taking this finding and building on it and then later I follow up on your work. It seems more likely you are going to get progress this way.

DW: *From Alex's point of view, this kind of collaborative working appears to be happening in Europe. I asked him, having recently attended the EHPS conference and now attending the DHP conference, what was his perspective on Health Psychology in Europe compared to the US?*

AR: From what I can see, there is an integrated community here that is different from what you typically find in the US. In the US, you find health cognition research tagged on to either a broader social psychology meeting or a behavioural medicine meeting. In both cases you can see the work but it is often overwhelmed by other stuff. Europe is a place where [this kind of work] is front and centre.

DW: *But, does this mean that Health Psychology loses something here because it is less inter-disciplinary?*

AR: Well this is where it gets complicated and you don't know whether you are looking at different systems or are you are looking at the same system but at different stages of development. I think that for some of the work that is being done here you would

want to see that [interdisciplinary work] to begin to evolve, particularly as the work moves from not just delineating the predictors of behaviour but really more aggressively testing those models in clinical interventions. At the same time I have been impressed here, that there is a lot of cross-collaboration done. There seems to be much more of a shared effort so you have lots of groups working on implementation intentions, a bunch of groups working on issues around illness perceptions and risk perceptions, and it appears, at least as an outsider, they are working more cooperatively on the problem [than in the US]. If this perception is accurate and I'm correct to assume that there is a benefit to working more cooperatively, one would expect there to innovations coming out of the European groups in the hear future. We are going to have to wait and see.

DW: *Alex also noted that research in Europe has perhaps benefited from the physical and conceptual distance from the theoretical models that it has been evaluating, allowing a more removed and, thus perhaps, more critical approach:*

AR: There is something different about people doing research on their own or their mentor's theories. When you are doing research on other people's theories you have some perspective and distance. For example, when we do work on our model of message framing even if we try to be as objective as we can possibly be, it is hard not to feel invested in the outcome. But when other people are working on our model, they not only may be able to remain object, but also be able to more readily detect weakness in the model. Much of the work that's been done here on the theory of planned behaviour may have benefited from the fact that people could take a critical look at the model, whereas in the US a lot of the work may be tied up with people who developed the model. Again, it is an empirical question. As more models start to emerge [out of Europe], people in the US may find themselves in a better position to test and evaluate them.

DW: *I asked Alex to what extent he thought there was convergence between the US and Europe in their approaches to Health Psychology*

AR: I think generalisations are dangerous, but in the areas that I work there is a lot of synergy. If I think about the time that I finished graduate school in 1993 there may have been an article here and there in an APA journal that was written by someone from Europe but that would have been the exception. Now it's no

(Continued on page 8)

an interview with

Alex J. Rothman*(Continued from page 7)*

longer the exception and I think that's facilitated synergy – you can't work on the same projects if you don't know what other people are doing. It used to be if you wanted to know what was being done over here you had to read **the European Journal of Social Psychology** and now that is no longer the case.

DW: *One potential forum for international contribution and debate will be the new EHPS journal **Health Psychology Review** coming out in 2007. This will be the first review journal in Health Psychology and will be edited by a multi-national team. I asked Alex, as an associate editor on the new journal, what he thought it would bring to the discipline:*

AR: People aren't doing enough theoretical writing and thinking and critiquing and that's a real problem. I think there are a number of reasons for it, one of them is actually structural - people are going to write the things that they know are going to get published, and I know from my own experience, getting theoretical papers around health published can be difficult. So I think the journal affords a phenomenal opportunity for theoretical innovation. The arrival of the new journal will really serve as a spur [for] new ideas, new thinking, more critical thinking about theories, and more integration of findings. However, the success of this new initiative will depend on people starting to write types of articles that they haven't tended to work on in the past. I think its going to take a little bit of time to get up to speed but once it does I predict that it will be so successful that it will breed competitors. But if you've got a system where everybody across the globe is reading and writing in the same journal you'd think that has to be productive.

DW: *I asked Alex what he thought about the future of health psychology generally.*

AR: The future is interdisciplinary collaborations that link different levels of analysis whether it's the psychological and the structural or the psychological to more biological experiences. The trick is going to be doing it in a way that everybody is equally comfortable around the table and everybody's contribution is equally valued. The push towards all these interdisciplinary initiatives sometimes makes people worry "well does that mean I not only have to be a social psychologist but also I now need to be a doctor and a bio-statistician and an anthropologist?" and my answer is no - what you need to be is a really good X whatever X is, but at the same time you have to also be able to interact effectively with people who do Y as opposed to X. We may find that our ability to engage in

these conversations and interactions will naturally evolve as we engage in more and more interdisciplinary collaborations.

DW: *In terms of his own work, Alex sees himself developing research on process health messages and decision making, using experimental techniques to empirically test and develop theory-based interventions.*

AR: I see my own work as continuing to try to demonstrate that you can do basic science and develop a rich understanding of the decision processes that people engage in as they reason about their health and then take those principles and integrate them into interventions in order to see how those principles really work in complex environments. I am a strong believer in the power of the laboratory and there is tremendous value in being able to use a controlled laboratory setting to get rid of all of the noise in order to obtain a clear look at the relationship between two variables. But we sometimes forget that one of the reasons we controlled the noise was that it probably matters in some way or another and so you have got to, at some point, let it in, and interventions are a phenomenal way [to do that].

DW: *More philosophically, Alex would like to further explore the systems and structures that scientists work in and how we can change existing practices and perceptions to advance the field.*

AR: I've become more and more interested in studying how we as researchers think and act -- what shapes the thinking and work we do, how the systems we utilize operate? [People need to be more] comfortable with the value of challenging their ideas and finding out when their predictions do not hold. We need to appreciate the value of learning not only when and where a variable predicts behaviour, but also when and where it does not. It would be wonderful if everything was simple; that we could rely on three variables to explain behaviour and could assume that they matter all the time. If this were true we could quickly put ourselves out of business and go on vacation, but unfortunately life is more complicated than that and we need to be more comfortable with this idea.

Those seeking to explore Alex's theoretical discussion further can read about some of the themes from the DHP keynote speech in his article:

Rothman, A.J. (2004). "Is there nothing more practical than a good theory?": Why innovations and advances in health behavior change will arise if interventions are used to test and refine theory. *International Journal of Behavioral Nutrition and Physical Activity*, 1:11.

keynote report

Emotions and the heart: psychological risk factors for cardiovascular disease

by Professor Derek W. Johnston

The past

The idea that emotions contribute to heart disease has a long history. In the 18th century John Hunter, the Scottish surgeon and anatomist, and a famously quick tempered man with angina, reportedly said “My life is in hands of any rascal who chooses to tease or annoy me”. He died of a heart attack after losing his temper at a committee meeting in his medical school. Over 100 years ago William Osler, a Canadian physician with a dominant position in Anglo Saxon medicine described the typical heart disease patient as “a keen and ambitious man, the indicator of whose engine is always at ‘full speed ahead’”, i.e., an early recognition of the Type A personality. Today if you ask survivors of myocardial infarction (MI) what they think caused their heart attack, 70% believe that stress is involved (Gudmundsdottir, Johnston, Johnston, & Foulkes, 2001). Despite this long history and the current lay acceptance of the link between emotion and heart disease, the scientific study of the association is comparatively recent. Only 30 years ago, Weiner’s (1977) massive text book on psychosomatics “Psychobiology and Disease” did not include a chapter on heart disease and myocardial infarction (MI) had only two entries in the index. Dorothy Levenson’s (1994) splendidly gossipy history of the American Psychosomatic Society hardly mentioned cardiovascular disorders (CVD) until Type A personality is first mentioned in the 1960s. Perhaps most surprisingly no paper on CVD was included in “Classics from Psychosomatic Medicine, 1959-1979”. There were exceptions to this apparent lack of interest in heart disease. Friedman and Rosenman started their highly influential work in the late 50’s that culminated in the report of the Western Collaborative Group study in 1975 and in 1977, Jim Henry summarised his extensive studies of the effects of stress on the cardiovascular systems of mice and placed it in a wider social and cultural context in his wonderful monograph “Stress, Health and the Social Environment” (Henry & Stevens, 1977). However it is broadly true that the scientific study of the role of emotion as a risk factor for cardiovascular disease is a product of the last forty years.

How far have we gone?

In attempting to establish the importance and possible causal significance of a risk factor epidemiologists still rely on Bradwell Hill’s famous eight criteria. These are strength of association,



Professor Derek W. Johnston
Professor of Psychology
University of Aberdeen

consistency, specificity, temporality, biological gradient, coherence (perhaps more usually seen as biological plausibility), experiment and the little considered category of analogy. When we apply these criteria to emotion as a risk factor in cardiovascular disease it can be argued that the greatest advances have been made on the psychobiological basis of cardiovascular disease (biological plausibility); prospective epidemiological studies of emotion and CVD (temporality) and the greatest disappointment has been in the comparative failure of interventions designed to alter emotion to reduce subsequent CVD (experiment).

Biological Plausibility

The dominant psychobiological model is some variant of the reactivity hypothesis first proposed by David Krantz and Steve Manuck in 1984. This deceptively simple model proposes that stress (and by implication negative emotions) lead to altered physiological response in some people and that these responses are harmful to the arteries. The model usually incorporates a diathesis (vulnerability) component and asserts that specific individuals are, because of inherited or environmental influences, susceptible to the effects of stress or emotion, and hence if exposed to stress will suffer health damaging consequences. The reactivity hypothesis is usually applied to the effects of chronic stress (or repeated acute stress) on arterial deterioration but it is now also appreciated that stress and emotion play an important role in the acute process that trigger acute coronary events, such as a myocardial infarction (Johnston, 2002). Understanding of the pathophysiology of arterial deterioration and acute coronary events has changed dramatically in the last

(Continued on page 10)

keynote report (cont'd)

(Continued from page 9)

decade and it is now appreciated that it is a very active, highly complex process in which inflammatory mechanisms are critically involved. The reactivity hypothesis was originally proposed in a period when CVD was seen as a rather simple passive process and there was a danger that emotion would be seen as less and less important as our physiological understanding increased. The opposite has in fact happened and the last few years have seen the emergence of several essentially similar well documented and plausible models of the role of stress, emotion and related processes in cardiovascular disease (Black & Garbutt, 2003; Kop, 1999; Steptoe & Brydon, 2005).

My colleagues and I have for many years been examining the relationship between cardiovascular reactivity to laboratory stressors and CV reactivity to stressors in real life. If the reactivity hypothesis is valid then those individuals who produce the largest CV response in the laboratory must react more frequently or more intensely to stressful events and emotions in everyday life. The picture that emerges from studies we have carried out over the last 15 years suggests that laboratory reactivity does indeed generalise to real life and that when individuals prone to CV hyper-reactivity encounter stressful events in real life they show increased CV reactions. In our most recent study (Johnston, Tuomisto & Patching, in press) participants who showed the largest increase in heart rate to a variety of laboratory stressors also showed much larger increase in heart rate when speaking in public and when they reported feeling tense and aroused during the day. See also Johnston (1992) and Jain, Schmidt, Johnston, Brabant, & von zur Muhlen (1998).

Prospective studies

Since the landmark Western Collaborative Group Study (Rosenman, Brand, Jenkins, Friedman, Strauss, & Wurm, 1975) there have been well over 100 substantial prospective studies of stress and emotion as possible risk factors for heart disease. Kuper, Marmot & Hemingway published an authoritative systematic review in 2002. In studies of initially healthy populations they find that depression was a reliable risk factor for heart disease in 15 out of 22 studies, as was stressful work characteristics in 10 out of 13 studies. Depression was also a reliable risk factor in populations with pre-existing cardiovascular disease (18 from 34 studies showed this). There were too few studies of work characteristics in the unhealthy group to support any conclusion. They find the evidence on anxiety to be less convincing and, in common with most other reviewers, they find no evidence that Type A or

Hostility is a risk factor in those with pre-existing heart disease and, rather more controversially, they also conclude that Type A or Hostility is not a risk factor in the healthy either. Incidentally they show that social support is a powerful protective factor in the healthy and unhealthy alike. Strike and Steptoe (2005) in a comprehensive review found that emotion and stress are important triggers for acute coronary syndromes.

Experiment (the effects of interventions)

By far the most convincing way of establishing causality is by experiment. In applied fields the experiment of choice is the randomised controlled trial in which the putative causal factor (stress, negative emotion etc) is reduced and, if the emotion is indeed a risk factor then the harmful consequence should also be reduced. Experiments of this type are expensive and difficult to mount and are consequently rare. I would like to discuss three RCTs, all with participants with pre-existing heart disease: Recurrent Coronary Prevention Program (RCPP), Enhanced Recovery in Coronary Heart Disease Patients (ENRICHED) and the exhaustion intervention trial (EXIT). RCPP (Friedman, Thorensen, Gill, Powell et al., 1984) was an attempt to reduce Type A Behaviour in survivors of a MI. It was wonderfully successful. Over a four-year period Type A behaviour was reliably reduced and recurrent MI fell by 50%. However it has not been influential, probably because of the consensus that Type A behaviour is not a risk factor in the group being studied. Scientifically the outcome is puzzling and practically, there is little appeal in altering a behaviour that appears to be unrelated to recurrent heart disease. Nevertheless something happened in the RCPP and we would benefit greatly from knowing what aspect of the complex intervention involved carried the therapeutic power, and through what mechanism. ENRICHED (Writing committee for ENRICHED investigators, 2003) has a much more secure epidemiological foundation. In this study post MI patients who were either depressed and/or perceived themselves as lacking social support (both well established risk factors) received interventions designed to deal with these risks. The results were disappointing. There was little specific effect of the intervention on depression or social support and no effect on recurrent MI. EXIT (Appels, Bar, van der Pol, Erdman, et al., 2005) was trial of a therapy designed to reduce vital exhaustion (a risk factor for recurrent MI that many see as akin to depression) in patients following angioplasty. It was equally disappointing. The intervention had little effect on exhaustion and absolutely no effect on reducing recurrent coronary events. These negative studies naturally lead one to ask if negative emotions can be

(Continued on page 11)

keynote report (cont'd)

(Continued from page 10)

usefully altered in patients following an acute coronary syndrome. Given the success of cognitive behavioural therapies in reducing emotional disorders it appears very unlikely that negative emotions cannot be helpfully reduced in patients with heart disease. Indeed we showed that a very simple intervention focusing on the patient's primary concerns reduced anxiety and depression in patients following an MI (Johnston, Foulkes, Johnston, Pollard & Gudmundsdottir, 1999).

Conclusion

- There has been an immense increase in the understanding of the mechanisms involved in heart disease. This new understanding is consistent with the view that emotional processes are risk factors for cardiovascular disease.
- There is evidence from laboratory and real life studies that stress and related emotions produce the physiological responses seen as critical in current biological models of coronary artery disease.
- There is epidemiological evidence that negative emotions, especially depression, work stress and acute stress and emotions are risk factors for Coronary Artery Disease and Acute Coronary Syndromes.
- There is not strong evidence that altering stress or emotion reduces heart disease.
- There is a need for studies that both reduce psychological risk factors and have enough power to detect effects of such reductions on heart disease

References

- Appels A., Bar F., van der Pol G., Erdman R., Assman M., Trijsburg, W., van Diest J., & Mendes de Leon, C. (2005). Effects of treating exhaustion in angioplasty patients on new coronary events: results of a the randomized exhaustion intervention trial (EXIT). *Psychosomatic Medicine*, 67, 217-223.
- Black P.H., & Garbutt, L.D., (2002). Stress, inflammation and cardiovascular disease. *Journal of Psychosomatic Research*, 52, 1-23.
- Committee of the American Psychosomatic Society. (1995). *Toward an integrated Medicine: Classics from Psychosomatic Medicine, 1959-1979*. Washington, DC, American Psychiatric Press.
- Friedman M, Thorensen C.E., Gill J.J., Powell L.H., Ulmer D., Thompson L., Price V.A., Rabin D.D., Breall W.S., Dixon T., Levy R., & Bourg E. (1984). Alteration of Type A behaviour and reduction in cardiac recurrences in post myocardial infarction patients *American Heart Journal*, 108, 237-248.
- Gudmundsdottir H., Johnston M., Johnston D.W., & Foulkes J. (2001). Spontaneous, elicited and cued causal attributions in the year following a first myocardial infarction. *British Journal of Health Psychology*, 6, 81-96.
- Henry, J.H., & Stephens, P.M. (1977) *Stress, Health and the Social Environment: A sociobiologic approach*. New York, Springer-Verlag.
- Jain, A., Schmidt, T.F.H., Johnston, D.W., Brabant, G., & von zur Muhlen, A. (1998). The relationship between heart rate and blood pressure reactivity in the laboratory and in the field: evidence using continuous measures of blood pressure, heart rate and physical activity. *Journal of Psychophysiology*, 12, 362-275.
- Johnston D.W. (2002) Acute and chronic psychological processes in cardiovascular disease. In, Schaie, K.W., Leventhal, H., & Willis, S.L., Eds. *Effective health behavior in older Adults*, New York, Springer. pp 55-64.
- Johnston, D.W., Tuomisto, M., & Patching, G.R. (in press) The relationship between cardiac reactivity in the laboratory and in real life. *Health Psychology*.
- Johnston, D.W., Anastasiades, P. Vogeles, C., Clark, D.M., Kitson, C., and Steptoe, A. (1992). The relationship between cardiovascular responses in the laboratory and in the field: the importance of Active Coping. In T. H. Schmidt, B.T. Engel, and G. Blumchen (Eds), *Temporal variations of the cardiovascular system*. Berlin, Springer-Verlag. pp 127-144.
- Johnston M., Foulkes J., Johnston D.W., Pollard B., Gudmundsdottir H. (1999) The impact on patients and partners of inpatient and extended counseling and rehabilitation: a controlled trial: *Psychosomatic Medicine*, 61, 225-233
- Kop, W.J. (1999) Chronic and acute psychological risk factors for clinical manifestations of coronary artery disease. *Psychosomatic Medicine*, 61, 476-487.
- Krantz D.S. & Manuck S.B. (1984). Acute psychophysiological reactivity and risk of cardiovascular disease: a review and methodological critique. *Psychological Bulletin*, 96, 435-464.
- Kuper H., Marmot, M., & Hemingway, H. (2002). Systematic review of prospective cohort studies of psychological factors in the etiology and prognosis of coronary heart disease. *Seminars in Vascular Medicine*, 2, 267-314.
- Levenson, D. (1994). *Mind, body and medicine: a history of the American Psychosomatic Society*. American Psychosomatic Society.
- Rosenman R.H., Brand R.J., Jenkins C.D., Friedman M, Strauss R, & Wurm M. (1975) Coronary heart disease in the Western Collaborative Group Study: Final follow-up experience of 8 1/2 years. *Journal of American Medical Association*, 233, 872-877.
- Steptoe A., & Brydon, L. (2005). Psychoneuroimmunology and coronary heart disease. In K. Vedhara & M.R.Irwin (Eds) *Human Psychoneuroimmunology*. Oxford, Oxford University Press.
- Strike P.C., & Steptoe, A. (2005). Behavioral and emotional triggers of acute coronary syndromes: a systematic review and critique. *Psychosomatic Medicine*, 67, 179-186.
- Weiner H. (1977). *Psychobiology and Disease*. New York, Elsevier.
- Writing Committee for the ENRICHD investigators (2003). Effects of treating depression and low perceived social support on clinical events after myocardial infarction: the Enhanced Recovery in Coronary Heart Disease Patients (ENRICHD) randomized trial. *Journal of the American Medical Association*. 289, 3106-3116.

conference report

Social change and new challenges for health psychology: Highlights from the 20th conference of the European Health Psychology Society

by Emely de Vet & Benjamin Schüz, Co-Editors

Warsaw, Poland played host to the 20th annual meeting of the European Health Psychology Society, held from 30 August to 2 September 2006. The program featured six keynote lectures, 231 oral and 272 poster presentations. Contributions came from all over the world, with the United Kingdom, Poland, and the Netherlands being most represented.

The theme of this year's conference being "social change and new challenges for health psychology", professor Susan Michie spoke directly to this issue in her welcome address to conference delegates. Prof. Michie expressed that health psychologists need to be aware of the social significance of their research. Health psychology research may contribute to social change by examining such things as the causes of health inequalities in society, individual self-regulatory processes in health behaviour change or inter-individual differences in adjusting to stress and illness. She also underscored that a key task for the EHPS in the future will be to establish, maintain and improve strong links to research and funding programmes within the European Union and associated countries.

Social relevancy was especially prominent in Stevan Hobfoll's keynote, which sought to demonstrate the impact of stress on people's daily lives, in particular the role of major external stressors such as war, terror and natural disasters. While these stressors threaten psychosocial and economic resources, beneficial outcomes may also result, such as tightening social bonds within the family. Indeed, the development of posttraumatic stress disorder and depressive symptoms are indirectly impacted upon by resource gains and losses due to major stressors such as terrorism. Social support may play a protective role, thereby buffering the individual from the impacts of major stressors.

Professor Ralf Schwarzer's keynote built upon this idea by providing further insight into the various facets of social support and the way in which support may protect from negative stress

responses. He discussed the importance of shifting perspectives on the relationship between social support and self-efficacy. On the one hand, receiving social support might foster optimistic control beliefs, but on the other hand, self-efficacy might facilitate seeking and receiving social support.

EHPS 2006 Conference Evaluation (N = 54)

summarised by Andries Oeberst

Membership Status

Full Member = 33

Student = 13

Eastern European = 1

Non-member = 7

Previous EHPS conference attendance

Yes = 39

No = 15

Balance of programme

	Fine	Too much	Too little
Nr of orals	47	7	0
Nr of poster sessions	42	8	1
Nr of posters	37	15	0

Another socially relevant topic at the conference was the aging and life-span approach to health psychology. In many Western societies, medical and social improvements are allowing people to live longer lives. As the baby-boom cohort ages, continued efforts aimed at promoting (mental) health and prevention of degenerative diseases and illness in this stratum of the population presents a particular opportunity for health psychology both now and in the future.

Additionally, the communication of genetic risks, transforming societies, the role of social-economic status, social context and culture in health represent challenges for future health psychology research.

(Continued on page 13)

conference report (cont'd)

(Continued from page 12)

Health psychology can also contribute to social change by increasing our theoretical understanding of health behaviour change. Consistent with earlier EHPS meetings, this year's meeting emphasised testing health behaviour change theories and

The program quality

"How would you rate the quality of the..."

(1=poor/ 5=excellent)	M	SD	Range
...conference in general	4.2	0.8	2-5
...scientific program	4.0	0.8	1-5
...keynotes	3.6	0.8	2-5
...oral presentations	3.8	0.7	2-5
...poster presentations	3.7	0.8	1-5
...chairing 4.1	0.8	1-5	

The conference quality

"How was the..."

(1=poor/ 5=excellent)	M	SD	Range
...time schedule	4.2	0.7	2-5
...conference venue	4.1	0.8	2-5
...social program	3.9	0.9	1-5
...accommodation	4.0	1.0	1-5

summarised by Andries Oeberst

interventions based on these theories. It is noteworthy that the standards discussed and applied in the testing of these theories have improved to a great extent towards stricter testing, thanks to the introduction of the use of standardized protocols as suggested by the CONSORT statement. Not only has the testing of theories improved, the theories themselves have also experienced a shift. From motivational theories such as the Theory of Planned Behaviour to stage theories and goal and self-regulation theories, the focus has shifted from the more distal view of behaviour change as a result of motivational processes to a more proximal view of the micro-processes involved in the actual regulation of behaviour change. Such proximal views may imply that health behaviour change activities should be guided by individuals' prioritizing and setting of goals, their deciding on how to achieve a goal, and to planning the entire sequence of activities that is needed to achieve a goal.

Although there seems to be a shift in theorising on health behaviour change, most of health psychology models still rely on the assumption that

health behaviour change is a rational process determined mainly by cognitions. Although research suggests that cognitions and behaviour are less consciously controlled than previously thought, the models we apply remain untouched by these insights. In his keynote lecture, Professor Paschal Sheeran pointed out that health behaviour may be the result of dual processes. In his lecture he showed that health behaviour is caused by both rational as well as irrational processes. A future challenge of health psychology research and theorising is in translating both routes into effective health promoting interventions. One example for such dual processing would be the processing of risk information, where information on health threats is processed consciously and eventually transformed into protective measures, while at the same time eliciting emotional responses to health threats such as fear.

Alexander Rothman outlined that it is crucial to transfer these ideas into sound theory-based interventions which can then be used to test the assumptions of theory. This remains a key challenge for health psychology on its route towards increased scientific rigour and social impact.

"How would you rate the conference in terms of..."

(1=poor/ 5=excellent)	M	SD	Range
...value for money	4.0	0.8	2-5

"How well did the conference facilitated the following aims and objectives?"

(1=poor/ 5=excellent)	M	SD	Range
...dissemination of good quality research	4.0	0.8	2-5
...opportunities to meet and talk with colleagues	4.2	0.9	1-5

summarised by Andries Oeberst

In closing, the city of Warsaw provided an ideal setting for discussion of the role that health psychology can play in achieving social change. Many future challenges and opportunities were outlined, and we look forward to discussing the progress that a year brings at this year's 21st annual meeting in Maastricht, the Netherlands from 15-18 August 2007.

EHPS 2007 conference announcement



EHPS 2007
European Health Psychology Society

21st Conference of the European Health Psychology Society

“Health Psychology and Society”

Maastricht, the Netherlands
August 15th – 18th 2007

Conference website: www.ehps2007.com

Deadline: early registration May 1, 2007

Maastricht University and Hasselt University are very pleased to invite you to the 21st EHPS Conference to be held in Maastricht, The Netherlands, with satellite events at Hasselt University, Belgium.

The EHPS Conference presents a platform for health psychologists to present the latest empirical research findings, reviews and conceptual innovations. The central theme of this conference is health promotion and interventions at a population level, specifically the role of health psychology in understanding the problems that our society encounters and in finding solutions for those problems. Aspects of this broad main theme will be discussed in keynote lectures and invited symposia.

For further information contact the Conference office: ehps2007@fd.unimaas.nl

EHPS 2007 funding announcements

The Executive Committee of EHPS is pleased to announce that EHPS and its interest groups CREATE and Synergy will be able to offer grants to support conference and/or workshop attendance at our Maastricht 2007 Annual Conference. This year we are offering a total of seven grants. The purpose of these grants is to encourage talented researchers and graduate students who don't have access to funding to attend the EHPS conference and CREATE or Synergy workshops. We hope that this experience will encourage them to be more involved in the Society and its interest groups in the future.

Grant Description

For the upcoming 2007 conference the following grants will be offered:

Synergy Workshop participants: 2 grants for researchers who plan to attend the Synergy workshop and who are EHPS members. Each grant is for €500 toward workshop registration and travel.

CREATE Workshop participants: 2 grants for graduate students who plan to attend the CREATE Workshop. Each grant is for €300 toward workshop registration and travel.

EHPS Conference only: 3 grants for graduate students and researchers. Each grant is for € 500 toward conference registration and travel. Grant is contingent upon acceptance of your paper or poster for the conference.

Grant application

For further details about this grant and application materials, please go to www.ehps2007.com

Deadline for the grant applications is May 5th, 2007. You will be informed of the results by May 15th, 2007.

Please send all application materials electronically (include scanned copies of the official letters and student ID cards) to Karen Morgan at: kmorgan@rcsi.ie

EHPS 2007 conference workshops

CREATE 2007 Workshop**“Intervention Mapping”**

12th – 14th August, 2007
Hasselt, Belgium

Facilitators

Prof Gergo Kok, Prof Herman Schaalma, Dr. Rob Ruiter

Application deadline

May 11th, 2007

Payment deadline

June 15th, 2007

For more information or to apply:

<http://www.ehps.net/create/>

SYNERGY 2007 Workshop**“Culture, health and illness representations – Developing an international agenda for cross-cultural health psychological research”**

12th – 14th August, 2007
Hasselt, Belgium

Facilitators

Michael Diefenbach, Alison Karasz, Jeanne Edman

Submission deadline

March 23rd, 2007

Registration deadline for accepted workshop participants

June 30th, 2007

For more information or to apply:

<http://www.ehps2007.com/Synergy.html>

Pre-Conference Workshops**“Advanced Interpretative Phenomenological Analysis”**

Afternoon August 14th – Morning August 15th
2007

Facilitator

Jonathan Smith, Birkbeck College, London

Level

Intermediate, Advanced

Prerequisites

Participants in the workshop must have conducted some work with Interpretative Phenomenological Analysis (IPA).

For more information:

www.ehps2007.com

“Economic Evaluation of Health Promotion Interventions”**Facilitators**

Sylvia Evers & André Ament, Maastricht University, The Netherlands

Mixed Models / Multilevel Models”**Facilitator**

Geert Molenbergs, Hasselt University Belgium

<http://www.ehps2007.com/pre-postconf.html>

Post-Conference Workshop**“Four Fundamental Qualities of Qualitative Research: Epistemology, Ethics, Reflexivity, and Interpretation”**

August 18th 2007

Facilitator

Kerry Chamberlain, Massey University, New Zealand

Level

Introductory, Intermediate

Content

This workshop will focus on improving the quality of qualitative research practice by examining the fundamental assumptions underlying practice, and exploring how these impact on research practices and practical ways in which these can be incorporated into a qualitative project, regardless of the specific methodology adopted.

For more information:

www.ehps2007.com

conference announcements



6th Annual Meeting of the International Society for Behavioral Nutrition and Physical Activity

Oslo, Norway
June 20th – 23rd 2007

Conference website

<http://www.isbnpa.org/meeting.cfm>

Deadline for submission of late breaking abstracts (posters only)

March 18, 2007

Deadline for early registration

April 30, 2007



XXIXth International Congress of Psychology

Berlin, Germany
July 20th – 25th 2008

Conference website: <http://www.icp2008.org/>

Deadline for abstract submission

31 October 2007

First deadline for reduced congress registration fee

1 February 2008

Deadline for submission of rapid communication posters

1 March 2008

Second deadline for reduced congress registration fee

20 June 2008

Division of Health Psychology Annual Conference 2007

University of Nottingham Park Campus
September 12th – 14th 2007

Conference website

<http://www.dhp2007.org.uk>

Registration will open in April 2007

To be added to the registration waiting list please contact the BPS Conference Office:

Tel: 0116 2529555

Fax: 0116 2557123

Email: dhpconference@bps.org.uk



Fifth Biennial Conference of the International Society of Critical Health Psychology

Boston North Shore
Endicott College Campus
July 18th – 21st 2007

Conference Website:

<http://www.ischp2007.org>

conference announcements (cont'd)

**Xth European Congress of Psychology**

**Prague, Czech Republic
July 3rd – 6th 2007**

Conference website
www.ecp2007.com

Late registration deadline
May 31, 2007

**IV^e Congrès International de
Psychologie de la Santé de Langue
Française**

**Toulouse, France
June 20th – 22nd 2007**

**First Conference of the
Central and Eastern European
Society of Behavioural Medicine**

**Pécs, Hungary
August 20th – 22nd 2007**

Conference website
<http://www.cebem-net.hu/>

Deadline for workshop/teaching proposals
April 30, 2007

Deadline for abstract submission
May 31, 2007

Deadline for early registration
June 30, 2007

advertisement

**SPECIAL ISSUES IN HEALTH PSYCHOLOGY:
A GREEK PERSPECTIVE**

Edited by F. Anagnostopoulos and E. C. Karademas
Forwarded by Prof. Susan Michie

Special Issues in Health Psychology: A Greek Perspective reflects advances in European Health Psychology regarding “all walks of life”, such as in-patient and out-patient health services, as well as schools, prisons, and communities. The Edition provides an in-depth treatment of specific topics within Health Psychology and includes 13 chapters (in 345 pages) divided into two sections: (1) good health maintenance, health promotion and disease prevention; (2) illness behaviour and health-care quality. The Edition presents the research activity undertaken and the knowledge gained by Greek health psychologists working home or abroad.

The authors have tried to give some answers to critical and interesting issues: immunisation and parental decisions, smoking prevention, sexual behaviour among inmates, cancer related information seeking, quality of life in end-stage renal disease, older people with cancer, communication skills, quality of life of men with erectile dysfunction, the impact of culture on cancer attitudes, PTSD following a physical illness, school quality of life, cross-cultural factors in patient satisfaction, CBT for health anxiety and somatic complaints.

Special Issues in Health Psychology: A Greek Perspective is published with the support of the Division of Clinical and Health Psychology of the Hellenic Psychological Society.

Livani Publishing
Athens 2007
ISBN: 978-960-14-1398-3

ehps new members

The European Health Psychology Society would like to welcome

Philippe C.G. Adam	Stephan Dombrowski	Lukasz Kaczmarek	Beatriz Rueda
Bogdana Alexandrova	Louise Donnelly	Theano Kalavana	Vesselina Russinova
Pascal Antoine	Frank Doyle	Friederike Kendel	Osvaldo Santos
Katja Antoniw	Hans Feenstra	Karen Maeve Keogh	Maya Schroevers
Emily Arden-Close	Marisa Finn	Noem Keresztes	Arie Shirom
Chris Armitage	Maria Fotiadou	Willemieke Kroeze	Ingrid Steenhuis
Jennifer Ashcroft	Jill Francis	Claudia Kufeld	Veronika Ströbl
Elisa Barilli	Sónia Maria Gomes	Rita Kulakauskaite	Aurora Szentagotai Tatar
Kristina Beliauskaite	Alexandre Galinha	Ida Larsen	Ghiorghe Talau
Svein Bergvik	Andrea Gibbons	Anthi Loutsiou-Ladd	Jochen René Thyrian
Sandra N. Boersma	Fabien Girandola	Raimmonda Lukosiunaite	Dominic Upton
Mirela Bogatean	Elena Gluchova	Natalie Mallach	Daiva Vaitkute
Evelina Bogdanova	Silke Gräser	Noleen McCorry	Eija Valli
Melanie Braun	Jolita Grigaityte	Stefania Miclea	Winfried Van der Sluijs
Silke Burkert	Indre Grinciute	Olga Missiriadou	Lidiya Vasileva
Amanda Chng	Anneli Hardy	Maria Nicoara	Mona Vintila
Veronique Christophe	Ari Haukkala	Sam Nyman	Rimantas Vosylis
Sinéad Conneely	Monique Heijmans	Ringaile Petrikonyte	Thomas Webb
Etã Sobal Costa	Harriet Hogarth	Katarzyna Pietron	Marleen Williams
Irina Catrinel Craciun	Nicholas Hulbert	Diana Prialgauskaite	Lee Williams
Hannah Dale	Nigel Hunt	Vinga Rakauskiene	Rachmad Djati Winarno
Bridget Dibb	Yousaf Jamal	Tabea Reuter	Alison Wright
Vithleem Dimitrakaki	Daphne Jansen	Mieke Rijken	
Diane Dixon	Francine Jellesma	Alexander Rothman	

ehp editorial board

editors

Falko Sniehotta

University of Aberdeen, Scotland
f.sniehotta@abdn.ac.uk

Vera Araújo-Soares

Alliance for Self Care Research
The Robert Gordon University, Scotland
v.l.b.araujo-soares@rgu.ac.uk

co-editors

Bejamin Schuez

Free University of Berlin, Germany

Dawn Wilkinson

University College London, England

Emely de Vet

VU Universiteit Amsterdam,
the Netherlands

Gerard Molloy

University College London, England

Nihal Mohamed

Mount Sinai Hospital,
United States of America

editorial assistant

Justin Presseau

University of Aberdeen, Scotland

ehps executive committee (2006-2008)

president

Britta Renner

International University Bremen, Germany

president elect

Irina Todorova

Health Psychology Research Center, Bulgaria

past president

Susan Michie

University College London, England

secretary

Yael Benyamini

Tel Aviv University, Israel

membership officer and treasurer

Christel Salewski

Magdeburg–Stendal, Germany

ordinary members

Winifred Gebhardt

Leiden University, the Netherlands

Vera Araújo-Soares

Alliance for Self Care Research
The Robert Gordon University, Scotland

David Hevey

University of Dublin Trinity College, Ireland